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orchestrating ACO success

how top performers achieve shared savings

Accountable care organizations are at the forefront of the healthcare industry's transition to value-based care; those that succeed will provide a leading example for the industry to follow.

Medicare accountable care organizations (ACOs) are disrupting health care, creating new power centers, and transforming care delivery. Although just 28 percent of ACOs have achieved positive bottom-line results so far, ACOs can have an outsized impact on physician and hospital competition where they exist.

ACOs may be sponsored by physician groups or by hospitals. The jury is still out regarding whether one of these two types of sponsorship will emerge as most effective for achieving value in American health care, or whether the relative market presence of either model will vary by market.

The best way to compare physician and hospital sponsorship is by looking at the experiences of ACOs participating in the Medicare Shared Savings Program (MSSP).[a] In the MSSP, both types of organizations play by the same set of rules, allowing their success to be objectively measured and compared. There now are 434 ACOs in the MSSP. The most recent performance data available for assessing MSSP ACO results, however, is for the 333 ACOs that participated in the program in 2014. To provide a basis for understanding the key success factors for ACOs, we start with an analysis of the performance of these MSSP ACOs, comparing results for physician-sponsored ACOs (60 percent of the program total) and hospital-sponsored ACOs (40 percent).

After this analysis, we share insights into effective ACO strategies based on comments made by successful (and very enthusiastic) leaders of top-performing ACOs. Many of these leaders see their ACO programs addressing a vast range of opportunities for improvement in the quality and cost of care, which

a. Using publicly available data from CMS and ACOs, MSSP-participating ACOs were categorized as hospital-sponsored and physician-sponsored. If a hospital has a role in governance, the ACO was categorized as hospital-sponsored, even though most hospitals work hard to engage physicians in governance. ACOs that lacked any hospital involvement were categorized as physician-sponsored.

AT A GLANCE

Leaders of the top-performing accountable care organizations in the Medicare Shared Savings Program attribute the success of their organizations in large part to seven strategies:

- Seek action-oriented leadership.
- Transform primary care physician practices.
- Keep patients out of the emergency department.
- Ensure all transitions are smooth.
- Make effective use of available data.
- Share information on physician performance.
- Keep patients engaged.

ACOs THAT GENERATED SAVINGS GREATER THAN OR EQUAL TO THEIR MININUM SAVINGS RATE (MSR), 2013-14

	2013	2014
Physician-Sponsored ACOs		
Number Generating Savings ≥ MSR	36	63
Total Physician-Sponsored ACOs	132	201
Percentage Generating Savings	27%	31%
Hospital-Sponsored ACOs		
Number Generating Savings ≥ MSR	22	29
Total Hospital-Sponsored ACOs	88	132
Percentage Generating Savings	25%	22%
Total		
Number Generating Savings ≥ MSR	58	92
Total ACOs	220	333
Percentage Generating Savings	26%	28%

have allowed them to enhance care in ways that have never before been possible. The strategies of these successful ACOs can help others succeed, whether physician-sponsored or hospital-sponsored.

Physician-Sponsored ACOs Outperformed Hospital-Sponsored ACOs

In 2014, more than half of MSSP ACOs (181 of the 333) reduced costs relative to their benchmarks, but only 28 percent (92 of 333) generated savings greater than their minimum savings rate (MSR), the threshold that makes ACOs eligible to receive a share of those savings.

Notably, physician-sponsored ACOs tended to outperform their hospital-sponsored counterparts. A higher proportion of physician-sponsored ACOs than hospital-sponsored ACOs met their MSR—31 percent compared with 22 percent, respectively, in 2014.

Physician-sponsored ACOs, as a group, also showed improved performance between 2013 and 2014, while hospital-sponsored ACO performance slipped over the same time frame. It will be important to monitor future performance.

Physician-sponsored ACOs also were more likely than hospital-sponsored ACOs to achieve savings in two successive years. Of the 213 ACOs that participated in both 2013 and 2014, 21 percent achieved shared savings in both years. Among these, 30 out of 36 successful physician-sponsored ACOs (83 percent) were able to repeat their success a second year, while only 14 of 22 hospital-sponsored ACOs (64 percent) were able to do so.

The better performance of the physician-sponsored ACOs is particularly noteworthy because these ACOs are considerably smaller on average than the hospital-sponsored ACOs (with averages of 12,000 beneficiaries and 21,000 beneficiaries, respectively). Smaller ACOs must achieve higher MSRs to be eligible for a share of savings.[b]

Physician-sponsored ACOs accounted for the majority of top 10 ACOs. In 2014, six out of the top 10 ACOs, ranked by total savings generated, were physician-sponsored ACOs. Results for 2013 showed a similar proportion. When ACOs were ranked by savings per beneficiary for 2014, eight of the top 10 were physician-sponsored ACOs.

Among ACOs that shared in savings, physician-sponsored ACOs had higher average gains per beneficiary. Given their smaller average size and higher MSR requirements, this result is, perhaps, not surprising, given that they would have to generate higher gains to share in savings.

b. The minimum savings rate varies from 3.9 percent for MSSP Track 1 ACOs with fewer than 6,000 assigned beneficiaries to 2 percent for MSSP ACOs with more than 60,000 beneficiaries.

Why Have Physician-Sponsored ACOs Been Performing Better?

Although success continues to elude the majority of both hospital-sponsored and physician-sponsored MSSP ACOs, it is apparent that physician-sponsored ACOs have been performing better. One possible interpretation for this relative success is their straightforward motivation to reduce costs in contrast with the inherent ambivalence of hospital-sponsored ACOs regarding reductions in utilization of entities owned by health systems, especially inpatient hospitals.

It makes sense that physician-sponsored ACOs are motivated to generate another revenue stream to help offset pressures on fee-for-service revenue. With their unambiguous goal, they also are in a stronger position to apply direct pressure on physician colleagues to change their behavior relatively quickly, so that all will benefit financially.

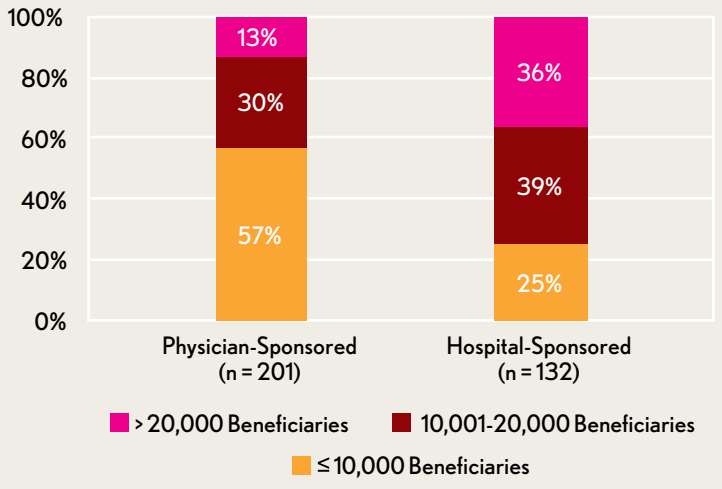
Because optimizing shared-savings distributions is the goal, physician-sponsored ACOs also try hard to keep ACO operating costs down. Some leaders of physician-sponsored ACOs are frustrated that their boards do not invest more to achieve better results.

Some contend that hospital-sponsored ACOs are less aggressive than physician-sponsored ACOs in their efforts to reduce the cost of care because of concerns about reducing hospital revenues. But the dynamics are more complex than that. For hospitals, an ACO is a strategic opportunity to align with physicians and prepare for delivering value-based care. ACOs also are an opportunity to gain market share and defend against possible competitor ACOs, which could steer patients away from their hospitals.

To some degree, both types of ACOs also owe their success to various factors that have little to do with commitment, effort, or skill. Some ACO participants, for example, may have been able to achieve savings because they are in a region with historically high utilization. These regions simply have more room for improvement than areas that are already efficient. It also is not clear to what extent the success of physician-sponsored ACOs is attributable to physicians being more likely to form ACOs in areas where costs have historically been high and opportunities are better. Moreover, smaller ACOs show greater variability in cost results, both higher and lower. Some physician-sponsored ACO success may be due to statistical variability, given their smaller attributed populations.

There is one other challenge for physician-sponsored ACOs. Despite their success at reducing costs, these ACOs are more likely than hospital-sponsored ACOs to leave money on the

ACOs PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM IN 2014, BY NUMBER OF ASSIGNED BENEFICIARIES AND SPONSORSHIP



TOP 10 ACOs PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM BY TOTAL SHARED SAVINGS, 2014

ACO	Sponsorship	Location	Total Shared Savings
Memorial Hermann ACO	Hospital	Houston, Texas	$22,723,305
Palm Beach Accountable Care Organization, LLC	Physician	Palm Springs, Fla.	$14,455,933
Physician Organization of Michigan ACO, LLC	Physician	Ann Arbor, Mich.	$12,075,693
Oakwood Accountable Care Organization, LLC	Hospital	Dearborn, Mich.	$8,147,793
ProHEALTH Accountable Care Medical Group, PLLC	Physician	Lake Success, N.Y.	$8,019,532
Millennium Accountable Care Organization	Physician	Fort Myers, Fla.	$7,977,169
RGV ACO Health Providers, LLC	Physician	Donna, Texas	$7,528,797
Qualuable Medical Professionals, LLC	Physician	Kingsport, Tenn.	$7,406,111
Delaware Valley ACO	Hospital	Villanova, Pa.	$6,567,267
Mercy Health Select, LLC	Hospital	Cincinnati, Ohio	$6,518,339

Source: Veralon ACO Database

table due to inadequate reporting of quality metrics. In fact, in 2014, five physician-sponsored ACOs did not share in any savings because they were unable to report on quality successfully. Only one hospital-sponsored ACO found itself in a similar situation. On average, of those ACOs that generated savings and met their MSR, physician-sponsored ACOs received 40 percent of the savings they generated (total potential shared savings is generally 50 percent of generated savings, subject to quality performance), and hospital-sponsored ACOs received slightly more—43 percent.

Optimizing Performance

ACOs that have not yet achieved shared savings—regardless of sponsorship—can learn from how the successful ACOs have been focusing their attention. Health systems and hospitals that have not sponsored ACOs but share a market with one or more ACOs also can gain insight into how best to work with these ACOs if they understand the predominant MSSP ACO success factors.

Based on the MSSP ACO results, there is a long list of potential strategies and tactics by which ACOs might achieve success. The seven strategies discussed below, however, were identified as being most important by leaders of successful ACOs. A positive theme that runs through their comments is perhaps most aptly expressed by one leader: "We're finally addressing issues where we could not get traction for years. It's incredibly satisfying to be improving care."

Seek action-oriented leadership. Rapid transformation is at the core of ACO success. The best operational manager in the world won't achieve transformation as well as the inspiring leader who can rouse clinicians and administrators to go after "unreasonable" goals. For successful ACOs, this leader almost always is a physician who is ready to take immediate steps and drive change.

Transform primary care physician practices. Achieving real change in primary care is uniformly identified as the highest priority for an ACO. Despite many years of discussion, primary care

physicians still need to fully shift their focus from "sick patient visits" to keeping patients well. It sounds trite—but it is absolutely critical: Primary care physicians need to realize that they are responsible for the full range of their patients, including both the complex patients who need extra attention and the patients who do not seek office visits.

Accomplishing this shift in focus requires a true transformation of the practice model, beyond checking off the boxes for a patient-centered medical home designation. It requires creating practices where the most discerning healthcare professionals would want their family members to receive care.

Such practices are extremely attentive to patients with complex conditions, who may have multiple chronic illnesses, and they welcome the ACO's help in managing the care of these patients. Practice staffing includes care management nurses (often provided through the ACO) who assist in coordinating care for complex patients to ensure seamless, ongoing care.

These practices also consistently start care management immediately, with whatever data are available, rather than being paralyzed by a lack of sophisticated analytic tools. They make sure their physicians have real-time information on hospital admissions and discharges, and they are able to ensure smooth transitions for patients.

They also take steps to ensure patients are seen at the right time in the right setting. For example, the practice will make sure that a patient who calls on Friday morning is seen that afternoon so the patient can avoid ending up in the emergency department (ED) on Saturday.

The physicians in such practices also take their own calls from the ED, rather than having them handled by the physician on call, in the interest of avoiding unnecessary workups and admissions.

TOP 10 ACOs PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM BY GENERATED SAVINGS PER BENEFICIARY, 2014

ACO	Sponsorship	Location	Gains per Beneficiary
AllCare Options, LLC	Physician	Palmetto, Fla.	$2,331
Medical Mall ACO*	Physician	Jackson, Miss.	$2,218
Rio Grande Valley Health Alliance, LLC	Physician	McAllen, Texas	$1,838
RGV ACO Health Providers, LLC	Physician	Donna, Texas	$1,751
Winchester Community Accountable Care Organization	Hospital	Winchester, Mass.	$1,747
Physicians ACO, LLC	Physician	Houston, Texas	$1,670
Integral Healthcare, LLC	Physician	Spring Hill, Fla.	$1,598
Collaborative Health ACO	Hospital	Natick, Mass.	$1,575
Independent San Diego ACO*	Physician	La Mesa, Calif.	$1,552
Accountable Care Options, LLC	Physician	Boynton Beach, Fla.	$1,488

* ACO did not share in savings.
Source: Veralon ACO Database

Adopting these kinds of best practices is a significant challenge for most practices. Much of the change required can be achieved by working with and empowering office staff. Some ACOs provide assistance through practice transformation coaches or consultants.

Keep patients out of the ED. For an ACO, the ED should be a last resort. ED visits can save a patient's life—but they can, and often do, endanger patients as a result of poor communication rather than poor care. If a patient who could have been managed at home arrives at the ED, that patient all too often will receive a full workup. Possibly, the patient will be admitted, and if the patient loses strength as a result of the stay, he or she might need to be discharged to a nursing home (or if the patient came from one, be returned to it in worse shape and in need of more intensive care).

With commitment from the primary care practice and cooperation of the ED physicians, this situation can often be prevented. Primary care physicians, therefore, should encourage hospitals to coordinate care decisions through them. For example, whenever a patient makes an ED visit, the ED should call the patient's primary care practice, and the patient's primary care physicians, rather than the practice's on-call physician, should take the call.

AVERAGE GAIN PER BENEFICIARY AMONG ACOs THAT SHARED IN SAVINGS, 2013-14

Ownership	Average Gain 2013	Average Gain 2014
Physician-Sponsored	$963	$767
Hospital-Sponsored	$760	$619
Both Physician- and Hospital-Sponsored	$886	$719

The primary care physician then can share critical information on the patient's baseline condition. ("She has a history of congestive heart failure that's been well-managed. Just be sure she's taking her Lasix and looks OK. I'll see her in my office tomorrow.")

With proper attention to keeping the attributed population healthy—particularly the complex cases—and to ensuring patients have access to their primary care physicians, many ED visits can be avoided altogether.

Ensure all transitions are smooth. When patients move between care settings—for example, hospital to home, and hospital to nursing facility—they are at particular risk for mishaps. By definition, their condition is changing, so this is a particularly vulnerable time for patients and families. The traditional, fragmented fee-for-service delivery system does not handle these transitions well. It is an ideal area of opportunity for ACOs.

Successful ACOs identify patients who are facing these transitions, ensure communication and follow-up with the primary care physician, and build transition-of-care programs to support effective communication, handoffs, and monitoring.

Make effective use of available data. Some successful ACOs have sophisticated IT systems, and some do not. Expensive, integrated IT systems are not a requirement for success. The important thing is to use the available data.

Ideally, an ACO can identify complex patients using risk-stratification tools in a sophisticated IT system. However, if that kind of tool is not available, an ACO should have access to data that *are* immediately available. Using Medicare claims data, it is possible to create a list of all patients

hospitalized in the past year, which care management nurses can review on a case-by-case basis to determine whether care management could have a significant impact. This exercise is quick, and can avoid "analysis paralysis." There is no shortage of patients for whom care management will help; to have the greatest impact on costs and quality, ACOs should start with those who are easy to identify and are likely to have plenty of interactions across multiple settings of care.

One data challenge for ACOs and similar programs is that there often is a significant lag time in receiving claims data. To overcome this delay, it may be possible to obtain real-time admission, discharge, and transfer information from a health information exchange (HIE), if there is one in the ACO's region. If the region lacks an HIE, hospital-sponsored ACOs can look at who was admitted to the hospitals that are part of the ACO, and physician-sponsored ACOs can push hospitals to provide these data.

Share information on physician performance. Physicians are competitive and accustomed to succeeding, but not all contribute equally to ACO performance; some participating physicians work in ways that promote ACO success, and others work in ways that detract from that success. Successful ACOs motivate physicians in the latter group to better align their practices with organizational standards for excellence by sharing performance data at the physician level. This step is important because successful ACO leaders understand that financial incentives are not enough to engage physicians.

Performance should be measured in real time. A conventional, six-month reporting lag of claims data means that it will take at least nine months to begin to implement changes, with the result that if you rely only on the claims data, a full year is likely to pass before the ACO and physicians know whether their efforts are working.

Instead, ACOs should measure and report the key metrics of practice transformation, including:
> Use of care management
> Awareness of hospitalized patients
> Availability of Friday afternoon appointments
> Ability to take calls when patients are in the ED

These metrics, which can be tracked weekly, are leading indicators of future success.

Keep patients engaged. A critical concern is keeping all patients attributed to the ACO active in receiving wellness care. Success with this effort will not only help prevent unnecessary ED visits, but also keep attribution steady. As one ACO leader put it, "Providers need to create a predictable relationship with a patient, so that patients feel confident they are being taken care of, and don't wander."

When patient turnover is high, management resources are wasted on patients who no longer are attributed to the ACO. Keeping patient turnover in the single digits is critical.

Game Changers for the Future

Some industry analysts may suggest that the better performance of physician-sponsored ACOs will lead them to emerge as the dominant model. However, the two-thirds of physician-sponsored ACOs that failed to generate savings are unlikely to stay in the program over the long term unless their performance improves. On the other hand, hospitals and health systems that sponsor ACOs have strategic reasons to stay the course and seek longer-term improvement in performance.

It is possible that many physician-sponsored ACOs may fold after three years or sell to hospitals and health systems. Meanwhile, hospital-

sponsored ACOs may renew for a second three-year contract, often with no downside risk, even if profits are slow to come. New models, like the Next Generation ACO, expand the options, meaning successful ACOs can gain more risk and reward, and additional flexibility in how they manage care. ACOs also may enter into other payer contracts that could affect these decisions.

Regardless of whether an ACO is physician-sponsored or hospital-sponsored, the strategies for achieving success are similar—real change in primary care, keeping patients out of the ED as much as possible, smoothing care transitions, maximizing the value of the data you can get, sharing physician performance information, and keeping patients engaged.

Despite lower-than-expected savings results to date, ACOs are still game-changing factors in a rapidly shifting competitive market. Successful ACO leaders are both passionate about their work and fulfilled by it. They are fixing long-standing systemic problems and significantly improving care delivery. And patients, physicians, and hospitals alike are feeling the impact. ■

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