Can ACO’s Cross the Chasm?
EXECUTIVE SUMMARY

ACOs are now well past their early lifecycle stage but are still a long way from mature, covering less than 10% of the population. Despite nearly 1000 in operation, the challenges currently outnumber the success stories. While few expect ACOs to disappear, their eventual characteristics [size, providers included, measurements, etc.] are yet to be determined.

In order to “cross the chasm,” at a minimum, more success stories, better technology and friendlier regulations are needed.

Current results show promise but are not yet compelling. The latest roadblocks come from CMS [in the MACRA APM rules] and the IRS while numerous practical issues associated with systems and sharing data remain to be solved.
For the medium and longer term, it is becoming clear that ACOs have to evolve to encompass effective population health management, even though the metrics and tools needed are extremely limited at this point.

In this whitepaper, we outline the ACO landscape including progress to date, current types of ACOs, current challenges and trends and some examples.

ACO PROGRESS TO DATE

In March 2012, Leavitt Partners identified 157 ACOs covering approximately 7-million lives. According to the firm’s latest report, released in partnership with the Accountable Care Learning Collaborative, roughly 838 ACOs had been established as of January 2016. More recent estimates place the number at close to 1000.

The growth in ACOs includes a growth in the number of lives covered by ACO contracts. Leavitt Partners estimates that 28.3 million people were covered by an accountable care arrangement at the beginning of 2016. Collectively, the count of ACOs grew by 94 from 2015 to 2016 (a 12.6% increase). The number of accountable care contracts also increased, with 1,217 identified.

According to CMS, the 20 ACOs in the Pioneer ACO Model and 333 Medicare Shared Shavings Program ACOs generated more than $411 million in total savings in 2014, which includes all ACOs’ savings and losses. At the same time, 97 ACOs qualified for shared savings payments of more than $422 million by meeting quality standards and their savings threshold. The results also show that ACOs with more experience in the program tend to perform better over time.

![Figure 1 - “ACOs over Time” Health Affairs Blog](image-url)
TYPES OF ACOs

According to Leavitt Partners and Stephen M. Shortell PhD, MPH, MBA of the Berkeley School of Public Health, there are 6 major types of ACOs, three that are health system or hospital-centric and three that are physician-centric:

1. Full Spectrum Integrated
2. Hospital Alliance
3. Independent Hospital
4. Independent Physician Group
5. Physician Group Alliance
6. Expanded Physician Group

According to a recent Leavitt Partners survey, the first two types average many more affiliated physicians and a higher percentage of employed physicians vs. the other types.

As a general rule, the physician types are more nimble, allowing them to move faster. In early studies, they have also shown the most success in cost savings. Some associate this with the conflicts hospital-centric ACOs face between keeping people out of the hospital (a major source of cost savings) and their traditional revenue stream from in-patients.

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McWilliams, J. Michael; Hatfield, Laura A; Chernew, Michael E; Landon, Bruce E; Schwartz, Aaron L., "Early Performance of Accountable Care Organizations in Medicare," New England Journal of Medicine, April 13, 2016 DOI: 10.1056/NEJMsai16001
Can ACO’s Cross the Chasm?

ACO CHALLENGES

Impact of Proposed MACRA APM Rules

According to a NAACOS survey, if the proposed APM requirements are finalized, 56% of Medicare ACOs are likely to leave the MSSP, which hosts the vast majority of Medicare ACOs. 11% of such ACOs were unsure whether they would remain in the program and 32% said it was very or somewhat likely that they would stay in the program.

In a poll conducted in February by RBMA, 77% of 94 respondents reported they are not participating in an ACO. Nearly two-thirds of these respondents (63%) indicated they are not currently participating in an ACO and have no intention of ever participating, while an additional 14% reported they are not currently participating, but are considering doing so in the future. Of the 23% currently participating in an ACO, almost 10% have achieved shared savings while 14% have not. The results are noticeably similar to those of an August 2013 poll, which found 74% were not participating in an ACO (with 23% considering doing so) and 26% actively participating, including only 5% that had achieved shared savings and 21% that had not.

IRS Ruling

A June 2016 IRS ruling rejected an Accountable Care Organization’s (ACO’s) request for tax-exempt status, saying the ACO did not meet the test for tax-exempt status because it was not operated exclusively for charitable purposes. The unidentified ACO was created by a nonprofit healthcare system and coordinates care for members with commercial insurance and, according to the IRS, provides benefits for some physicians in its network, consequently negating any charitable activities.

While the ruling does not apply to Medicare-only ACOs, it is expected to slow ACO growth unless the ruling is overturned. Especially considering that two-thirds of ACOs to date are commercial. ACO advocates expect that some members of Congress may propose legislation to create a more favorable tax status for commercial ACOs. Certainly commercial insurers and others involved with these ACOs will be lobbying to change the ruling. Otherwise, many feel that the tax implications will prevent the formation of new ACOs and may even cause existing ones that are struggling to disband.

Sustainable Financing Models

CMS has finalized changes to the way it evaluates whether Medicare ACOs are saving money, responding to persistent complaints that the program was harder for efficient providers because they had to compete against their own success.

Under the finalized changes, when an ACO signs up for a second or subsequent three-year contract

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5 RBMA Radiology Hot Topics February 3-10, 2016 (pdf)
6 Dickson, Virgil, "CMS Finalizes Changes to ACO Cost Targets," Modern Healthcare, June 6, 2016
Can ACO’s Cross the Chasm?

period, cost benchmarks will be adjusted based on regional versus national spending data. This modification is intended to measure participants’ success against other providers in the same region rather than an ACO’s own past performance.

But as the benchmark is reset over time, ACOs will be face shrinking incentives to participate since the benchmark will get progressively lower based on past successes. Unless payers adjust their approach, this method penalizes efficient providers. The decreased rewards could be one reason some pioneer ACOs have withdrawn from the program.

Effective Care Coordination Requires Organizational Collaboration

While many strive to collaborate across organizations, it can be discouraging for providers working outside of integrated health systems and multi-specialty practices since independent organizations often have different ideals and care team structures. Also, organizations may opt not to participate due to the associated high start-up costs, a history of competition, and/or apprehensions regarding revenue reduction.

To achieve effective care coordination, ACOs have are working to overcome differences by establishing integrated cross-organizational care teams which facilitate timely and accurate data exchange, and by coordinating administrative tasks.

Patient-Centered Care

Providing patient-centered care has also presented significant obstacles for ACOs. A large portion of ACO models attribute patients retrospectively based on utilization. While this method preserves patient choice, it means the ACO cannot determine which patients are assigned until long after services have been provided. In addition, patients generally do not engage in the governance or design of ACO programs or operations.

Patient input can result in more patient-friendly operations and produce greater patient engagement. More importantly, effectively engaging patients can help address the social determinants of health which impact health outcomes and costs.

A prospective attribution method, which assigns patients to an ACO based on past utilization patterns, may be more effective in building relationships and encouraging providers to be proactive with patients, resulting in greater patient engagement and more effective ACO care coordination activities.

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Can ACO’s Cross the Chasm?

**Measurement Limitations**

While many ACOs are starting to see positive results with cost control and quality improvement, there are limits with current measures versus capturing important health outcomes.

Quality metrics generally focus on something easily measured, such as lower avoidable readmissions, but the challenge is that these may not accurately measure the overall health of the patient. As a result, it can be difficult to evaluate the impact of specific interventions on cost and quality.

Metrics that measure a patient’s own assessment of his or her health outcomes could be a more reliable assessment of patient experience but are challenging to capture. ACOs that employ systems to collect data as well as measure specific racial, ethnic or language-based health disparities have the potential to improve quality, patient-centeredness, and reduce costs.

**Aligning Payers**

Many ACOs have contracts with Medicare, Medicaid, and commercial entities. However, this can present challenges in that they are often complex and may widely differ in governance requirements; payment structures; quality metrics; reporting requirements; and data availability.

Though disparities have the potential to create substantial administrative burdens on ACOs and impede improvement efforts, some ACOs are working to establish arrangements for economies of scale by serving Medicare, Medicaid, and commercial populations under one ACO arrangement. In addition, safety net providers are also participating in multi-payer initiatives by developing an independent practice association (IPA) which functions as an ACO.
Can ACO’s Cross the Chasm?

Data Sharing

Establishing a cross-provider infrastructure for effective data sharing requires significant upfront provider investment and commitment and has proven to be a challenge for many ACOs. This can present another barrier for new ACOs due to the large number of providers that have yet to establish infrastructure, staff capacity, EHR interoperability standards, or health information exchange. Medicaid, MSSP and Pioneer models have limited funding targeted to rural or safety net providers for this purpose which adds yet another barrier.

Furthermore, state and federal regulations and policies requiring patients to opt-in to data-sharing arrangements create both assumed and legitimate barriers to information sharing. ACOs must ensure protection of patient information, while at the same time sharing data with other providers towards better patient care management which can also provide encouragement for provider investments in data sharing and analytics.

ACO EXAMPLES

To be successful, ACOs must adhere to the principles of strong philosophical alignment with top management, shared long-term objectives, aligned incentives, transparency and resource commitment, says Blue Shield of California CEO Paul Markovich. He adds there must be a strong belief in these principles from top management and among the ACO’s partners. Trust between providers and a payer is also an important factor and begins with all stakeholders truly wanting to deliver the best quality healthcare for the lowest price. Once trust is established, Markovich says, shared data analytics and payer-provided resources can add to an ACO’s success.

A study published in the June edition of the American Journal of Accountable Care examines one Medicare Shared Savings Program (MSSP) ACO which established shared savings for two successive years. But shared savings through the MSSP ACO program proved to be challenging for most participants in the first performance year. While approximately half of the ACOs reduced healthcare costs through the program, it was not enough to exceed the minimum savings rate. Only 24% of ACOs earned shared savings in the first year.

The Hackensack Alliance ACO was one of the few that benefited from shared savings arrangements through MSSP. In its first performance year, the Medicare ACO saved over $10 million in total and received $5.2 million in shared savings.

“The MSSP’s ACOs appear to offer ample opportunity to improve the quality of care for the patient while at the same time, reduce the cost of care,” wrote the authors of the study. “Initial factors that should facilitate these changes are having physicians certified as patient-centered medical homes by NCQA [National Committee for Quality Assurance] and providing financial support for increased care coordination.”

Researchers attributed the success of the Hackensack ACO to its efforts to promote patient-centered care, increase care coordination, and use big data analytics. Hackensack attributed its shared saving success to the use of patient-centered medical homes, designed to put primary care at the center of a patient’s healthcare experience.

Similarly, the Steward Healthcare ACO sees its “robust IT infrastructure” as key to the success of integrated care delivery. The ACO boasts “a complex network of electronic health records,” with 3,000 physicians, 10 hospitals, 24 affiliated urgent care providers and six ambulatory surgery centers.

“Our hospitals are on one EHR, however, while employees and affiliate providers are on several different types of EHRs operating in hundreds of databases,” said Trafton. “The greatest challenge has been the aggregation of the EHR data into a centralized data warehouse where it can be combined and matched with claims data.”

Steward has seen success by integrating data, having developed “a robust, payer-agnostic, quality program with the ability to identify gaps in care for a patient across multiple quality metrics,” said Heather Trafton, Steward’s executive director of performance management, population health and quality.

Integrating clinical information from the EHR enables the approximation of a real-time data feed about what is happening with the patient on any given day. “It allows for intervention,” Trafton said, “whether that is most appropriately done by care management, a pharmacist, a health coach or PCP.”

“With this information we have been able to create a successful patient outreach program with a single point of contact and tracking system on projected compliance. Without the integrated data, a patient could receive duplicate screening studies and have multiple outreach by different members of the care team.”

One physician-owned participant in the Medicare Shared Savings Program (MSSP), South East Michigan Accountable Care (SEMAC), likewise discovered that data analytics and population health management technologies are a wise investment for success in the challenging environment of value-based care.

“We saved $24 million in our first year in 2012, which led to a performance bonus of $12 million,” said Executive Director Anthony Vespa. “In the second year, we were on track for almost $12 million in savings, but we fell a little short of our minimum savings ratio, so we did not earn a bonus. We’re currently waiting for the third year results.”

An initial contract with a data analytics partner led to a certain level of insight into patient needs and utilization, but the ACO wasn’t seeing the efficiencies it needed and chose to part ways with the first vendor, says Vespa.

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11 “Bresnick, Jennifer, ACO Success Relies on Population Health Management Tools,” HealthITAnalytics, June 1, 2016
“We had to make the effort to push the reports to our providers so they could work on reducing utilization, achieving quality goals, and narrowing gaps in care. It was becoming too labor-intensive to relay all the information to our providers.” Vespa explained, “We need data analytics to fill the insight void and help us achieve the efficiencies needed to continue to perform well in the MSSP world.”

“Population health management is critical. Not only is it being driven by Medicare, Medicaid, and commercial plans, but it’s necessary for any organization to achieve scalability. Without population health management technology, it would be impossible to work with your data. You just wouldn’t be able to do it.”
Can ACO’s Cross the Chasm?

CURRENT ACO TRENDS

Specific Subpopulations

Thus far, many ACO efforts have largely focused on high-need, high-cost populations with limited access to care and/or who receive fragmented care combined with little to no communication across physical and behavioral health providers.

Given the potential cost savings, ACO efforts to target these patients with high touch interventions continue. That includes those with limited access to care, high-need, high-cost patients and, specific age groups (e.g. pediatric patients with limited care). A number of ACOs employ protocols to classify specific populations in order to provide them with attainable and appropriate care.

In addition, many ACOs are working to develop partnerships with behavioral health providers, social service agencies, and other community-based organizations to address the social determinants of health.

These ACO structures offer primary care providers and specialists associated with a specific patient population the opportunity to benefit from the ACO and reap shared savings from better-coordinated care.

Consolidation

Throughout the U.S., providers and payers have begun consolidating market shares and some provider organizations are positioning ACO development as an important part of this strategy.

Larger ACOs may expand the opportunity for coordinated care, achieve savings with lower administrative burden, and may reduce financial risk from the variability in per patient costs.

However, the possible disadvantage of consolidation lies in its potential to increase total cost of care, marginalize smaller safety net providers (FQHCs; small physician practices), and limit consumer choices. Federal, state, and local officials are challenged to ensure anti-competitive practices from large entities do not adversely affect the market and patient population.

Regional Development

There has been increasing interest in ACOs responsible for an entire patient population in a defined geographic area.

Typically population-based cost measurements and payments are calculated as total cost of care across all services under the ACO scope. Fixed, prospective global payments allow ACOs to manage their own budgets in innovative ways, versus typical ACO shared savings agreements, which are based on the traditional fee-for-service model and adjusted based on shared savings.12

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12 Curry, Angie; Fee, James, “Ramping Up for Bundled Payments: Fostering Alignment Between Hospitals and Physicians,” hfm, May 1, 2016
Can ACO’s Cross the Chasm?

A number of ACOs have begun to integrate services beyond physical health, including behavioral health, long-term care, dental, and social services. They also offer flexibility in payment for items and services that are non-medical but may improve health, such as housing assistance and targeted case management.

Virtual and Rural Development

In most cases, early ACO adoption has taken place in urban and suburban settings. But as the ACO trend continues to catch on, interest is emerging among smaller provider organizations as well as in rural settings.

These organizations have found that through using technology to create “virtual” ACO arrangements, even small providers are able to organize and coordinate care more effectively, improve care coordination efforts and enhance preventive care.

Narrowing Provider Networks

In the commercial sector, some ACOs have started to experiment with narrow provider networks as a strategy for reining in costs and improving care. Managed care organizations (MCOs) have initiated many of these narrow networks which typically create an ACO with a limited number of provider organizations that have demonstrated a pattern of high-value care (i.e. exceptional performance on quality metrics) and a willingness to provide specific services for a lower price.

Due to the limited number of providers in the network, MCOs look to negotiate lower prices with providers which could also benefit these high-value providers, as they can gain greater patient volume.

Referral Patterns

Referral patterns are another area in which ACOs have begun experimenting. Referring patients to high-quality, efficient specialists can aid in controlling costs by lowering specialist costs due to a narrow network incentivized by lower co-pays for members referred to an in-network provider.

Improved Data Analytics

As ACOs continue to expand and improve in coordinating care, many see an investment in advanced data analytics and forecasting tools as the key toward greater understanding of patient subpopulations.

Commercially available tools, hired contractors and consultants, and the ability to aggregate data beyond medical procedures, may be particularly helpful in addressing social determinants of health at the population level. These and other tools can also help improve risk adjustment methodologies and result in more accurate payments for high-risk patient subsets.
CONCLUSION

Even though the conversation around ACOs has shifted over the past year, most expect the move toward ACOs and similar forms of payment based on cost and quality outcomes to continue. ACOs have continued to grow and ACO payment policies are evolving. While not all ACOs have yet achieved the “Triple Aim”, many ACOs have improved quality and patient experiences with concurrent cost reduction.

At the same time, there is a growing realization that the challenges to continued growth are daunting and could, in fact, delay or even derail the ACO model. Policy pressures will certainly continue to encourage the transition, but that won’t be enough.

Targeted research and investment is needed to identify the major differences between successful versus failed ACO models as a guide for future ACO activity. We should expect to see better tools and processes plus an understanding of multi-payer alignment and sub-population management as a result.

For the longer term, there is a growing recognition that managing a population is a better way to care for patients. The industry has survived many early ACOs struggling and now even Medicare, along with other insurers and providers, has begun to plan for population-level payments as an eventuality as opposed to just a possibility.

Policy makers, payers and providers must continue their efforts to encourage innovative ACO enhancements to improve quality, reduce costs, and enhance the overall patient experience. But the real driver of whether ACOs can “cross the chasm” will come from hard work by those involved in today’s ACOs. They must lead the way by overcoming the inevitable barriers.
Can ACO’s Cross the Chasm?

Background

ACOs are designed to achieve the Triple Aim of “improving the experience of care, improving the health of populations, and reducing per capita costs of health care” by shifting varying degrees of financial responsibility for patient outcomes to providers. A staple of the delivery reforms embedded in the Affordable Care Act (ACA), Accountable Care Organizations (ACOs) are defined by CMS as groups of doctors, primary-care offices, specialists, acute-care hospitals, nursing homes and other health care providers, working in collaboration toward the overall goal of coordinated care for a set group of patients to ensure the right care is provided at the right time, while also avoiding unnecessary duplication of services and preventing medical errors. If groups are able to lower costs, such as by preventing expensive hospital admissions, and achieve high quality scores, they get to reap the rewards by sharing in some of Medicare’s savings.

Many ACOs are currently participating in one of the Medicare ACO programs:

- Medicare Shared Saving Program (MSSP) - a program that helps Medicare fee-for-service providers become an ACO;
- Advanced Payment ACO Model - a supplementary incentive program for selected participants in the Shared Savings Program;
- Pioneer ACO Model - a program designed for early adopters of coordinated care. No longer accepting applications.

The number of ACOs across the U.S continues to steadily increase with nearly 1000 in operation or planned, vs. fewer than 100 five years ago. This past January, CMS announced 121 new Medicare ACO participants and the growth trend is likely to continue, according to a December report from Leavitt Partners which predicts that 105 to 176 million patients may be covered through an ACO by 2020.

Need for ACOs: Lack of Coordinated Care

A recent Nielsen Strategic Health Perspectives survey highlights some of the problems that ACOs are trying to solve:

- 89% of primary care physicians say they often remind patients about preventive screenings, but only 14% of patients say they get these reminders.
- More than two-thirds of adult Americans are overweight or obese, yet only 5% of patients report that their physicians recommended a weight loss program.
- Only half of patients are experiencing physicians who better know their history, primarily due to the ability to share information through electronic medical records.
- Patients with multiple chronic illnesses, who would most benefit from care coordination, receive only slightly more follow-ups and care management than everyone else.
- Only about one-third have 24/7 access to care through their physician’s office other than the emergency room.

13 “Accountable Care Organizations (ACO),” CMS, Page last modified: January 6, 2015
14 Sampson, Catherine, “Number of Accountable Care Organizations Continue to Rise,” RevCycleIntelligence, April 28, 2016