Case Comparative Analysis of Select Market-Based Pioneer Accountable Care Organizations

A report by staff from the Division of Health Policy and Management of the School of Public Health at the University of Minnesota for the Medicare Payment Advisory Commission

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September 2014

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An In-Depth Exploration of First Year Experiences of Comparable Organizations Participating in Pioneer ACO in Select Markets

Abridged Report prepared for the
Medicare Payment Advisory Commission

July 30, 2014

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Acknowledgements

We gratefully acknowledge the many Pioneer ACO leaders and organization executives who generously provided time within their busy schedules to participate in our site visits and data gathering about their experiences with the Pioneer ACO program. We appreciate the many individuals who made our site visits to these Pioneer ACOs possible, especially the many support staff at these sites who coordinated schedules, procured conference rooms and telephones, made site visit arrangements and attended to numerous details that were critical to our on-site visits. We are grateful to our MedPAC program officer, David Glass, Principal Policy Analyst, and his staff for their comments, questions, and guidance on the project. Finally, we appreciate the support of the Medicare Payment Advisory Commission for the opportunity to conduct this special study project.

The research guiding this report was completed with support from the Medicare Payment Advisory Commission, contract MED14P0032. The findings and interpretations are those of the authors. Endorsement by MedPAC is not intended, nor inferred herein.

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Executive Summary

Underpinning Medicare's Pioneer Accountable Care Organization (ACO) Model are provider incentives designed to encourage organizational innovation in service delivery to improve quality of care, patient experience, and lower growth in expenditures for the Medicare fee-for-service (FFS) population. Early findings from an evaluation of the effects on Medicare spending for the 32 Pioneer ACOs' first year experience show that for the majority of Pioneer organizations, spending growth per beneficiary was similar to their local markets. However, eight of these Pioneer ACOs "had significantly lower growth in total Medicare spending per beneficiary than their local market comparison groups" [1]. Yet for Pioneer ACOs of similar organization types operating in the same market, where one might expect similar results, the results were mixed.

Given these differences in results, it is appropriate to examine the organizational context and strategies used by Pioneer ACOs as they implemented their ACOs in order to help inform the Medicare Payment Advisory Commission's (MedPAC) work in evaluating and improving the Pioneer ACO and Medicare ACO programs. To better understand these issues, MedPAC contracted with the University of Minnesota to collect and analyze information from Pioneer ACOs in three markets regarding market dynamics, organization structure and history, ACO capitalization, business strategies, program incentives, working relationship with the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI), operational implications of Pioneer ACO work, their first year results as compared with expectations, and other contextual factors affecting their Pioneer ACO results.

In an attempt to discern differences in Pioneer ACO strategy, implementation, and context, the University of Minnesota research team conducted site visits and interviews with key informants from paired organizations of similar type (integrated delivery systems [IDSs], physician groups, and independent practice associations) in three distinct, large metropolitan markets situated in the southwest, north central, and northeast geographic regions of the United States. We used findings from these interviews to create a case study of the first year Pioneer ACO approach for each organization. To examine Pioneer ACO approaches and experiences within each geographic market, we compared the case study findings of similarities and differences between paired organizations in each market. These findings are briefly described in the executive summary and are described in more detail in the full report (which was made available to MedPAC Commissioners and staff). Finally, we examined case study findings across all six sampled organizations. Findings from this comparison are presented in the executive summary below. Because the organizations in this study were not randomly selected,

the organizational strategies described as more or less beneficial to achieving results in these Pioneer ACOs do not necessarily reflect the prevalence of similar approaches used in Pioneer ACOs across the country.

In general, while the ACO organizations compared in this study are of similar organization type and serve Medicare patients in the same geographic market, they differed on dimensions that appear to have influenced their first year experience with the Pioneer ACO program. The executive summary below describes these differences and apparent influences on their Pioneer experience. In this case study comparative report document, we report the statements of respondents from sampled ACOs and draw our findings from these statements. We do not make any judgment as to whether these statements accurately reflect cause and effect of aspects of the program or market dynamics, or that those statements necessarily represent a technically accurate description of the Pioneer program and its overall impact to date.

Summary of Findings across All Three Study Markets

Organizational characteristics. These Pioneer ACOs varied on numerous attributes, including: organization type (e.g., integrated delivery system, physician group, or independent practice association); structure (e.g., partnerships versus employed assets models); infrastructure (e.g., breadth and depth of information technology capabilities and analytic capability); level of engagement of primary care providers around value-based care strategies across payer types; depth of care management programs (e.g., care coordination, case management, transitions options, skilled nursing programs, and emergency department case coordination); and history with managed care systems.

These organizational factors combined with varying market dynamics, such as the penetration rate of Medicare Advantage, and the illness burden and socio-demographics of the population served, all influenced which levers were available to the Pioneer ACOs to drive behavior change and system transformation. The combination of these elements and the aforementioned organizational characteristics differed across the ACOs in this study.

Motivations for entry. There was some variation in the reported motivations for entry among these ACOs, including reputation in the marketplace, desire to participate with CMS on this major innovation, desire to align the ACOs' Medicare patients with other payers' ACO arrangements, and the desire to be "part of the solution." ACOs that were most successful balanced those motivations with rigorous analyses to identify their expected attributed ACO population and to forecast their financial performance. Additionally, some conducted analyses to select providers for their ACO network. One organization reported that the decision to enter the

program was made by executives without any rigorous analysis. In contrast, another organization used extensive provider profiling to find their most aligned physicians and recruited them to enter the program.

Execution of strategies. Organizations utilized a variety of strategies to manage beneficiaries' care across the continuum. The most prevalent beneficiary-focused intervention was the use of care managers, particularly among recently hospitalized beneficiaries. Other examples included receipt of care by hospitalists employed by the ACO, home visits to assess beneficiaries' living conditions and functional status, and embedded providers within skilled nursing facilities. Organizations also highlighted several provider-focused programs, such as regularly scheduled utilization and spending reports; interdisciplinary care team conferences for discussing a provider's high risk patients; and provider training in palliative care communications.

Information to support program and care management. Each organization had the necessary infrastructure in place to manage administrative claims data and to conduct analyses. Organizations noted the importance of using data to perform risk stratification and to generate reports on beneficiaries' utilization and spending. These analyses were used to facilitate identification of patients for whom additional interventions could be directed, such as case management. In general, the Pioneers entered the program with advanced information technology (IT) capabilities. Among those, the Pioneers with the most advanced capabilities around risk stratification and other actuarial functions had the greatest advantages. Pioneer ACOs use of a single electronic medical record was not a major determinant of success, as the two ACOs that achieved shared savings used multiple electronic platforms. However, several Pioneers did note that using a single platform made implementing care management interventions and collecting data for quality reporting easier. Several organizations also noted that they developed many of the quality reporting tools for the Pioneer program independently of their EMR vendors, as those vendors did not support the Group Practice Reporting Option (GPRO) reporting process through standard development.

Quality performance measurement. All of the participating Pioneer ACO organizations emphasized concerns about the choice of quality measures for the Pioneer program, reporting requirements, and quality benchmarks. Quality benchmarks were seen by respondents as having been based on the experience of a non-comparable quality measurement program, and some quality benchmarks as unrealistic to achieve. Organizations cited several examples of problems with measure selection and definitions. Some independent practice association (IPA) organizations also emphasized particular challenges related to pulling charts to facilitate the measurement of certain outcomes, such as fall risk assessment. Most organizations also

expressed frustration regarding the process of reporting quality measures, noting that mid-term introduction of major changes to the process by CMMI provided insufficient time for them to respond, and that they did not feel that CMMI took into consideration the magnitude of costs incurred by the organizations related to fulfilling these changing reporting requirements.

Physician engagement. The Pioneers' ability to engage their physicians in the ACO was reported to be a major determinant of their success. There were several organizational and contextual dimensions that affected this ability, namely:

- Panel size: There were differences in the number of individual Pioneer beneficiaries affected and how frequently and effectively an organization could communicate with physicians. For example, one ACO described the challenges of communicating specifically about Pioneer to a primary care physician (PCP) with only 2-3 attributed beneficiaries.
- Approach to care management initiatives: The ACOs implemented different approaches to engaging their physicians in care management. For example, one ACO used a decentralized approach to care management, leaving it to the individual practices to implement care management, whereas other ACOs centralized the implementation.
- Financial incentives: Several organizations reported that they wanted to distribute financial incentives to physicians based on individual physicians' performance to reward their efforts, but few had done so to date.

Attribution and beneficiary engagement. Participating Pioneer ACO organizations expressed concern with the existing attribution model and felt that it limited patient engagement options which became a barrier to patient identification with the ACO. The integrated delivery systems with historical evidence of a close attachment of their existing Medicare patients to their system were more comfortable with accommodating these limitations inherent in the attribution method and also in accommodating the Pioneer program's constraints on the type of communication with the attributed patients that was allowed. However, less well integrated independent practice associations and more recently formed medical groups desired greater opportunities to increase attributed patient recognition of and identification with the new ACO. Further, medical groups with extensive managed care experience wishing to fully implement the array of care management systems being used for their capitated managed care population strongly advocated even more active options for patient identification, such as an identification card that identifies them as a Medicare Pioneer ACO patient as they seek care. 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. Even though most organizations in general advocated further movement in

program design away from traditional FFS toward managed care, they also acknowledged the need for an ACO alternative to managed care plans. One organization with an extensive experience with and a preference for managed care plans noted that while baby boomers appear to have greater comfort with managed care plans than earlier cohorts, there would likely always be those who would not join a managed care health plan and for whom the ACO is their best option for receiving coordinated care.

These organizations also varied regarding the extent of care being provided to their attributed beneficiaries by non-ACO providers, so-called "leakage". The relative extent of leakage across the ACOs seemed to be related to the initial degree of Medicare beneficiary attachment to the delivery system before entering the ACO program. That also may have produced the ACOs' varying degree of estimation accuracy in planning for which patients would be attributed to their Pioneer ACO.

Perspectives on the savings model. The savings model included a cost component which compared an expected per member per year (PMPY) cost target or benchmark with an ACO's actual PMPY cost using a methodology that accounts for risk selection. In addition, a quality component established the portion of any cost savings that could be claimed by the ACO based on achieving quality benchmarks. The universally expressed opinion of the participating ACOs was that the cost benchmark that is based on FFS trends was unfair for already low cost ACOs. Study participants also noted they believed that where there was high Medicare Advantage (MA) penetration, the FFS patients remaining who were eligible for ACO attribution were of higher risk than is available for attribution in low MA markets. They further believed that this higher relative risk was not adequately accounted for under the existing method. Risk selection had been addressed by comparing cost changes over time for the same cohort of ACO patients. In addition, an adjustment for differences between the ACO's population and the Medicare FFS benchmark reference population was based primarily on age and gender risk factors. All but one ACO reported that they would prefer a risk adjustment method based on claims-based morbidity data rather than the current method. Most organizations also advocated for a prospective benchmark to replace the retrospective trend method. Additionally, these ACOs stated they did not fully understand the behavior of the decedent adjustment and, combined with the retroactive trend component, believed the model was "unnecessarily complex." They also noted that the model seemed overly sensitive to factors other than an ACO's performance at achieving savings, and that it made it very difficult for organizations to effectively monitor and forecast outcomes. Finally, as discussed above, there were also universal and strong objections to what was described as the "unrealistic" benchmarks for the quality performance component of the savings model.

ACO recommendations for program improvement. Because these participating Pioneer ACO organizations had at least some established experience base with other payers in risk-based contracts, capitation arrangements, and other performance and value-based contracts (including Medicare Advantage plans), they understood how to work with payers and beneficiaries around the sets of program design options that can be applied in these products for success. All of the participating organizations had recommendations regarding the use of alternative approaches in the areas of plan design and benefit design features, attribution or assignment methods, beneficiary identification and engagement, and the payment model. They acknowledged the constraints on CMS for changing many policies and practices of the current FFS Medicare program, but would like to further explore options to improve flexibility to better achieve the goals of the Pioneer ACO and ACO initiatives in general.

A common concern among the ACOs was that the Pioneer program retains too much of its open-ended, fee-for-service (FFS) roots, which they perceive as severely limiting their ability to improve continuity and care coordination. The ACOs in the southwest and northeast regions preferred a managed care, HMO-like model, but knew that was not feasible. All ACOs recommended changes that would move closer to a preferred provider organization, preferred provider organization (PPO)-like or tiered network type model. Suggestions included a less passive alignment method, one that better aligns the attributed beneficiary with the ACO such as having the beneficiary prospectively identify their primary care provider, or a benefit design that supports in-network care such as a cost-sharing reduction for care provided in-network. This benefit design would have the added value of requiring the branding of the ACO and improving the alignment of the beneficiary with the ACO. One such option mentioned is a PPO-like Medicare supplemental insurance product. Even without such a benefit option, the ACOs in general are seeking opportunities to increase beneficiary identification with and attachment to the ACO.

Pioneer ACOs' relationship with CMS and CMMI: These participating Pioneer ACO organizations expressed a desire to be seen as partners in research and experimentation with CMS rather than solely as demonstration project participants. These ACO leaders stated that CMS and CMMI were making a good faith effort and "doing the best that they can." However, they expressed a desire to work more closely with the agency in structuring innovative processes and interventions that support doing ACO work and population health management in their unique organizational settings and contexts.

In summary, while the ACO organizations that were compared in this study are of similar organization type and serve Medicare patients in the same geographic market, they differed on

dimensions that appear to have influenced their first year experience with the Pioneer ACO program.

Executive Summary Pairwise Market Comparisons

This section summarizes key similarities and differences between each pair of Pioneer ACO organizations located in the three geographic markets on the dimensions of motivation for entry, preparation for program participation, care management initiatives, quality measurement and reporting, and suggestions for changes to the Pioneer program design. The organizations are designated in this report by labels that first refer to their geographic market region in the United States (NC for the North Central, SW for the Southwest, and NE for the Northeast regions) followed by a "1" or "2" to designate the specific Pioneer ACO.

Select North Central Market Region Pioneer ACOs

While both NC-1 and NC-2 are integrated delivery systems, the former developed primarily through hospital and physician group acquisition while the latter developed through organic growth of a large multispecialty group practice. These alternate pathways resulted in differences in organization, physician culture, and physician practice integration into the larger organization. NC-1 viewed Pioneer as a learning opportunity, and the next natural step in its evolution to risk-based contracting. In contrast, NC-2 saw Pioneer as a financial model improvement to the PGP demonstration in which they had previously participated, because, among other features, PGP had a lower shared savings rate. The organizations employed different approaches for engaging providers. NC-1 selectively invited providers to participate in the Pioneer ACO from within their owned practice groups, while NC-2 opened participation in Pioneer to their entire integrated primary care network. NC-1 overestimated the size of their attributed beneficiary population, and was surprised by the much smaller number and variable degree of PCP alignment of their attributed population. In contrast, NC-2 predicted their attributed beneficiary population with more accuracy, finding that the attribution produced the expected and desired population validated by their internal assignment system. The ability to more accurately predict beneficiary assignment may be due to NC-2's PGP demonstration experience.

Both NC-1 and NC-2 performed fairly rigorous preliminary analyses in preparing for the program, particularly around the potential financial returns and the size of their attributed patient populations. Also, both organizations maintained strong data infrastructures with internal capabilities for risk stratification and predictive modeling to support ACO-related care initiatives (e.g., care management and improving post-acute care transitions and efforts to reduce

readmissions from skilled nursing facilities). Both ACOs recommended waiving some FFS rules, such as was done with the three-day stay requirement, to better support care and cost management.

Concerns were expressed by both organizations about CMS's choice of specific quality measures and the targets which apply to Medicare ACOs. These organizations financed their Pioneer ACO operations as they would other payer contracts, under the assumption that these would be added operational expense and that the current systems and processes would support their Pioneer program activities. However, both of these organizations found that the actual operating costs, especially for IT and quality reporting, far exceeded their original expectations. Both organizations expressed frustration regarding the large internal costs faced by the organizations when CMMI would make changes to the quality reporting process.

Both organizations found that patients were confused by the introductory Pioneer ACO letter and data sharing opt-out instructions. Because of this and the lack of other tangible benefits that can be offered to ACO beneficiaries, both organizations concluded there was not a good reason for them to communicate with their Pioneer beneficiaries directly about their participation in the ACO program. Both organizations advocated for benefit features like a reduced cost-sharing benefit for Pioneer ACO patients to increase their engagement and loyalty to the provider.

NC-2 respondents added that for them, conducting beneficiary outreach, given the program constraints on what can be communicated and how it can be communicated, added more confusion than was beneficial for understanding the program. They felt that with their brand knowledge and loyalty, and their history of special programs for their Medicare patients, they did not need to add this confusing new beneficiary message about Pioneer ACO; while NC-1 respondents were mixed about the importance of beneficiary engagement in their program performance. NC-2 reported that less than 1% of attributed beneficiaries opted-out of information sharing. To them, this seemed to attest to the brand loyalty and trust they had developed independent of the Pioneer ACO program.

Both ACOs expressed the concern that the payment model was too complex, with inputs that seemed hard to predict and were not directly related to their own performance, and with too much volatility throughout the year to be able to determine performance trends. Both NC-1 and NC-2 expressed concern with the current model's method of accounting for risk variation. They both were concerned that in a high penetration Medicare Advantage (MA) market like their metropolitan market area, relatively healthier beneficiaries will tend to choose MA, while a sicker cohort within each age and gender group will choose FFS. There was additional concern and puzzlement over the transparency and behavior of the decedent adjustment. Both organizations

advocated for a more interactive and responsive relationship with CMS. Both see the ACO as "still an experiment and a learning opportunity" rather than a "tried and true" model and think that CMS should better recognize that. This includes greater awareness of the variability inherent in the metrics used that may influence the performance measurement for the payment model.

Select Southwest Market Region Pioneer ACOs

Both organizations in the Southwest region (SW-1 and SW-2) had many years of experience under full capitation and delegated managed care functions through contracts with numerous Medicare Advantage health plans. They also participated in the Brookings-Dartmouth ACO initiative. Leaders from both organizations described their capabilities as quite advanced and that they were already doing population health management. These organizations expressed similar motivations for entering the Pioneer ACO program. They saw Pioneer as a natural extension of their deep capabilities in managed care and they wanted to play a role in charting the future of the Medicare program for the triple aim of improving quality, patient experience, and lower growth in expenditures for the FFS population.

Despite having similar organization structures, large independent practice associations, and having an overlapping Medicare FFS market geographic service area, these organizations reported very different populations among attributed Medicare FFS beneficiaries in their respective Pioneer ACOs. SW-2 noted that the attribution method produced the expected and desired population, whereas SW-1 found it produced quite different results than expected.

SW-1 reported they had the highest proportion of dual (Medicaid/Medicare) eligible patients among all Pioneer ACOS, at 31% of their patient population. This statistic and the fact that 60% of their participating physicians were from the independent practice side, where the organization had very little influence or experience in working with these physicians to coordinate care on behalf of their FFS populations, made it very difficult for SW-1 to succeed with the Pioneer model. In contrast, SW-2 had strategically chosen a limited set of providers who expressed interest in participating, and who had been extensively engaged with the organization in other value-based contracts and experiences in use of care management tools and related provider health information systems. Use of this engaged limited set of providers may have contributed to SW-2's success with the Pioneer model.

Both organizations reported the use of risk stratification to inform deployment of program resources to support care coordination and management. Both also indicated the use of well-developed information systems to support provider decision-making. From these ACOs we heard both optimistic and pessimistic views with respect to the claims data provided by CMS to

the two organizations. One organization (SW-2) noted how valuable these data were (relative to not having them), while the other (SW-1) focused on issues of incompleteness (e.g., no behavioral or substance abuse claims) and the challenges they faced as CMMI/CMS modified the process of data transmission.

Both organizations criticized the choice of quality measures, and that some measures required chart pulls, which are more challenging for IPAs or those with practices using different EMRs compared to integrated delivery systems. Both ACOs voiced frustration and concern with what they described as its unrealistic benchmarks. Leaders from both organizations reported that the actual operating costs, especially in IT costs and quality reporting, far exceeded their original expectations.

Both organizations felt it would be of benefit to provide beneficiaries an identification card, similar to that done with Medicare Advantage plans or other payer plans, especially for notification when beneficiaries were either hospitalized or visited an emergency department (ED). Neither could get their ID card suggestions approved by CMMI (however, SW-1 did receive notice they could trial a card with a small number of beneficiaries, but left the Pioneer program before implementing such). SW-2 advocated for what they called the "third option" for Medicare plans (Medicare Supplemental PPO benefit design, patient self - identification, and full up-front capitation) for those ACO beneficiaries that would likely never join an HMO (their preferred model).

Both ACOs reported they preferred prospectively determined global capitation to the current approach tied to retrospective FFS trends. Both organizations reported they preferred a risk adjustment method based on claims-based diagnosis data to the current method being used to account for risk. SW-1 had evidence that their attributed patients were riskier than their MA patients and riskier than any other Pioneers' patients and felt that a more adequate method of accounting for risk selection might impact their Pioneer ACO success. More generally, leaders from both organizations strongly advocated that CMS design ACO initiatives that offer a real advantage for those true "pioneers" in the country who can move transformation along more readily. They also stressed the importance of CMS in having a flexible and timely response process to react and adjust to emerging issues related to scaling and sustaining the advances in these truly "pioneer systems," while at the same time, offering an easy on-ramp for those providers with little or no internal managed care experience.

Select Northeast Market Region Pioneer ACOs

Both Northeast region organizations (NE-1 and NE-2) are physician practice-based and comprised of medical groups and independent practice associations (IPAs). However,

differences in their specific organizational structures during the first year of the Pioneer program make this pair unique relative to the other pairs that were studied. NE-1 is comprised of six medical groups that had come together, under an IPA arrangement, for clinical integration and a shared electronic health record (EHR). Several of the groups had once been part of staff model HMOs under global capitation. After NE-2 entered the Pioneer program, they established an equal ownership arrangement with first one and then six hospitals through an umbrella organization of limited liability corporations (LLCs), i.e., hospital LLC paired with physician group LLC. This arrangement was established to improve the care system alignment specifically for the Pioneer program.

These organizations expressed differing motivations for entry. While both organizations mentioned wanting to be partners with CMS in designing payment models and getting ahead of the curve as payments moved from volume to value, NE-1 also viewed Pioneer as a payment model that would help integrate their group, which, until Pioneer, was more of an alliance of medical groups. For NE-1, Pioneer was the first contract held at the level of the IPA, rather than by the individual practices. Pioneer provided enough volume in high utilizer Medicare FFS patients that the organization and its provider groups could become "payer blind" in how they provide care management services. They also said participation was a competitive issue, considering the number of Pioneers in their market region. In contrast, NE-2 reported that their organization wanted to participate because of their academic mission and an organizational culture that invites pilot projects like Pioneer. They also shared a similar sentiment, relating the desire to treat all patients the same in a global payment model.

As "physician-centric" organizations, both Northeast region ACOs invested in developing relationships with downstream providers but differed in their hospital partnering strategies. NE-2 decided to partner directly with hospitals as part of their organization and engaged them directly in their Pioneer strategy. In contrast, NE-1 engaged hospital partners through preferred partner expectation agreements that documented explicit statements of partnering expectations and on which partners receive feedback. These preferred partner expectations agreements were also used with skilled nursing facilities (SNFs) and are being planned for use with specialty providers. NE-1 felt it had an advantage in Pioneer in that it did not own a hospital organization or SNF. Both organizations worked collaboratively (with other ACOs) to share SNF coverage as well as define guidelines for SNFs on expectations of care levels, communication levels, and discharge processes.

Both ACOs acknowledged that the attribution model for their Pioneer had produced the expected and desired populations, but each experienced some misalignment from their own system perspective. NE-1 experienced a stable year-to-year 21% churn rate due to eligibility

changes or death, but some churn between the ACO and non-ACO provider systems was apparently due to marginally shifting changes in the plurality mix of Evaluation and Management (E&M) services between the groups. NE-1 recommended that Pioneers be allowed to designate a subset of PCPs within their participating national provider identifier (NPI) list.

Both organizations were critical of the lack of completeness of the claims data they received for their attributed beneficiaries, and raised concerns about the missing information on substance abuse and behavioral health as well as on outliers who had exceeded the truncation threshold. With respect to quality reporting, both organizations indicated frustration about the lack of standardization of measurement definitions, noting issues about how the Pioneer ACO definitions differed slightly from other populations as well as how the quality benchmarks were set too high to be feasible. Both organizations described having unanticipated expenses in Pioneer, particularly in IT and quality reporting, in some part due to the changing requirements and standards of the program. Both expected that start-up costs could be absorbed into their operations, but found the infrastructure investment required was far more than anticipated.

Both organizations found that beneficiaries were confused by the Pioneer ACO notification and data sharing opt-out decision letter. One (NE-2) felt that they should not be held at risk if patients choose to opt-out of data sharing. Both organizations found patient engagement in a FFS system difficult both in terms of identification with the ACO and also the ability to know where the patients are at any point in time in a FFS system. Both organizations advocated for patient self-identification as an ACO patient and one (NE-1) advocated for asking beneficiaries to choose a principal PCP. NE-1 advocated for the concept of a branded Medicare Supplemental PPO wrap-around product for this Medicare FFS population.

NE-1 advocated for risk adjustment, not accepting that the current payment model adequately accounts for risk selection. The decedent model was also an issue for these organizations. NE-1 found they did not understand the decedent adjustment, did not have the right data to monitor its performance, and felt the model elements themselves were like ‘black boxes’. Both Pioneer ACOs advocated for up-front, full capitation as an alternative to the current approach. Finally, both Northeast region ACOs advocated for a more interactive and responsive relationship with CMS.

About the Project: Case Comparative Analysis of Select Market-Based Pioneer Accountable Care Organizations

Background

Existing payment systems for the Medicare fee-for-service (FFS) population lack provider incentives for creating accountability to achieve the triple aim of better care for individuals, better health for populations, and more efficient care resulting in lower growth in expenditures in Medicare. The Patient Protection and Affordable Care Act includes investment opportunities to encourage such innovation [2]. One such innovative response, authorized by the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI), is the Pioneer Accountable Care Organization (ACO) Model. Using a competitive application process, health care organizations with experience offering coordinated patient-centered care and operating in ACO-like arrangements were able to enter into arrangements with CMS beginning in January 2012 to assume financial accountability for a designated Medicare beneficiary population while simultaneously pursuing specified quality objectives [3] [4].

In the Pioneer ACO model, organizations share savings with the Medicare program if the quality of care and Medicare spending growth for its aligned population meet predetermined targets, and analogously, the organization shares in the loss if it fails to meet its targets. In a July 2013 press release, CMS reported that 13 out of 32 Pioneer ACOs produced shared savings in the initial year, while two organizations had losses. Additionally, nine organizations left the Pioneer program; some transferred to the Medicare Shared Savings Program and some withdrew completely. [5].

While all Pioneer ACOs are required to have some experience operating in ACO-like arrangements, significant variation exists among them with respect to their prior experience level with risk-based contracting, in addition to their governance, market position, and the regulatory environment in which they operate. These factors may be expected to influence key strategic and operational decisions related to Pioneer ACO program implementation and results achieved by these organizations. Through key informant interviews with a limited but diverse set of Pioneer ACOs, questions were explored concerning these structural and background factors, capitalization, Pioneer ACO business strategies, program incentives, CMS interactions on their Pioneer ACO, operational implications of Pioneer ACO work, first year results as compared with expectations, and contextual factors. In this report the research team provides the Medicare Payment Advisory Commission (MedPAC) with a case study comparative analysis of the first-year experience of six Pioneer ACOs operating in three select geographic areas: the Northeast,

North Central and Southwest market regions of the U.S.A. This report includes an executive summary of findings; the full report also includes case study descriptions for each of these six Pioneer ACOs and detailed case comparisons for each pair that operate in the same geographic market. The report is intended to help inform future policy decisions related to ACO program design.

Project Aims and Methods

Research Objectives. This research project was designed to understand the experiences of select health care organizations participating in the first year of the Pioneer ACO program in three geographic markets. The research sought to understand differences and similarities in organizations' Pioneer ACO strategy, how they implemented their Pioneer ACO, their perceptions of success and effectiveness, and their recommendations on refinements to the Pioneer ACO program.

Specific aims for the study were to:

- Describe organizational context, strategies for improving quality and producing savings, and operations and performance management strategies of Pioneer ACOs;
- Describe experience with the Pioneer ACO attribution, payment, quality measurement and reporting and related methods and policies;
- Describe perceptions of the success and/or effectiveness of the Pioneer ACOs;
- Identify specific recommendations for modifications to improve the Pioneer ACO model; and
- Describe factors that are identified as contributing to Pioneer ACO success.

Study Design. This research employed a qualitative case study comparative design to:

- Compare and contrast the first-year experiences with implementing the Pioneer ACO model in three distinct geographic markets; within geographic markets, the pairs of Pioneer ACO organizations are similar, but across markets, organizations vary in structure (integrated delivery systems, independent practice associations (IPAs), and networks of IPAs), and
- Compare and contrast the first year experiences with implementing the Pioneer ACO model across all six organizations and three geographic markets.

Study Population and Data Collection. Markets and organizations were proposed for the study based on selection criteria that were developed to maximize contrasts in geographic diversity, organization type, market position, legal/regulatory constraints, and first-year results. In conjunction with MedPAC staff, three geographic markets of interest were identified and

within these markets, pairs of Pioneer ACO organizations were identified based on the selection criteria. These sample characteristics include:

- Market 1 – North Central U.S. region*:* Both organizations are integrated health care delivery systems. In their first-year experience, neither organization achieved shared savings; both remained in the Pioneer ACO program.
- Market 2 – Southwest U.S. region*:* Both organizations are identified as independent practice association networks of primarily independent medical group practices, along with a smaller employed medical group. Each organization experienced different first-year results, with one not achieving cost savings and leaving the program and the other achieving cost savings and remaining in the ACO program.
- Market 3 – Northeast U.S. region*:* Both organizations are blended groups of owned and independent physician group practices. Each organization has ties to academic medical centers and teaching programs. Each organization experienced different first-year results, with one not achieving shared savings targets and the other achieving shared savings. Both remained in the ACO program.

The selected Pioneer ACO organizations were initially invited to participate in this study by letter from MedPAC and by follow-up telephone contact. The research team asked organization leaders to identify key Pioneer ACO informants who were knowledgeable about their first year experience and who would be willing to participate in interviews conducted during a site visit or, in one case, by telephone. Across all participating sites, from February through May of 2014, a total of 25, 60 to 90-minute semi-structured individual and small group interviews were conducted with 74 Pioneer ACO key informants. After receiving consent for participation and permission for audio-recording of interviews, interviews were recorded and these recordings transcribed for use in qualitative analysis.

With input from MedPAC staff, the University of Minnesota research team developed a 'master' interview protocol. The master interview guide included questions on all themes and areas of interest for this study as well as follow-up prompts for interviewers to ensure the full range of information was gathered. Topics in the master interview guide covered the following topic areas (full master interview guide provided in Appendix A):

- Organizational context (strategic, structural, managerial and financial factors, experience with outcomes-based contracts)
- Decision to participate in Pioneer ACO

- Strategies for improving quality and producing savings
- Operations and performance management
- Attribution and payment methods
- Perceptions of ACO success / effectiveness
- Refinements to the Pioneer ACO program
- Additional issues and/or recommendations

A subset of items from the master interview guide was selected for each interview and group of respondents because interview respondents spoke from specific areas of expertise (for example, financial management or data analytics). While each individual interview did not cover the full range of interview topics, the set of interviews conducted within each sampled organization (the unit of analysis) covered the full range of topics. Where possible, interview topics were repeated with multiple respondents in an organization to ensure that we collected a range of possible opinions and perspectives from a range of key informants in each organization on each topic. For example, in every interview, topics including perceptions of Pioneer ACO success and effectiveness as well as refinements to the Pioneer ACO program were included. The study was reviewed and determined exempt from review by the University of Minnesota Institutional Review Board.

Analysis. Key themes and findings were determined through qualitative analysis informed by a Rapid Assessment Process approach. Rapid Assessment Process (or RAP) is defined as "intensive, team-based qualitative inquiry using triangulation, iterative data analysis and additional data collection to quickly develop a preliminary understanding of a situation from the insider's perspective" [6].

At least two project investigators participated in each key informant interview. Following each interview, individual investigators completed a rapid assessment of findings, aided by a pre-designed template form, to describe 'take away' themes from that interview (RAP form provided in Appendix B). After this rapid individual analysis of the interview data, the full team of investigators then met to debrief each interview and identify key findings and themes that arose during that interview.

Based on the Rapid Assessment Process, the research team developed a list of emerging data themes. This list was revised and edited iteratively throughout the data collection process as additional interviews provided a greater scope of data and information. In addition, once the interviews were transcribed, each was coded into six main codes and sub-codes (codebook provided in Appendix C), which were used to confirm the emergent themes, detail specific content, and facilitate the organizational comparisons.

At the end of the RAP and thematic coding analysis process, the themes were used to prepare the individual Pioneer ACO case studies utilizing a standard case study analysis approach [7], followed by a case study comparative approach [8] to explore and contrast themes across the paired Pioneer ACO organizations. A final step in the analysis was the description of conclusions based on a comparison across all case study results.

Pioneer ACO Case Study Comparisons

For each of the six ACO study organizations, the full report contains a case study summary of findings which summarizes the findings from interviews with each organization's key Pioneer ACO leader informants and a table that provides a summary of the conclusions from the comparisons, i.e., what similarities and differences were found. These case study descriptions precede each of the sections of the full report in which the detailed findings from the comparisons of the paired market-based ACOs are presented.

Note: the detailed full report is not a public document; it was prepared for the Medicare Payment Advisory Commission.

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Appendix A: Interview Guide - Master

MedPAC Project: Case Comparative Analysis of Select Market Based Pioneer Accountable Care Organizations
INTERVIEW PROTOCOL
(Roman numeral items are question domains; interview questions are in bold and numbered; probes [bulleted and in brackets] follow the questions)

I. **Organizational Context: Strategic, Structural, Managerial and Financial Factors, Experience with Outcomes-Based Contracts** *(Purpose: Describe organization, history, development of and structure of Pioneer ACO, key players, market and financial factors, and other ACO-like contracts)*

1. **We'd like to start by asking you for some background information on your organization and your Pioneer ACO. Please tell us about your organization's history and describe your Pioneer ACO.**
   - [Pertinent details about organization's history, legal structure, governance, overall management related to Pioneer ACO and its management structure.
   - What structural or management changes (if any) were made in order to participate in the Pioneer ACO Demonstration Project?]
2. **Tell us about the capitalization required for your Pioneer ACO. What level of capitalization was required and what method was used?**
   - [What is the capital and ownership structure of your organization?
   - What was your initial investment? What was the source of the capital required for this initiative? E.g., equity, debt? Both? Other?
   - What does your organization consider an adequate underlying balance sheet for your Pioneer ACO work? What is your ability to financially sustain your Pioneer ACO over time? Under what resulting performance scenarios?]
3. **Describe what experience your organization had with strategies in population based health care management (such as care transitions and case management) prior to your Pioneer ACO work. What prior experience did you have with outcomes-based contracts involving shared savings, quality improvement targets, or risk?**
   - [Describe any other ACO-like arrangements you have with other payers. Self-funded Commercial? Network Exchange products? Medicaid?] Do you contract with Medicare Advantage plans or run your own MA plan?
   - How long have you had these? About how many patients (or what proportion of your patients) do these consist of?
   - Do they include quality improvement targets and/or shared savings?
   - Do you anticipate additional ACO-type arrangements with other payers or expansion with current payers in the next two-three years? Which payers? (Self-funded Commercial? Network Exchange products? Medicaid? Medicare Advantage?)]
4. **What partnerships or strategic alliances did you need to engage with to support your Pioneer ACO business strategy? Tell us about these. How well did these strategies work for you?**
   - [With what types of organizations or providers were these? How did you choose these partners? Are you still engaged in these partnerships? Knowing what you know now, would you have done anything differently? If so, what?]
5. What communications strategies did you use to educate health care providers and potential beneficiaries about your Pioneer ACO?
   - How was the Pioneer ACO model communicated to potential beneficiaries?
   - How was the change to the Pioneer ACO model communicated internally to staff and health care providers?

II. **Pioneer ACO: Decision to Participate** *(Purpose: Understand decisions regarding participation, and continuation or decision to leave, factors related to likely future participation.)*

1. **Tell us about your decision to apply to become a Pioneer ACO.**
   - [What opportunities did you foresee? What concerns did you have? What were your goals in participating? What expectations did you have related to participation?
   - What internal organizational factors contributed to these decisions? Hospital(s)? Specialists?
   - What specific market factors? Provider competitive issues? Payer network strategies? Insurance Exchange?]
2. **Describe your local market related to provider competition and your ACO development.**
   - [Were there any marketplace drivers that influenced the development of your Pioneer ACO?]

III. Pioneer ACO: Strategies for Improving Quality and Producing Savings *(Purpose: Understand expectations for achieving results, assumptions about interventions that would lead to success, differences between expectations and actual results and factors related to these, strategies going forward, and what they would do differently)*

1. **We'd like to know about the care delivery strategies you decided to use in your Pioneer ACO. What specific strategies were adopted in order to achieve savings? Were these new initiatives or already being done as part of efforts with other payers?**
   - [If with other payers, describe these, who was leading these efforts, and who provides oversight?]
2. **Tell us about what quality improvement strategies you chose to use in your Pioneer ACO. Were these new initiatives or already being done as part of efforts with other payers? How well did the quality improvement strategies you chose help you achieve your quality improvement expectations?**
   - **[**If with other payers, describe these, who was leading these efforts, and who provides oversight?
   - How did you make decisions on what quality improvement strategies you were going to pursue? What did you choose to focus on and why? How did you expect to manage this work?

- How well did you achieve quality improvement targets? What practice or operational factors were facilitators of or challenges to achieving quality improvement targets? Knowing what you know now, would you have done anything differently? If so, what?]

3. **What expectations did you have for cost savings with your Pioneer ACO? How well did the care delivery strategies you chose help you achieve savings expected?**
   - **[**How did you make decisions about your savings targets? The strategies to achieve the targets? Were there organizational or market-related factors that contributed to the decisions about strategies?
   - What were your targets? How did you manage this work?
   - How well were you able to achieve these targets? Knowing what you know now, would you have done anything differently? If so, what?]
4. **What, if any, incentive strategies did you use to achieve results? Tell us about how well these worked for achieving your goals.**
   - [How did you decide what and whose behaviors needed to change for success? How did you decide what incentives you needed to use to change behaviors? How did you determine how large these incentives should be?
   - What provider-centric strategies (e.g., performance targets tied to compensation) do you use? How well are these working? What will you continue (if staying in program)? What new ones will you try?
   - How are any savings to be distributed among internal stakeholders with in ACO? Hospital? Primary care? Specialists? Is the distribution based in part or completely on which specific providers have contributed to productivity gains (earned savings)?
   - Are hospitals compensated for lost revenue from reducing avoidable admissions? Does the hospital support ambulatory care programs to reduce Medicare readmissions beyond the Pioneer program?
   - Knowing what you know now, would you have done anything differently? If so, what?]

IV. Pioneer ACO: Operations and Performance management *(Purpose: Understand the implementation and first year performance of Pioneer ACO operations, first year outcomes as compared with expectations, strategies for preventing leakage to non-ACO providers, strategies for engaging providers, experience with strategic business alliances and partnerships, and strategies for engaging beneficiaries. Understand how data and analytics were used in care management for individual beneficiaries and for the Pioneer ACO beneficiary population)*

1. **We'd like to hear about how you managed internal operations and monitored performance related to your Pioneer ACO. Describe your Pioneer ACO business strategy. What things did you do differently from business as usual in order to manage your Pioneer ACO in its first year of operation? Looking back now, how well did these work for you? What, if any, operational changes do you plan to implement in the future?**
   - [What factors, if any, presented as barriers or facilitators to implementation success?
   - What information systems and data are being used to monitor performance?]
2. **Describe what data and analyses you employed to understand baseline information about population care needs and costs for your Pioneer ACO.**
   - **[**Tell us about any analytics for decision-making you have developed. Please describe the tools being used.
   - Do you monitor high use or complex patients for care management?
   - Has CMS been supportive in supplying data useful for managing your population and tracking performance?
   - What role did the electronic health record play in your Pioneer ACO program initiatives? In program monitoring? In other aspects?
   - Knowing what you know now, would you have done anything differently? If so, what?]
3. **Describe how you track overall performance on quality measures and on cost of care for the attributed population? What metrics were used to monitor progress?**
   - **[**What metrics were used to determine which practice strategies (e.g. care coordination, care transitions management, patient education) were successful or not?
   - What plans do you have for these metrics for year two? What if any, metrics are you planning to use in the future?
   - Has the development of useful analytics for decision-making been on track or have there been delays?
   - Has CMS been supportive in supplying data useful for managing you population and tracking performance?
   - What role did the electronic health record play in your Pioneer ACO program initiatives? In program monitoring? In other aspects?
   - Knowing what you know now, would you have done anything differently? If so, what?]
4. **How have you engaged primary care providers in your Pioneer ACO? How well did these strategies work for you? How about engaging specialists? How well did these strategies work for you? Knowing what you know now, would you do anything differently for primary care providers? For Specialists?**
   - **[**What was your strategy to engage specialists within the organization; outside of the organization?]
5. **We'd like to know about the outcomes you had in the first year of your Pioneer ACO. Describe your outcomes in health, spending targets, and use of health care services for your assigned beneficiaries. How did these results compare with what you expected?**
   - [If different: Explain how, in what areas. To what do you attribute these differences?]

V. Pioneer ACO: Attribution and Payment Methods *(Purpose: Understand first year experience with and perceptions of payment model, beneficiary assignment, unintended effects)*

1. **Tell us about your aligned beneficiary population. Was it the population you expected?**
   - [What information does CMS provide on your aligned beneficiaries for population health management? How accessible are these data? How useful? How timely?
   - How have these data been used to inform practice and care delivery for Pioneer ACO beneficiaries?
   - How has the attribution method affected your Pioneer ACO? Have you experienced any unanticipated effects on your ACO?

- From your organization's perspective, do you have any recommendations for how attribution could be improved?]

2. **How have you engaged beneficiaries and health care providers in your Pioneer ACO? What beneficiary-centric strategies did you use? How well did these work for your Pioneer ACO? Describe your Pioneer ACO program communication with beneficiaries and providers.**
   - [Have you done any analysis to understand why some beneficiaries were attributed to your Pioneer ACO and not another? (moved out of service area, beneficiary algorithm changed, or different health care patterns year to year) If so, what did you learn?
   - For the future, what communication or other engagement strategies with beneficiaries will you continue (if staying in program)? What new ones will you try?]
   - Have you had any issues with provider engagement in the Pioneer ACO?
3. **Did you have any leakage of care to providers outside your Pioneer ACO for attributed beneficiaries?**
   - [If so: What have you done to address leakage of care to non-ACO providers for services you are able to provide? (For Northeast and North Central sites: To your knowledge have you been affected by leakage due to snowbirds' seasonal living arrangements? Is this "snowbird" phenomenon of concern to you?)
   - Is leakage to another Pioneer ACO an issue?
   - Knowing what you know now, would you have done anything differently? If so, what? What do you have planned to do differently in the future?]
4. **Tell us about your experience with the Pioneer ACO payment method.**
   - [Was the payment method what you expected? Did the method contribute to the performance results you expected? (Why or why not?) How accurate was the benchmarking/target for determining savings? How appropriate was the shared savings/risk formula?)
   - Are there features of the Pioneer payment model that have led to unintended performance results? (Are there some that may lead to unintended performance results? Are any of these due to unreliable measurement, possibly due to small numbers? What about the unintended influence of factors other than the actual performance of your organization? (e.g., Method for accounting for case mix/risk, e.g., death adjustment)? Assigned patient turnover? Unreliability (inconsistency over time due to measurement error) of key metrics; Aggregation of data to generate quality measures and the role of quality in the payment model?)
   - In what ways are the ACO payment models from other payers similar to the Pioneer model? In what ways are the ACO payment models from other payers different from the Pioneer model?
   - Do you have any recommendations for specific improvements to the Pioneer ACO payment model? (Prompt specific dimensions: Beneficiary attribution? Setting benchmark/target for determining savings? Risk adjustment? Set of quality measures? Quality measure weighting for payment? Shared savings/risk formula? Other?)]

VI. Perceptions of Pioneer ACO Success/ Effectiveness *(Purpose: Understand perceptions of success or lack of success and perceived reasons to continue or discontinue participation.)*

1. **Does your organization believe your Pioneer ACO was successful in its first year? Why or why not?**
   - [If not, what adjustments will be made (provided the organization has chosen to continue participation)?
   - How did factors such as organizational culture, climate, workforce composition, turnover, experience with teamwork, patient satisfaction, changing market dynamics, etc. affect your Pioneer ACO work and results?
   - Overall, how well did the mechanics of the demonstration operate for your ACO? How did these mechanics support or deter successful operation? (Probe for specifics of these perceived issues)]
2. **Tell us about your decision to continue (or discontinue) participation in the Pioneer ACO program.**
   - [Were there unanticipated Pioneer ACO program features you encountered? Unanticipated decisions by CMS?
   - Internal changes within your organization? Changes in the market context?]

VII. Refinements to the Pioneer ACO program *(Purpose: Discuss and determine organizational reaction to possible refinements or changes to the program)*

1. Options for refining the program. Would these changes be helpful, or not, and why?
   - Attribution: have ACO identify specialists who may be primary care providers and have a one stage rather than two stage attribution algorithm.
   - Know benchmark (target) in advance (prospective benchmark) rather than wait until end of performance year. Savings (loss) would be calculated from prospective benchmark.
   - Engage patients: Improve letter, allow ACOs to waive cost sharing for primary care, recommend PAC providers.

VIII. **Additions and recommendations** *(Purpose: Determine any additional issues organizations perceive as important related to the Pioneer ACO program)*

1. Are there additional issues or topics about which we did not ask that you think we should know about?

2. Do you have recommendations on improvements to the Pioneer ACO program?

Appendix B: Rapid Assessment Process Guide

After each interview or set of interviews, the interviewers used a Rapid Process Assessment form in order to memo findings of particular significance heard in each interview. This process helps to capture interesting findings, researcher impressions, and thoughts about potentially significant presenting findings immediately after the data collection. These early memos of findings are shared and discussed with the whole research team in the post-site data collection debrief meetings and then used as a body of impressions for further analysis as the collection of data proceeds. Content areas are organized to correspond with the interview guide (see below for content area topics used in the form).

1.) Organizational context: strategic, structural, managerial and financial factors, experience with outcomes-based contracts:
2.) Decision to participate in Pioneer ACO program:
3.) Strategies for improving quality and producing savings:
4.) Operations and performance measurement:
5.) Attribution and Payment methods:
6.) Perceptions of Pioneer ACO Success/Effectiveness:
7.) Reaction to suggested refinements to the Pioneer ACO program:
8.) Additional issues/topics and recommendations on improvement to the Pioneer ACO program:
9.) Key insights:
10.) What did you feel needed more clarity and potential follow-up questioning?

Appendix C: Codebook

Code #	Category
1	**Pioneer ACO Description**
1.1	*Organization Type & Structure*
1.2	*Scope of ACO (number of providers, geographic spread)*
1.3	*Governance & Leadership*
1.4	*Other*
2	**Entry into Pioneer ACO Program**
2.1	*Experience with Risk-Based Contracts*
2.2	*Motivations for Entry*
2.3	*Analysis Prior to Entry*
2.4	*Other considerations*
3	**Approaches in Executing Program**
3.1	*Care Management*
3.2	*Coordination/Transitions in Care*
3.3	*Data & Value Analytics*
3.4	*Quality metrics & reporting*
3.5	*Communication:*
3.5.1	*Physician Network*
3.5.2	*Wider Organization*
3.5.3	*Partners (e.g. SNFs, Home Health, etc.)*
3.5.4	*Beneficiaries*
3.6	*Program Financing*
4	**Perspectives on Pioneer ACO Performance**
4.1	*Other comments*
5	**Perspectives on Pioneer ACO Design**
5.1	*Risk Adjustment*
5.2	*Attribution vs. PCP Assignment*
5.3	*Quality metrics & reporting*
5.4	*Payment Model*
5.5	*Beneficiary Engagement*
5.6	*Prospective Benchmarking*
6	**Recommendations for MedPAC**
6.1	*Experiences w CMMI*
6.2	*Other Comments*