Levers of Successful ACOs

Part 1
Identifying the Levers of Successful ACOs

Value-based payment models have proliferated over the past several years in an attempt to address the unsustainably high costs and variable outcomes of health care in the U.S., and to test innovative models to solve these particular challenges and promote high-quality, low-cost care. While there are several approaches to value-based payment, accountable care organizations (ACOs) have been the most popular vehicle for value-based payment model adoption to date, with over 923 ACOs covering approximately 32.4 million lives across the country.[1] ACOs can take a variety of forms, differing by provider configuration,[2] contracted payers, payment methods,[3] and more. While approaches to ACO implementation vary, the principles of population health management remain the same.

> *An ACO is a provider-led entity that agrees to assume financial responsibility for the cost and quality outcomes of a defined population.*

Now, several years into the accountable care movement, health care stakeholders are closely studying the structures and behaviors of existing ACOs to learn about the attributes of successful organizations. Understanding the levers of ACO success will be increasingly important for a number of reasons:

1. **Supporting vulnerable providers** – While all providers could benefit from the study of ACO success factors, the dissemination of successful strategies will be especially important for smaller, independent organizations without the capital to invest in custom, hands-on support. Moreover, these are the types of organizations who also cannot afford to get it wrong the first time. Their investments, and the order of those investments, are crucial, as is their configuration and the construct of their partnerships.

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1   Muhlestein D, Sanders R, McClellan M, Growth of ACOs and Alternative Payment Models in 2017 (2017)
2   Leavitt Partners, A Taxonomy of Accountable Care Organizations (2014)
3   HCTTF, Accountable Care Financial Arrangements: Options and Considerations (2016)

2. **Evaluating potential partners** – The transition to value requires health care stakeholders to seek new types of partnerships.[4] By better understanding the levers of ACO success, payers, purchasers, and providers will know how to accurately evaluate potential ACO partners.

3. **Influencing future ACO adoption** – The greatest driver of future ACO growth will be the success of existing ACOs, as fence-sitting providers will be swayed by participants' success or failure. This applies not only to new ACOs considering these arrangements for the first time, but also to those who are electing whether to renew ACO contracts or expand with additional payers, and those actively participating and looking for opportunities for improvement.

4. **Enabling the sustainable transition to a value-based health care economy** – There has been much debate around how to measure the success of early ACO programs.[5] While certain metrics can be used to evaluate financial and quality achievements, the actual impact of these initiatives is yet to be determined. It is important to remember that ACOs are not intended to be a short-term solution for savings. Instead, the ultimate goal of payment reform is to transform the way providers deliver care. Therefore, understanding long-term success factors will require deeper analysis into the delivery changes that lead to high-value outcomes.

Recognizing the importance of identifying and disseminating these success levers, the Health Care Transformation Task Force[6] (HCTTF) designed and conducted a nearly 12-month qualitative study analyzing the elements of ACO success. This report details that work, outlining research methods and describing key findings across a number of domains. The information contained in this paper represents the experiences of select ACOs, including HCTTF and non-HCTTF members, and is supported by additional evidence found in the current literature.

How to Use This Resource

The objective of this document and its subsequent reports is to move beyond high-level themes to provide a tactical guide for *understanding, prioritizing,* and *implementing* the levers of ACO success. While the principles in these reports should be broadly applicable across all ACO types, the application of these tactics will vary based on a number of factors including an organization's history, structure, governance, and market.

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4 Leavitt Partners, Defining High-Value Providers for ACO Partnerships

5 Song Z, Fisher ES. The ACO Experiment in Infancy—Looking Back and Looking Forward. JAMA. 2016;316(7):705-706. doi:10.1001/jama.2016.9958

6 The HCTTF is a consortium of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry— including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs. Our members aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

The HCTTF recommends that ACOs and other health care stakeholders leverage these resources to:

- Evaluate proficiency across key activities
- Educate organizations about the importance of these key activities
- Prioritize improvement efforts based on unique organizational needs

Methods

The Accountable Care Work Group set out to determine the factors that enable ACO success in ways that are scalable and applicable across the public and private sectors. To do this, the Work Group conducted a multi-step project which included, among other things, a series of in-depth interviews with leaders of successful ACOs to investigate the common structures and strategies that enable success.

Project steps:
1. *Determine selection criteria*
2. *Develop interview guide*
3. *Conduct interviews*
4. *Code and analyze transcripts*
5. *Supplement with HCTTF member experience and literature review*

Defining "Success"

In order to determine which organizations should be interviewed for this research, the Work Group first established a definition for ACO "success." While the aim of this work was to identify levers that are scalable and applicable across public and private ACO contracts, the Accountable Care Work Group chose to focus on Medicare ACO activity as the foundation for interviewee selection and analysis. The standardized policies and transparency of CMS programs allowed for clearer identification and comparison of ACO success levers across organizations. With this decision to focus on Medicare activity for ACO subject selection, it was determined that the interviews would primarily focus on soliciting information related to managing Medicare beneficiaries, with the assumption that levers for success will change based on the population served and the relationship with the payer. However, while the criteria were intentionally Medicare-focused, the Work Group leveraged the Leavitt Partners ACO database to identify ACOs that met the initial criteria and had at least one commercial ACO contract so that commercial strategies could be included as an important, yet secondary, consideration.

It was determined that all interviewed ACOs must meet the following criteria:

- Shared savings rate ≥2%
- Quality score ≥90%
- Below-average baseline[7]
- ≥5,000 ACO-covered lives
- More than one year under an accountable care contract
- At least one commercial ACO contract (in addition to a Medicare ACO contract)
- Diverse geographic representation (preferred)

Using the PY 2015 Medicare ACO performance results and the Leavitt Partners ACO database, 21 Medicare Shared Savings Program (MSSP) and Pioneer ACOs were identified as meeting the criteria. The Work Group then narrowed this list to 11 final ACOs in 8 states (Table 1).

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7   ACOs with below-average baselines – or lower expected average expenditures – were considered more desirable to study based on the hypothesis that these ACOs began with less excess expenditures, and therefore, a shared savings rate ≥2% was even more meaningful.

Table 1: Interviewed Organizations	
ACO Name	**Headquarters**
Allina Health	MN
AnewCare Collaborative, LLC	TN
Atrius Health	MA
Arizona Connected Care, LLC	AZ
Aurora ACO	WI
Banner Health	AZ
CaroMont ACO	NC
Coastal Medical, Inc.	RI
ProHealth Solutions, LLC	WI
Providence Health & Services	WA
MemorialCare	CA
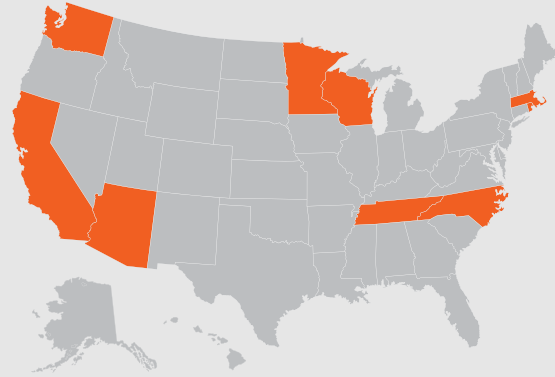
Primary Research and Analysis

Within each ACO, the HCTTF interviewed senior decisionmakers involved in designing and implementing accountable care-related activities across the ACO. To standardize the areas investigated, all ACOs were interviewed using the same interview guide (see Appendix). Interview transcripts were then coded to enable a thorough qualitative analysis.

The information below represents key findings from the analysis, outlining the common structures and strategies across some or all studied ACOs.

Findings

Throughout the course of these interviews, the HCTTF collected a large breadth of information regarding ACO structures and strategies. Although each organization had differing approaches and experiences achieving ACO success, common themes emerged. Following the qualitative analysis, the Task Force organized shared success levers into three major categories: **1) High-Value Culture, 2) Proactive Population Health Management, and 3) Structure for Continuous Improvement**. This paper briefly introduces the three categories, outlining their sub-topics and setting the stage for the subsequent in-depth reports which include aggregated findings, real-world examples, and recommended strategies.

Achieving a High-Value Culture

Perhaps the most elusive yet most important element for achieving long-term success is developing a culture conducive to value. Having a high-value culture means that all levels of the organization – particularly the leadership – demonstrate an internally-motivated commitment to excellent patient outcomes (quality) that are achieved at the lowest possible cost. This category represents the underlying current that drives all improvement efforts, by ensuring the ACO objectives are prioritized at every level of the organization.

As true with most other elements, approaches to developing and maintaining a strong culture will vary from organization to organization. Still, all studied ACOs have pursued similar channels for engaging individuals across the organization:

- Involvement by senior decisionmakers (i.e., governance bodies) in ACO operations
- Physician and community practice engagement
- Expanded clinical partnerships

Proactive Population Health Management

Unsurprisingly, common to all studied ACOs is a dedication to proactive population health management. Managing the health of a defined population across the continuum of care requires a complete paradigm shift for most providers, as well as the development of new systems and processes. While challenging to learn and implement, population health management is the cornerstone of all accountable care success. In addition to its foundational importance for accountable care, population health management and its various components were mentioned most frequently in the interviews, and were said to have the greatest impact on practice transformation.

While population health approaches can take many forms, most ACOs studied had developed analogous operational elements. Those fundamentals include:

- Systems for identifying high-risk patients
- General care management functions
- Specific disease management programs

Structure for Continuous Improvement

To be successful under any value-based payment model requires a strong supporting infrastructure, but this is especially true of ACOs. The nature of this care model, combined with the added complexity of multiple providers with disparate systems and multiple payers with different requirements, makes careful investments in infrastructure a principal strategic decision for organizations participating in ACOs. In combination with workforce resources, this is the backbone of all performance improvement. A successful ACO leverages its supporting structure to learn about its organization, its people, its performance, and its patients, and then uses that information to create feedback loops for continuous learning and system improvement. ACOs identified essential elements that support continuous improvement:

- Operational infrastructure for performance measurement
- Tying performance to compensation and network contracts
- Participation in shared learning opportunities

Conclusion

While the concept of payment and delivery reform is no longer novel in health care circles, the application of those reforms is still in its infancy. Providers across the country are pursuing a variety of payment models and partnership strategies, and all are in different stages of value-based readiness. Public and private pressures will continue to drive the movement toward value, but the ultimate sustainability of this transition will be determined by providers' willingness to share learnings, and the willingness of others to apply those lessons. Organizations like the Health Care Transformation Task Force and other learning networks support providers and the broader stakeholder community in navigating these changes by investigating and disseminating proven strategies. Just as individual ACOs must foster a high-value culture by promoting transparency and an attitude of continuous improvement, so must the health care system by sharing freely the levers of success.

Acknowledgments

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Appendix

Interview Questions

1. **Brief History and ACO Overview**
    a. Tell me about the history of the ACO: When and why did the ACO come together?
        - ACO provider configuration (e.g., physician- or hospital-led; risk-bearing participants versus strategic affiliations versus referral network)
        - ACO contract details (e.g., payer, payment model, number of covered lives, start/end dates)
        - Date of first ACO contract
        - Percentage of total revenue under value-based payment
        - Geographical areas served (e.g., region, urban versus rural, etc.)

2. **Governance and Operations**
    a. What elements or activities related to the ACO's governance and operational structure have contributed to its success?
    b. Where does ACO leadership fit within the organization?
    c. In what ways are you measuring/tracking ACO success at the governance level? How have you changed your operation metrics to reflect your value-driven strategy?
    d. To what extent are patients and patient representatives involved in governance?

3. **Financial Structure**
    a. How has the ACO's financial structure enabled its success? For example, what specific activities related to financial readiness (e.g., financial systems, contracting, risk assessment and management, etc.) have most noticeably contributed to the ACO's success?
    b. Have you established systems for tracking utilization, revenues, and costs?
    c. We'd like to understand the financial incentives for participating providers. Do you offer performance-based earning opportunities? What incentive structures exist for contracted and/or employed providers?
    d. In addition to the ACO's internal financial structures, what external factors, if any, led to the ACO's financial success?

4. **Quality**
    a. How does your operational infrastructure enable and support quality measurement, improvement, and reporting (e.g., staff, HIT, protocols, etc.)?
    b. In what ways have you incorporated ACO quality measures into your providers' workflow?
    c. What changes have been made to instill a culture of ongoing quality improvement across the organization?

5. **Clinical Transformation**
    a. What are the top three care delivery changes that have most meaningfully and directly contributed to the success of the ACO? What evidence do you have to support this?
    b. What are your strategies for identifying and managing vulnerable populations?
    c. How are you managing chronic disease differently for your ACO population than before? Any new diseases/care management programs?
    d. How do you facilitate smooth and effective transitions of care?
    e. Any new work with post-acute care, behavioral health, and/or pharmacy integration?
    f. What do patients experience in your ACO that they would not experience otherwise?

    g.   How are you evaluating your progress toward clinical transformation? To what extent do you incorporate patient experience or feedback in those evaluations?

6. Data and IT Infrastructure
    a.   What HIT investments have proven to be most beneficial and why (e.g., clinical data integration/interoperability, improved decision support, telehealth capabilities, creation of rosters or other outreach tools)?
    b.   What data sets do you have access to (e.g., claims, EHR, patient experience, patient self-reported outcomes, health risk assessments, ADT feeds)?
    c.   How do you operationalize that data across the organization, differently than you did before, or differently for this population? How often and what type of data are shared with providers to support them in population health management?

7. Workforce Development
    a.   What strategies for engaging, re-orienting, and supporting ACO clinicians and other staff have been most beneficial?
    b.   What strategies for hiring, training, and deploying new staff contributed to the ACO's success, if any?

8. Strategic Partnerships
    a.   Have partnerships contributed to the success of the ACO? If yes, what partner(s) have been most influential? How/why did you choose them?

9. Lessons Learned
    a.   What have been the top 3 challenges/barriers to your success? If you could start again, knowing what you know now, what would you do differently?