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Structure Your ACO for Success: Invite the Right Players to the Table

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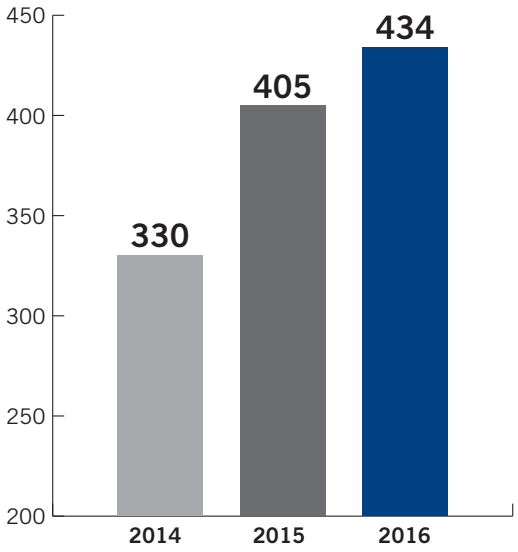
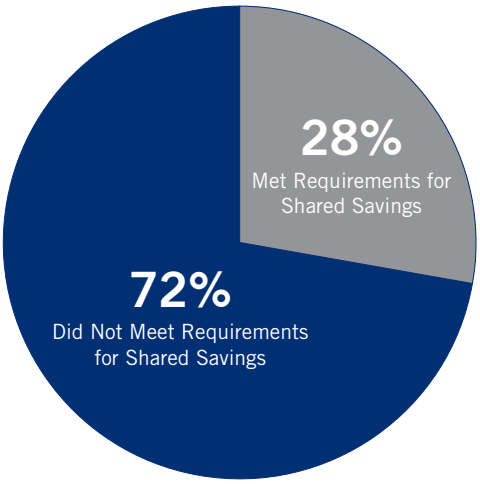
The Centers for Medicare and Medicaid Services (CMS) recently announced that it had accepted the applications of 100 new Accountable Care Organizations (ACOs) and 147 renewing ACOs into the Medicare Shared Savings Program (MSSP) for the 2016 performance year, bringing the total number of MSSP ACOs to 434.[1] For new, renewing, and current MSSP ACOs alike, the prospects for success in the program appear daunting: for the 2014 performance year (the most recent for which CMS has released final results), 92 out of 330 ACOs qualified for shared savings payments from the program[2], meaning that over 72 percent of ACOs did not meet the program's quality and cost savings requirements.

In spite of the obvious challenges to ACO success reflected in these performance figures, the fact that so many ACOs have elected to join or renew their participation in the MSSP reflects a laudable commitment to the goals of the program, as well as an optimistic outlook for success within it. Thoughtful ACO leaders will recognize that making good on this commitment and this optimism requires more than good intentions—it requires structuring and equipping their ACOs for success. Among the considerations that position an ACO for maximum effectiveness, an effective performance management system[3] and an equitable and transparent shared savings distribution model[4] have been demonstrated as essential attributes. To that end, in this paper we examine the question of MSSP ACO composition—i.e., what provider types should the ACO include—and explore the modalities by which the ACO can achieve the optimal structure and then effectively manage that ideal mix of providers toward an ever increasing realization of the Triple Aim.

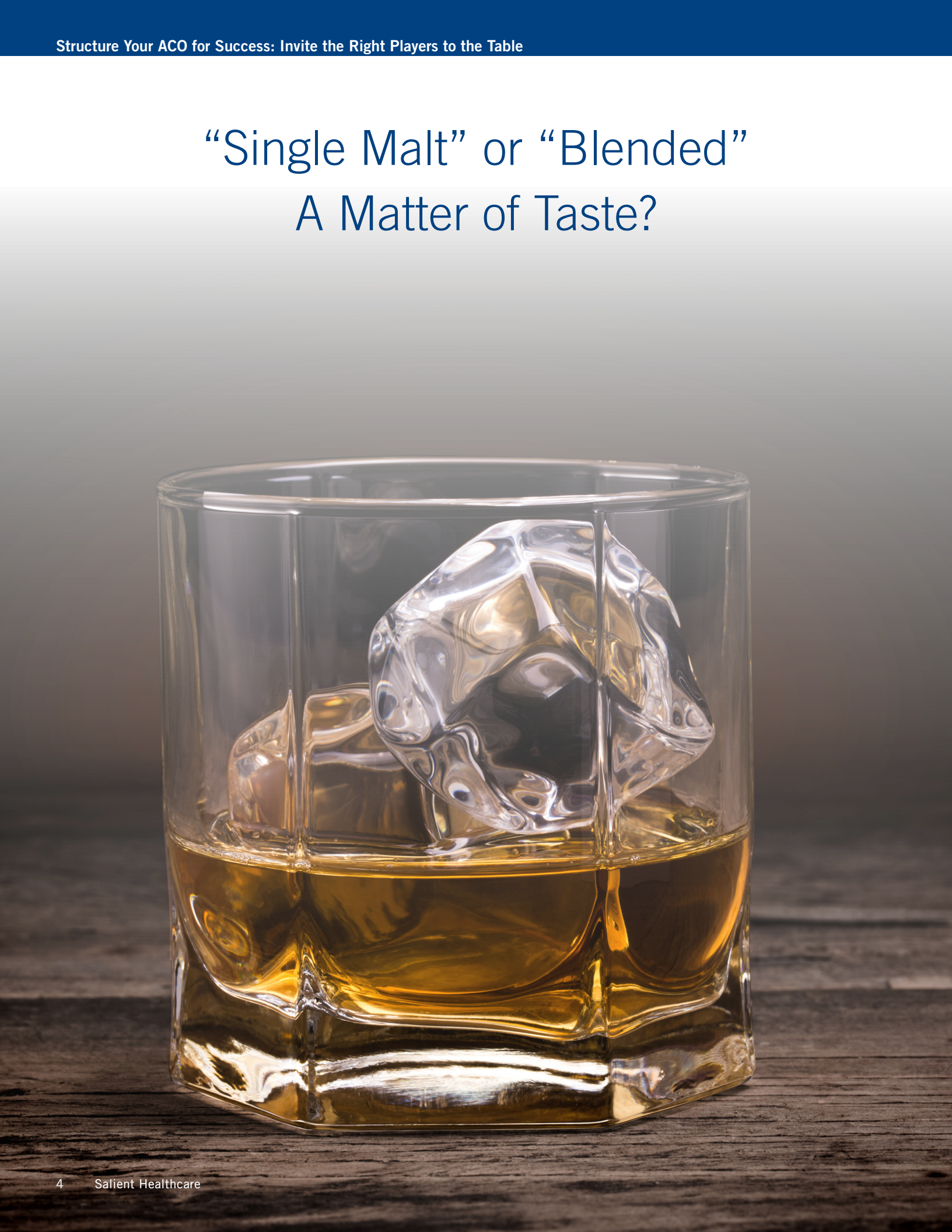
Growing Number of ACOs



2014 ACO Performance



"Single Malt" or "Blended" A Matter of Taste?

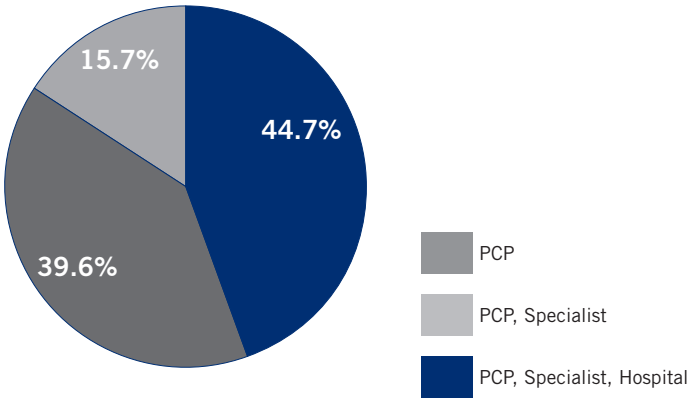


CMS defines ACOs as groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients.[5] Working from the CMS definition alone, one might assume that an ACO would include a variety of provider types—primary care physicians, specialists, and hospitals—in order to further the goal of "coordinated high quality care." Such an assumption makes intuitive sense in light of the additional objective embodied in the very name of the MSSP—shared savings—and the fact that specialty care represents a primary driver of the United States' high healthcare costs in comparison to other countries.[6]

It may come as a surprise then that the CMS final rule implementing the MSSP does not require ACOs to include specialty physicians or hospitals at all. Indeed, the only requirement is that an ACO include enough providers to cover the plurality of primary care services for at least 5,000 fee-for-service Medicare beneficiaries.[7] With that, CMS attributes patients to ACOs based solely on primary care services.

Given the apparent dichotomy between a CMS definition of ACOs that seems to favor a blend of provider types on the one hand and regulatory requirements that focus exclusively on a single type (primary care providers) on the other, it may be useful to examine the composition of current ACOs to determine whether one particular model predominates. A cross-sectional study in 2014 by Schulz et al. found that of 313 active MSSP ACOs for which organizational data was available, 140 (44.7%) included primary care physicians (PCPs), specialists, and one or more hospitals; 124 (39.6%) included PCPs and specialists; and only 49 (15.7%) included only PCPs.[8] Yet Hawken et al. found underrepresentation of surgeons and other specialists in the first 220 MSSP ACOs, with a mean of fewer than 20 specialists per 1,000 beneficiaries and 150 of 220 ACOs at or below the mean specialist participation rate.[9] From these findings, it appears that while the vast majority of MSSP ACOs do include a blend of provider types, specialist participation varies widely and in most cases represents a small proportion of the overall composition of most ACOs. The wide variation in specialist and hospital participation among existing ACOs and the low level of specialist participation overall suggest that no clear consensus has emerged as to how newly-forming ACOs (as well as existing PCP-only ACOs) should seek to structure themselves.

2014 ACO Structure Comparison



It Takes a Village to Achieve the Triple Aim

Since CMS participation requirements for the MSSP only address PCPs, and the present CMS patient attribution methodology accounts for primary care exclusively, a PCP-only ACO structure may appear most desirable at the outset. An ACO composed solely of PCPs will be simpler to organize and manage; likewise, such a structure lends itself to a more straightforward distribution of shared savings than a more complicated organization that includes specialists and hospitals—especially since hospitals may not initially contribute to the overall savings process.

PCP-only ACOs also make intuitive sense in light of historical undercurrents in the American healthcare system. In the recent past, many hospitals have focused almost exclusively on specialty care to the point of virtually ignoring primary care physicians for the simple reason that specialists drive more complex admissions and perform procedures that support the hospital's bottom line. In a volume-driven payment system primary care added little to the hospital's financial objectives. In the ACO world, however, the center of the universe shifts as hospitals become a cost center in the overall process of care delivery. It is not surprising under these circumstances that primary care doctors may not initially consider hospitals and specialists as attractive partners in the care process.

This reasoning, however attractive it may appear to nascent and existing PCP-only ACOs, overlooks a critical factor: while MSSP allows ACOs composed solely of PCPs, and patient attribution to ACOs takes place on the basis of primary care locus, CMS evaluates ACO performance on the total cost of care for attributed beneficiaries. As noted earlier, specialty care—particularly procedures or complex inpatient care—drives a significant portion of this total cost of care. Care coordination, in addition to being a stated CMS goal for ACOs[5], represents a significant means of achieving reductions in the total cost of care.[10,11] While PCP-only ACOs may be able to achieve some level of care coordination with specialists and hospitals, solidifying care coordination relationships within a "blended" ACO —with formal cooperation protocols, care management, data sharing agreements, etc.—will yield greater cooperation and cost savings than informal, ad hoc care coordin-ation arrangements can deliver.[12] Moreover, better care coordination—with fewer "missed handoffs," fewer unnecessary procedures, greater continuity of care, and better communication among the care team overall—will tend to deliver better patient outcomes and experience of care.[10,13,14]

For all these reasons, while we acknowledge that some of the most successful ACOs to date have been PCP-only organizations, we nonetheless contend that the most effective ACOs will adopt a blended model incorporating PCPs, specialists, and hospitals that positions them to leverage opportunities for enhanced coordination across the total continuum of care to achieve cost savings while improving quality and experience of care. While some

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hospitals and their closely attached specialists may still seek to maintain their volume, other organizations—whether spurred by consciousness of their communities, an institutional commitment to healthcare reform, or simply reading the writing on the wall with the advent of bundled payments and similar bellwethers of pay-for-volume's dwindling prospects—already actively seek to reduce unnecessary ER utilization and admissions and work to reduce preventable readmissions through better facility-practice coordination. Such hospitals and specialist networks represent potentially fruitful collaborators in the ACO mission. This will require strong relationships between the hospitals (who generally benefit from keeping beds full) and the PCPs (who benefit in the MSSP from keeping beds empty). The ACO itself should play a key role in the forming of these relationships, as well as develop shared savings methodologies that create incentives for the hospitals to reduce volume in some of their most profitable services. This will become increasingly important as ACOs face the prospects of exhausting the low-hanging fruit of "easy" savings and future payment models requiring greater risk-bearing by the organization.

But Who *Is* My Neighbor? Ask Your Claims Data

Whether an ACO's present composition consists exclusively of PCPs or already includes specialists and hospital representation, once the organization has decided to adopt or expand upon a "blended" model its growth and optimization will involve careful selection of specialists to achieve the greatest degree of coordinated care for the greatest possible proportion of the attributed population. To that end, the ACO's ability to utilize analytical tools will become increasingly important.

The most obvious methods for seeking specialist and hospital participation in an ACO include utilizing existing referral relationships, followed by a simple geographic approach—the "Yellow Pages" technique. These anecdotal methods alone, however, are insufficient due to the unique nature of ACO "networks." Unlike HMOs and other managed care models, ACOs do not have the ability to compel utilization of in-network providers and patients experience no financial consequences for seeking care from providers outside of their assigned ACO. Thus, soliciting specialists and providers without insight into actual utilization patterns may lead to the inclusion of providers who have little impact on ACO performance, as well as missed opportunities among specialists and hospitals that render more and higher-intensity care to the ACO attributed population.

For this reason, we suggest a more nuanced approach. The claims data provided by CMS to ACOs will offer substantial insight into which providers should be targeted for inclusion in the ACO—if the ACO has the visual data discovery and analytics capabilities to extract this nugget from the "ore" of raw claims. In particular, geospatial analyses can yield insight quickly into the providers and hospitals within the ACO's service area that already deliver the most care (by unique patients, service volume, and cost) to the ACO's patients. ACOs can use this data to develop short lists of specialists and hospitals that have the greatest potential to impact the total cost of care for the most ACO beneficiaries. These providers represent the "most valuable players" that ACOs should seek to acquire as participants. By utilizing such a data-driven targeted approach, ACOs will be able to optimize their networks to realize the greatest possible cost savings for their attributed populations; conversely, analytical review of the claims data likewise will reveal those providers and hospitals that are not delivering care to the ACO's beneficiaries efficiently.

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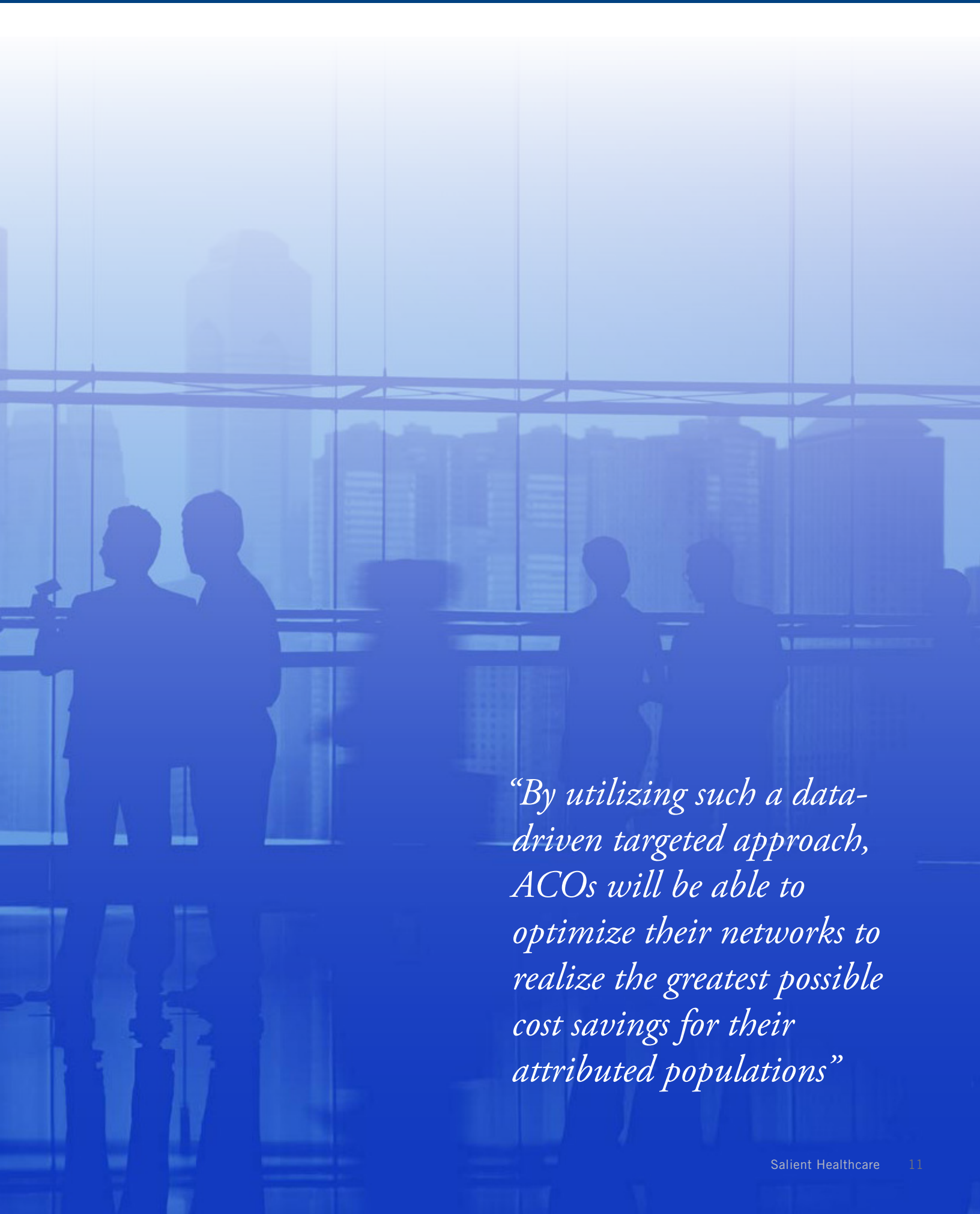

"By utilizing such a data-driven targeted approach, ACOs will be able to optimize their networks to realize the greatest possible cost savings for their attributed populations"

Coordinating Care Along the Complex Continuum

Once ACOs have identified and brought on board an optimal mix of specialists and hospitals via a data-driven approach, their task still stands only half-complete. To fully realize the potential improvements in cost, quality, and experience of care made possible by optimizing provider participation to encompass the total care continuum, the ACO will require a robust analytics platform that includes population health and care coordination capabilities to evaluate the performance of all providers. Whether PCPs serve as the "quarterbacks" (or the "armed gatekeepers") of the care coordination team, or the ACO or individual primary care practices retain dedicated care coordinators for this task, effective care coordination requires the ability to access and interrogate all the available data on their patient population, regardless of whether that data comes from CMS attribution and claims feeds, the PCP's own EHR, or specialists' or hospitals' systems.

In this regard, partnering with a hospital holds one particularly attractive benefit: the opportunity to leverage its Admission, Discharge, and Transfer (ADT) feed. This feed can provide the ACO with a "real time" notification (within days of the event) that one of the ACO's attributed beneficiaries has been in the hospital, instead of a 3-to-6 month lag that could see the beneficiary returning to the hospital multiple times before the ACO is aware of the initial visit. In turn, this can lead to a significant uptick in critical 7, 15, and 30-day follow-ups with PCPs after a hospital visit. These follow-up visits can drastically impact the chances of readmission, with attendant effects on avoidable hospital costs.

They require the capability to test their entire patient population against single or multiple criteria to identify candidates for early intervention, and they likewise must have the ability to view a specific patient's history including trending indicators and the capacity to drill into visit-level detail. Once the primary care provider and the care coordination team has determined the need for specialty or acute care, the specialist or hospital must have access to the same data the care coordination team uses in order to avoid "missed handoffs" as well as unnecessary or duplicative tests or procedures; intuitively, such data sharing will be far easier to facilitate within the context of the ACO rather than external to it.

The first paper in the Salient ACO series, Choosing the Right Performance Management System for Your ACO, provides an in-depth treatment of the attributes of an ideal ACO performance management system, encompassing essential population health management and care coordination capabilities. These attributes include the ability to synergize data from multiple sources into a comprehensive, cohesive picture of the ACO enterprise: its patients, providers, services, costs, and outcomes; the speed to answer questions and follow-up questions without disrupting workflows; intuitive self-service access to all the information relevant to any decision, be it clinical, financial, or operational; specific information that preserves all the fine-grained detail available in the original data; and the scalability to accommodate ACO growth or consolidation as well as future accountable care and value-based payment initiatives.[3]

"Effective care coordination requires the ability to access and interrogate all available data on the patient population."

Looking Ahead to Full Risk

The CMS methodology for evaluating MSSP ACO performance—holding them accountable for the total cost of care for their attributed patient population—offers a glimpse into the future of value-based payment models: shared risk and, eventually, full risk. Payment reform expert Michael Bailit characterizes shared saving as a "way station" along the way to full risk, pointing to the eventual exhaustion of "low hanging fruits" for cost reduction and the necessity of downside risk alongside gain-sharing in order to motivate further movement toward high-value care.[15] Indeed, among CMS' other ACO programs—the Pioneer ACO and the recently-announced Next Generation ACO—the future of two-sided risk is already here. Moreover, these and other CMS payment reform initiatives are driving the conversation in Medicaid and private payers as well. As the full-risk future draws nearer, care coordination among the entire continuum of care will become not merely optimal but mandatory. ACOs and their participating providers can embrace this "brave new world" of value-based payment now and gain a competitive edge by adopting and fine-tuning tools and techniques such as those we have described, taking advantage of the gentler learning curve afforded by shared savings programs to optimize their networks and develop seamless care coordination protocols now. Notwithstanding the understandable reluctance sometimes seen among primary care physicians to embrace as their ACO partners hospitals and specialist physicians that may have ignored primary care in the past, part of the growth process in healthcare reform should include trust-building among all the provider parties along the care continuum as the patient moves closer to the center of the care universe.

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