

Accountable Care NEWS

Three Shared Attributes Drive High-Performing ACOs

by Clare Pierce Wrobel, MHSA

The most recent results from the Medicare Accountable Care Organization (ACO) programs—the Medicare Shared Savings Program (MSSP), the Comprehensive End-Stage Renal Disease Care Initiative, the Pioneer ACO Model and the Next

Generation ACO Model—show that participants across the four programs reduced Medicare expenditures by \$836 million in 2016 alone.¹ However, results varied dramatically across the models and by type of provider. Physician-led ACOs on average did better than hospital-led ones, and organizations participating in the program longer were more likely to make savings, and by larger amounts.²

While three of the four models produced overall net savings, CMS did not realize net returns under MSSP, the largest ACO program. Despite 56% of MSSP participants reducing their expenditures and saving a total of \$652 million, CMS paid out more in shared savings. The reason for this is simple: Most provider organizations in MSSP participate in Track 1, which offers upside-only financial risk. Unlike the more advanced risk options that incorporate upside and downside risk, CMS does not recoup payments from ACOs in Track 1, whose Medicare expenditures exceed the financial benchmark.

For the Medicare ACO programs to be sustainable for CMS in the long term, more participants need to successfully produce savings, and more providers need to move to two-sided risk models. Yet, the two points are inextricably linked: Providers are unlikely to advance to a voluntary shared risk option unless they have confidence in their ability to succeed.

Study Examines Elements of ACO Success

To promote greater adoption of successful, two-sided risk models, the Health Care Transformation Task Force (HCTTF)—an industry consortium comprised of patients, payers, providers and purchasers—is sharing results of a qualitative study it designed and conducted to analyze elements of ACO success. Based on comprehensive interviews with leaders from high-performing ACOs, the report, entitled *Levers of Successful ACOs*, also includes strategy recommendations for organizations currently implementing or considering an ACO.³

High-performing ACOs were defined as those meeting the following criteria:

- Shared savings rate $\geq 2\%$.
- Quality scores $\geq 90\%$.
- Below-average baseline.
- $\geq 5,000$ 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 performance year (PY) 2015 Medicare ACO performance results and the Leavitt Partners ACO database, 21 MSSP and Pioneer ACOs were identified as meeting the criteria, but only 11 participated in the study. The study interviewed senior decision makers involved in designing and implementing accountable care-related activities across these ACOs. To standardize the areas investigated, all interviews followed the same interview guide, and the study coded interview transcripts to enable a thorough qualitative analysis.

Three Success Levers

Although each organization had differing approaches and experiences for achieving ACO success, common themes emerged. The shared success levers fell into three major categories:

1. **Achieving high-value culture.** Most high-performing ACOs interviewed had managed risk and/or pay-for-performance programs within their commercial lines of business before joining the Medicare ACO program. Pre-ACO value initiatives varied based on the payment arrangements made available in any given market; however, most executives interviewed expressed a belief that a large-scale transition away from fee-for-service payment was both imminent and desirable.

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The interviewees described strong commitment and involvement from the highest echelons of leadership in the pursuit of accountable care and healthcare transformation, even where success under the shared savings model might put overall system revenue at risk. Medicare compliance requirements obligated participants to establish a governing board for the Medicare ACO with specified representation, but several interviewees noted a strategic decision to integrate an ACO’s governing body within a broader structure of governance across an organization.

The participating ACOs utilized a variety of strategies to ensure clinicians understood and could act upon ACO requirements, which varied based on ACO structure and a physician employment model. Most ACOs followed a similar model of breaking an ACO into subgroups for the purposes of assigning clinical leadership and measuring performance. While population health initiatives were often driven by analytics to define target segments of the patient population and priority areas for improvement, high-performing ACOs relied heavily on clinical staff to review and refine implementation plans on the front end. Organizations also employed strategies to mitigate physician burn-out, or “transformation fatigue.”

2. **Proactive population health management.** High-performing ACOs developed methods for segmenting patient panels and prioritizing high-risk patients for care management programs. The interviewees described a variety of front-end tools used to stratify patients and segment a target population, including home-grown, analytic models; electronic health record (EHR) modules; and standalone, population health management software. Use of payer claims data to establish a risk score and consequent triggers for program assignment was most common. Several executives mentioned integrating tools into the EHR to make it easy for frontline staff to direct patients to care management and other programs available to ACO patients, such as highlighting insurance types in a patient header to alert clinicians that patients might be eligible for unique benefits.

ACOs differentiated population health programs between general care management functions and those tailored to meet the needs of individuals with specific conditions. Most high-performing ACOs also dedicated resources to supporting transitions of care, including navigating patients to the right post-acute care setting or wellness program, tracking patients at risk for readmission to the hospital and educating families and caregivers to make informed, shared decisions.

Most ACOs interviewed created patient rosters and registries for targeted conditions, building upon the systems and platforms described above that were utilized to identify high-risk patients. The disease management programs generally comprise two pillars: 1) implementing evidence-based, standard treatment protocols for patients with chronic disease, and 2) promoting effective patient self-management. Team huddles were another common approach for effective real-time management, and “overlap huddles” allowed for multiple teams to discuss a single patient and to develop care plans that fully consider all aspects of care.

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3. **Structures for continuous improvement.** Dedicated data, actuarial analytics and performance improvement resources were crucial investments for high-performing ACOs. Organizations hired quality improvement professionals with a variety of backgrounds, including registered nurses, registered health information administrators, medical technicians and others with a quality improvement skillset. Data analytics staffs were often recruited from payers for their claims analysis experience. Most of the hospital-led ACOs supported centralized performance improvement teams often reserved for cross-business unit efforts and larger interventions, with additional performance improvement staff dedicated to specific business units.

High-performing ACOs have tested various performance-based incentives at a group or individual level to incentivize continuous improvement, with most including quality performance as a component of employed physician compensation. Beyond direct compensation and contractual arrangements, high-performing ACOs have established structures to reward network-affiliated providers for continuous improvement through a combination of financial, educational and transparency mechanisms. Greater transparency on a provider-level performance—and variation—presented the most common tool for encouraging continuous improvement and behavior change.

The Medicare ACO methodology pressures participants to continually improve against their historical performance to remain successful, and high-performing ACOs have taken steps to inculcate continuous improvement structures to build upon earlier performance. However, it is difficult for ACOs to continually find year-over-year opportunities to produce savings and attain high-quality outcomes. On one hand, a model in which an ACO effectively competes against itself year after year is not a sustainable model. On the other hand, organizations could use currently available upside-only risk models to build capabilities to be successful with essentially no downside before taking the leap into more advanced risk-sharing models.

ACOs face additional challenges, including misaligned payer incentives, inflexible fee-for-service regulations and lack of transparency on price and quality across a system. Nevertheless, ACOs are addressing these challenges incrementally by piloting, refining and sharing lessons learned from implementing continuous improvement structures. These efforts will ultimately prepare participants to graduate to more advanced models and enable a sustainable transition to a value-driven system.

¹ "ACOs Across Demos, Program Saves Medicare \$70.6M in 2016." InsideHealthPolicy. Oct. 18, 2017.

² "Medicare Accountable Care Organization Results for 2016: Seeing Improvement, Transformation Takes Time." *Health Affairs Blog*. Nov. 21, 2017

³ "Levers of Successful ACOs." Health Care Transformation Task Force. Nov. 9, 2017.

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