

# Accountable Care Organizations: Looking Back and Moving Forward

*By Rob Houston and Tricia McGinnis, Center for Health Care Strategies*

## IN BRIEF

Accountable care organizations (ACOs) have become increasingly prevalent in the United States. These organizations shift more accountability for health outcomes to providers and many have shown positive results for improving care and reducing costs – for Medicare, Medicaid, and commercial populations. This brief, made possible by the Robert Wood Johnson Foundation, identifies key lessons from ACO activities across the country to date. It examines how ACOs can build upon these initial successes and informs policymakers, researchers, and foundations about key considerations to further the development of effective ACO approaches across the health care market.

Just three or four years ago, accountable care organizations (ACOs) were being compared to the mythical unicorn – an intriguing idea, but one impossible to see in reality. Today, ACOs are very much a reality, with roughly 750 in operation – for Medicare, Medicaid, and commercial populations – serving 23.5 million people across the United States.<sup>1</sup> ACOs are designed to achieve the Triple Aim of better health, improving patient experience, and lowering costs.<sup>2</sup> While not all ACOs have demonstrated success in delivering better health outcomes at a lower cost, many have achieved promising results.<sup>3,4,5</sup>

Although ACOs are rapidly emerging, the ACO model is still new and evolving. To investigate barriers, promising trends, and emerging opportunities for ACOs, the Robert Wood Johnson Foundation and the Center for Health Care Strategies convened ACO leaders, researchers, and subject matter experts from across the country in July 2015. The discussion revealed that leading ACOs are exploring common strategies to drive short-term success and long-term sustainability, such as: enhancing population health management approaches; providing effective, integrated care to high-need, high-cost subpopulations; and aligning Medicare, Medicaid, and commercial ACO efforts. This brief: (a) identifies key lessons from ACO activities to date; (b) examines how ACOs can build upon initial successes; and (c) informs policymakers, researchers, and foundations about considerations to further the development of effective ACOs.

## ACOs: An Overview

ACOs are designed to achieve the Triple Aim by shifting varying degrees of financial responsibility for patient outcomes to the provider level, e.g., physicians and hospitals, rather than the payer level, e.g., Medicare and managed care organizations (MCOs), where these responsibilities historically lie. Two factors are driving this shift: (1) providers, including care teams, are best positioned to effectively coordinate care for the patients they serve; and (2) if providers' financial compensation is tied more closely with health outcomes and efficiency, they will seek to improve care coordination for patients and make cost-effective choices regarding services and procedures. A delivery model that supports these features has the potential to improve patient outcomes and reduce costs.

To achieve the Triple Aim, ACO models typically involve three distinct, yet overlapping components:<sup>6</sup>

- **Value-based payment methodology:** ACOs incorporate value-based payment (VBP) arrangements that incentivize providers to focus on patient outcomes and health status rather than volume of patients seen or services provided. VBP approaches may take different forms, but typically go beyond pay-for-performance and include upside-only shared savings models, upside/downside shared savings models, or global payments.
- **Quality improvement strategy:** ACOs are responsible for tracking and measuring specific quality metrics to indicate that patient outcomes are improving and/or evidence-based processes are being used. Some, but not necessarily all, metrics may be tied directly to the payment methodology, meaning that performance on these metrics will trigger either a quality incentive (such as an increased percentage of shared savings) or a disincentive (such as not receiving any shared savings).
- **Data reporting and analysis infrastructure:** To coordinate care and effectively manage the costs of care across providers, ACOs must develop the data capacity to securely transmit patient information. In addition, ACOs must aggregate and analyze patient-level clinical and cost data to better target patients, provide services, coordinate care, and track overall cost and quality performance.

How these three components of ACO models are constructed and interact depends on what type of ACOs are formed. Some ACOs involving government payers, like those participating in the Pioneer ACO program, Medicare Shared Savings Program (MSSP), or some Medicaid ACO programs have detailed requirements for payment methodology, quality metrics, and/or data sharing. Other ACOs, especially commercial models, are more likely to use criteria developed through negotiations between the ACO and an MCO.

### Achieving the Triple Aim

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## ACO Progress to Date

ACO arrangements are forming in community settings and across Medicare, Medicaid, and commercial payers. There are roughly 750 ACOs established to date, serving approximately 23.5 million patients in all 50 states.<sup>7</sup> ACOs come in all shapes and sizes. Some large integrated health systems and hospitals have become ACOs; multi-specialty provider groups have developed ACOs without hospital participation; and smaller providers, such as federally qualified health centers (FQHCs), have banded together to form “virtual” ACO arrangements to help coordinate care for the participating member organizations.<sup>8</sup> There are even a few Medicaid ACOs that are led by MCOs. Some of these ACOs are already reporting positive results for improving patient outcomes and controlling costs; see Exhibit 1 for key attributes and broad results to date across the various ACO models.

Exhibit 1: Key Attributes and Broad Results of Current ACO Models

Attribute	Medicare		Commercial ACOs	Medicaid ACOs
	MSSP	Pioneer ACO		
<b>ACO Prevalence</b>	<ul style="list-style-type: none"> <li>333 ACOs in 47 states<sup>9</sup></li> </ul>	<ul style="list-style-type: none"> <li>18 ACOs in 8 states<sup>10</sup></li> </ul>	<ul style="list-style-type: none"> <li>528 commercial contracts<sup>11</sup></li> </ul>	<ul style="list-style-type: none"> <li>66 ACOs in nine active state-based programs<sup>12</sup></li> </ul>
<b>Key Model Features</b>	<ul style="list-style-type: none"> <li>Shared savings payment methodology</li> <li>33 quality metrics</li> </ul>	<ul style="list-style-type: none"> <li>Designed for large hospital systems</li> <li>Shared savings system with higher risk/reward potential than MSSP</li> <li>Same 33 quality metrics as MSSP</li> </ul>	<ul style="list-style-type: none"> <li>Often independent contracts between ACOs and MCOs</li> <li>Many feature narrow provider networks<sup>13</sup></li> </ul>	<ul style="list-style-type: none"> <li>Various approaches to payment including shared savings and capitation</li> <li>Various approaches to quality measurement</li> </ul>
<b>Results to Date</b>	<ul style="list-style-type: none"> <li>CMS has reported results for different cohorts of MSSP ACOs based on start date, which have shown significant savings, but it is difficult to aggregate these results,<sup>14,15</sup> though only 26% of ACOs received shared savings payments<sup>16</sup></li> <li>ACOs consistently improved on 27 of 33 quality metrics<sup>17</sup></li> <li>Increases in patient satisfaction relative to patients not enrolled in ACOs<sup>18</sup></li> </ul>	<ul style="list-style-type: none"> <li>\$304M in savings over three years<sup>19</sup></li> <li>ACOs consistently improved on 28 of 33 quality metrics<sup>20</sup></li> <li>Increases in patient satisfaction relative to patients not enrolled in ACOs<sup>21</sup></li> <li>Began with 32 participants; 14 have left the program</li> </ul>	<ul style="list-style-type: none"> <li>Not many publicly reported results available across programs due to proprietary information and difficulty comparing results<sup>22,23</sup></li> </ul>	<ul style="list-style-type: none"> <li>CO, MN, and VT have collectively reported \$129.9M in savings<sup>24,25,26</sup></li> <li>ED visits in OR decreased by 22%<sup>27</sup></li> </ul>

## Initial Priorities for ACO Development

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Virtually all ACOs tend to focus initially on similar areas of development, regardless of the payer, population, or model. Four key common areas are outlined below:

- **Adapting to a new business model.** The most common VBP method among ACOs is a shared savings/risk model. If the ACO achieves a total cost of care that is less than an established benchmark, it earns a percentage of the savings achieved, subject to meeting quality expectations. Profit maximization under this model requires a shift away from revenue-focused strategies to cost-containment strategies. This change also involves an important and difficult cultural shift for provider organizations and practitioners that takes time to get right.
- **Enabling efficient data sharing and analysis.** Timely and accurate data exchange among ACO providers is a precursor to success. However, ACOs -- especially those that are newly formed from multiple existing entities -- may have very different data systems, electronic health record (EHR) software, and administrative capacities to share data. ACOs must establish an effective data-sharing protocol to improve care coordination, which may require converting providers to use EHRs, establishing interoperability, and combining relevant clinical and cost data. Initial ACO efforts also tend to focus on building the in-house data analytic capacity necessary to manage the total cost of care and inform new care management strategies.
- **Stratifying patient populations.** ACO cost and quality improvement efforts are often grounded in analyzing the health needs of their attributed patients. ACOs typically stratify their patient population by common care needs, conditions, and expenditure levels and then deploy tailored interventions based on these characteristics. For example, patients who are homeless may need to be linked with a care team with a housing coordinator, whereas a high-risk pregnant mother would need a different constellation of care team members and interventions. Best practices in this area are still being developed, but it is clear that delivering the right intervention from the right person at the right time is a critical component of achieving the Triple Aim.
- **Improving care coordination and care management.** Many ACO efforts aim to achieve shared savings by eliminating inefficiencies, communicating better internally and across providers, and performing well on quality metrics. As previously mentioned, having integrated and interoperable data systems are a key element to achieving this goal, as patients often receive their care from multiple different systems. Additionally, most care coordination and care management programs establish personalized patient care plans that all care team members and providers can refer to and update. Other structures such as interdisciplinary care team meetings and real-time alerts to indicate when patients enter into a system of care are also cornerstones of successful care coordination and care management efforts.

By mastering these four foundational program elements, ACO providers and administrators hope to position their organizations to significantly lower the cost of care, improve quality, and achieve shared savings.

## Current ACO Trends

As well-established ACOs mature and learn from their initial efforts, several notable trends are emerging. Six of the most widespread developments in ACO design are outlined below.

### *Refining Strategies for Specific Subpopulations*

While MSSP ACOs, Pioneer ACOs, and most Medicaid ACOs tend to serve broad payer-based populations, most of these ACOs emphasize improving care coordination for subpopulations as the primary strategy for achieving cost savings. Many efforts to date have focused on high-need, high-cost populations (also known as super-utilizers). These patients often have poor access to care and the care they receive is often fragmented, without communication across physical and behavioral health providers. Care for these patients may be significantly improved through targeted high-touch interventions, and cost savings are more likely to accrue quickly through shared savings payment methodologies. Many ACOs are stratifying their populations to identify these patients and provide them with appropriate care. Given that the drivers of these patients' health needs often go beyond physical health, ACOs are developing partnerships with behavioral health providers, social service agencies, and other community-based organizations to address the social determinants of health as well. One initiative serving a specific subpopulation is Hennepin Health, which coordinates services for childless adults with incomes under 133 percent of the poverty level in Hennepin County, Minnesota. The organization, a partnership encompassing Metropolitan Health Plan, Hennepin County Medical Center, NorthPoint Health and Wellness Center (an FQHC), and the Human Services and Public Health Department of Hennepin County, provides physical health, behavioral health, and social services. The program addresses the full range of non-medical needs, including providing patients with respite or permanent housing. These efforts have been very effective. For the more than 100 patients that Hennepin Health has placed in housing, inpatient utilization dropped 29 percent, and inpatient costs fell 72 percent. These patients' ED visits also decreased by 55 percent and their ED costs lowered by 52 percent.<sup>28</sup>

While some ACOs focus solely on targeted subpopulations, other ACOs that serve a broader patient population have also aimed specific efforts at high-need, high-cost patients. ACOs must align the balance between targeted efforts and population-based models in order to help the whole of the population as well as the most vulnerable members. The Camden Coalition of Health Care Providers in New Jersey is a good example. Originally conceived as a program to help super-utilizers through data-driven targeting of patients and home-based care team visits, Camden Coalition is now a state-recognized Medicaid ACO that has expanded to serve a broader group of 35,000 patients, though it continues to target high-need, high-cost patients. There is also a rising number of ACOs serving specific age groups, such as pediatric patients, and conditions, such as behavioral health-focused ACOs or proposed Medicare ACOs focused on renal failure. These ACO structures offer primary care providers and specialists associated with a

specific patient population the opportunity to benefit from the ACO trend and reap shared savings from better-coordinated care.

### *Consolidation*

Across the country, both providers and payers are consolidating their market shares, and many provider organizations are positioning ACO development as an important part of such a strategy. By coordinating care effectively through a large ACO that serves many patients, providers have the potential to create economies of scale that can achieve greater savings with a lower administrative burden. Larger ACOs can also mitigate financial risk due to variability in per patient costs.

The potential downsides of this consolidated market power, however, include the potential for driving up the total cost of care, marginalizing smaller safety net providers such as FQHCs and small physician practices, and limiting consumer choice.<sup>29</sup> If such market consolidation continues, federal, state, and local officials should be vigilant to ensure that anti-competitive practices from these large entities do not adversely affect markets and patients. Some Medicaid ACO programs have already taken steps along this path, such as New Jersey's requirement that its Medicaid agency and the Department of Banking and Insurance evaluate the impact of its geographically based Medicaid ACOs on the areas they serve.<sup>30</sup>

### *Regional ACO Development*

There is a growing interest in ACOs that are responsible for the entire patient population in a defined geographic area within a state. Cost measurements and payments for such models are typically population-based (on a prospective per member per month basis) and calculated as a total cost of care across all services under the ACO's scope of services. Unlike typical ACO shared savings agreements, which are based on the traditional fee-for-service model and adjusted based on shared savings, these fixed, prospective global payments allow ACOs to manage their own budgets in innovative ways. For this reason, many of these ACOs integrate services beyond physical health, including behavioral health, long-term care, dental, and social services. Some geographically based models, like Oregon's Medicaid Coordinated Care Organizations, allow for flexibility in payment for items and services that are non-medical but may improve health, such as air conditioners or housing support for homeless individuals. While many of the population health-based models are in their infancy, increased profits may also be possible by decreasing total cost of care under capitated or global payments or creating more accurate risk-adjustment methodologies that account for non-medical factors such as the social determinants of health.

### *Virtual and Rural ACO Development*

While early ACO adoption has occurred primarily in urban and suburban settings, interest is emerging among smaller provider organizations and in rural settings. Such ACOs are using technology to create "virtual" ACO arrangements that allow smaller providers to organize and coordinate care more effectively. Many of these arrangements have a safety net focus and involve public hospitals, FQHCs, community health centers, and community-based organizations that can help address the needs of complex patients. One example of a virtual ACO is the Federally Qualified Health Center Urban Health Network (FUHN) in Minnesota, a collaborative of

10 FQHCs that serve the Minneapolis/St. Paul metro area. These FQHCs — which previously competed with each other for funding, patients, and resources — now work together to drive down costs and improve care as one of the state’s Medicaid ACOs.

Because access to care, especially specialist and behavioral health care, is difficult in rural areas, rural providers such as safety net hospitals and health centers are particularly interested in forming virtual arrangements to improve care coordination efforts and enhance preventive care. Some of these ACOs are also looking toward telemedicine as a promising way to bring patients and providers together virtually. An example of a rural ACO is Community Health Accountable Care (CHAC) in Vermont. The nine FQHCs that compose CHAC are located throughout the primarily rural state and share infrastructure and resources. CHAC serves all patient types as a rural MSSP ACO, Vermont Shared Savings Program Medicaid ACO, and through commercial arrangements with MCOs.

### *Narrowing Provider Networks and Referral Patterns*

ACOs, particularly those in the commercial sector, have been experimenting with narrow provider networks as a strategy for reining in costs and improving care. MCOs have initiated many of these narrow networks. In a typical arrangement, an MCO will create an ACO with a limited number of provider organizations that have demonstrated a pattern of high-value care (for example, exceptional performance on quality metrics) and a willingness to provide specific services for a lower price. Since there are a limited number of providers in the network, the MCO can negotiate lower prices with their providers than they normally would with a wider network. This could also benefit these high-value providers, as they can gain greater patient volume.

ACOs are also experimenting with referral patterns as a cost-containment strategy, referring patients to high-quality, efficient specialists. A recent study by the Integrated Healthcare Association found that commercial ACOs in California reported savings for patients who received more effective care direction, such as referrals to high-value specialists within the ACO’s limited network. This approach helped control costs in two ways: lower specialist fees due to a narrow network, and lower co-pays for members since they were referred to an in-network provider.<sup>31</sup> While such models could help reduce costs through high-value providers and negotiating leverage, there is also a balance that needs to be achieved, as limited networks could also restrict consumer choice and access to care based on location and wait time.<sup>32</sup>

### *Improving Data Analytics and Forecasting*

As ACOs continue to gain experience in coordinating care, many are investing in advanced data analytics to gain a greater understanding of their patient sub-populations and develop forecasting tools. While some ACOs have home-grown predictive modeling tools, others have purchased commercially available tools, hired contractors, or gained access to publicly available data resources. Washington State developed an integrated social service client database that links data across state agencies – including Medicaid, public health, criminal justice, family services – which gives it the capability to identify patient risk across agencies and track costs and outcomes at the state, community, family, or individual level. The database supports the

#### Investing in Data Analytics

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Predictive Risk Intelligence System (PRISM), a predictive modeling and decision support tool, that helps providers and administrators implement care management interventions for high-risk patients.<sup>33</sup> Washington's ACOs for public employees are using this database to target patients and improve care coordination. Once the state's Medicaid ACO program is launched, its participating Medicaid ACOs will have access to this tool as well. These tools could help improve risk adjustment methodologies and result in more accurate payments for high-risk patient subsets. Efforts such as PRISM, which aggregate data beyond medical procedures, may be particularly helpful in addressing social determinants of health at the population level.

## Barriers and Challenges

ACOs are at a critical juncture for identifying key challenges and emerging solutions that may help sustain these models. Conversations with ACO leaders, researchers, and policymakers reveal common challenges facing the ACO movement.

### *Creating Sustainable Financing Models*

Most ACOs initiate contracts under a shared savings or shared risk financial arrangement. One important aspect of the shared savings methodology is setting the benchmark; payers must decide how and how often to “rebase” the benchmark against which actual savings (or losses) are calculated. In the first few years of an ACO's operations, it may be feasible to put the necessary care management and technological pieces in place to achieve significant savings compared to the benchmark. However, as the benchmark is reset over time, this financial model creates diminishing incentives to participate since the benchmark gets progressively lower based on past successes. Unless payers adjust their approach, this method penalizes efficient providers. Some Pioneer ACO programs, such as the Dartmouth-Hitchcock ACO in New Hampshire, have cited this imbalance in rewards as a reason for their withdrawal from the program.<sup>34</sup>

Payers are considering a variety of approaches to offset this potentially powerful long-term disincentive for participation. In its most recent MSSP rules, CMS responded to this disincentive by changing the weighting of the annual benchmarking procedure from 60 percent for the most recent of the three calculated years to an even distribution.<sup>35</sup> This allows cost-effective ACOs to reap slightly more of the savings if they continuously decrease costs year after year.<sup>36</sup> Other potential approaches include: (1) transitioning to regional benchmarks; (2) holding the benchmark fixed over a longer period; and (3) transitioning to prospective global payments.

### *Working across Organizations*

Effective care coordination requires collaboration across organizations and can be achieved by creating integrated cross-organizational care teams, facilitating timely and accurate data exchange, and coordinating administrative tasks. Coordinating care may be particularly daunting for providers working outside of an integrated health system or multi-specialty practice, though even large health systems may struggle with coordination. Independent organizations are likely to have different ways of doing business, including varying: staff capacity and care team structures; workflow processes; EHR software; administrative structures; and communication methods with outside organizations. This is especially the case with organizations that have very




different business models – such as behavioral health providers and other community-based organizations – but are critical partners to effectively managing high-need, high-cost patients.

Further, some organizations may not be willing to participate in or collaborate with an ACO due to high start-up costs, a history of competition or mistrust of potential partners, or concerns about revenue reduction. To function effectively as ACOs, these organizations will need to determine ways to overcome these differences and enter into mutually beneficial partnerships.

### *Providing Patient-Centered Care*

While many ACOs tend to focus initial efforts on improving provider-led care, effectively engaging patients in their care and developing care teams that help patients meet their own care goals are critical elements for achieving success. This vision of patient-centered care is not new, as care delivery models such as patient-centered medical homes (PCMH) have laid the groundwork. However, the imperative to be more patient-centered is perhaps stronger under ACO models, as financial incentives could help drive positive care coordination efforts.

ACOs are beginning to look at ways to engage patients more effectively to improve patient experience and address social determinants of health that can impact health outcomes and exacerbate spending. For example, Maimonides Medical Center in Brooklyn, NY has a dedicated staff person whose job is to engage the Department of Corrections and facilitate care coordination for corrections-involved patients. This role has helped Maimonides coordinate care for individuals while they are still in jail and ease their transition when they are released by making sure they have things like prescriptions, Medicaid coverage, appointments scheduled with necessary providers, and housing plans. By shoring up these social needs, Maimonides is able to reduce the likelihood that these individuals will show up in the emergency department in crisis shortly upon release.<sup>37</sup>



### Addressing the Social Determinants of Health

ACOs are recognizing the importance of engaging patients more effectively and addressing social determinants of health that can impact health outcomes and exacerbate spending.

There are some significant barriers to providing patient-centered care through ACOs. One major barrier is that many ACO models attribute patients retrospectively based on utilization. While retrospective attribution preserves patient choice, it also means that the ACO does not know which patients will be assigned until they serve them for a long period of time. 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. Additionally, patients and consumers are largely not engaged in the governance or design of ACO programs or operations. It is possible that involving patients and soliciting their input could result in more patient-friendly operations and produce greater patient engagement.

### *Measurement Limitations*

Although many ACOs are showing positive results on controlling costs and improving quality, the measures ACOs are held accountable for are limited in terms of capturing important health outcomes. While quality metrics tend to capture performance on specific outcomes, such as

lower avoidable readmissions, or processes, such as screening for depression, they may not accurately measure the overall health of the patient. This makes it difficult to assess the true impact and efficacy of ACO arrangements. Patient experience should also be accounted for, and while such metrics such as the Consumer Assessment of Healthcare Providers and Systems survey are widely used, they generally focus on a patient's experience with his or her providers and the health care system. 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. Additionally, few ACOs are collecting data and measuring specific racial, ethnic, or language-based health disparities, which could be fruitful to improving quality, patient-centeredness, and reducing costs if addressed.

It also remains difficult to evaluate the impact of specific interventions and strategies on cost and quality. For example, conducting a randomized control trial of an ACO intervention to address a specific subpopulation is a lengthy process and is not realistic given the need to produce short-term results. In ACOs, like many health care interventions, it is difficult to benchmark values, isolate variables involving a patient's health status, and compare them to a control group since there are so many factors affecting the patient's health. By aligning or standardizing methodologies for evaluation purposes – including quality metrics, benchmarking, and risk-adjustment methodologies – more consistent conclusions can be drawn across ACO interventions.

### *Aligning ACO Models*

Many ACOs participate in contracts with Medicare, Medicaid, and commercial entities. These arrangements are often complex and may widely differ, including elements such as: governance requirements; payment structures; quality metrics; reporting requirements; and data availability. While different patient populations may require tailored quality measures and risk adjustment methods, this variation creates a substantial administrative burden on ACOs and can hamper improvement efforts.

Nevertheless, some ACOs are striving to achieve economies of scale by serving Medicare, Medicaid, and commercial populations under an ACO arrangement. These ACOs are forming from coast to coast, from large hospital systems like Montefiore Medical Center in New York to AZ ConnectedCare in Arizona. Some safety net providers are also participating in multi-payer initiatives, such as AltaMed, the largest FQHC in the United States based in Los Angeles and Orange counties in California. It has developed an independent practice association (IPA) to expand its network and function as an ACO. AltaMed's operations are all paid on a partially capitated basis (the clinic accepts Medicaid, Medicare, commercial, and dually eligible Medicare-Medicaid enrollees) and the IPA has a fully capitated arrangement for Program for All-inclusive Care for the Elderly enrollees.<sup>38</sup> While it may make sense from a business standpoint for ACOs to serve different populations using a single infrastructure, alignment remains elusive and it is not yet clear whether such alignment will lead to the economies of scale that providers are pursuing.

### Leveraging Economies of Scale

Some ACOs are striving to achieve economies of scale by serving Medicare, Medicaid, and commercial populations under an ACO arrangement.

### *Data Sharing*

While arrangements like ACOs help make the business case for provider investments in data sharing and analytics, challenges remain. Building the cross-provider infrastructure for effective data sharing takes a significant amount of upfront investment and commitment from those providers. While some may receive support through federal meaningful use incentives<sup>39</sup> as well as some state-based funding (e.g., State Innovation Model (SIM) grants), there are still many providers that have not built the infrastructure, staff capacity, EHR interoperability standards, or have a health information exchange capable of transmitting information among providers yet. The MSSP and Pioneer models have limited funding targeted to rural or safety net providers for this purpose and Medicaid and commercial ACOs generally lack access to additional funding beyond what is described above.

Additionally state and federal regulations or policies that require patients to opt-in to data-sharing arrangements create both perceived and legitimate barriers to information sharing. The most discussed regulation is 42 CFR Part II, which requires patients to approve the release of alcohol or drug abuse history or treatment. ACOs must determine how to protect patient information while also sharing data freely and effectively among providers to help manage patient care.

## Opportunities to Help ACOs Realize their Full Potential

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Medicare, Medicaid, and commercial ACOs are becoming more widespread and some of them have seen measurable success, but these models are relatively new and there is still much room for improvement. There are many ways that policymakers, researchers, and funders could foster their development. Below are six of the most relevant opportunities:

### 1. Encouraging movement toward greater accountability

Payers and ACOs are exploring key strategies to continue the shift toward greater accountability, including: transitioning to capitated or global payment arrangements; expanding scopes of services beyond physical health to include mental health and substance abuse services, long-term care, dental services, and social services; and using prospective attribution models so that ACO providers are aware of which patients they are responsible for and are encouraged to be more directly accountable for managing the health of these patients.

Policymakers and payers are already looking toward incorporating some of these strategies, such as the Next Generation ACO model's emphasis on prospective attribution, and will likely continue to pursue such endeavors to enhance accountability. Funders and researchers can also support initiatives that foster this shift at the provider level and/or determine the efficacy of these methods and their impact on costs, quality, and patient experience.

### 2. Breaking down policy and regulatory barriers

Policymakers can help providers and payers facilitate population-based or multi-payer ACO arrangements by breaking down barriers and regulations that inhibit data sharing. Policymakers can allow greater flexibility for funds designated for a specific purpose to be used for broader

activities. For example, CMS might expand the definitions of what Medicare and Medicaid funds can be used for, such as supporting social services payments, or what services qualify as medical expenses for MCOs. State governments could pool state social service (such as housing) and Medicaid resources to provide a unified source of funding to address non-medical needs that may contribute to higher utilization of health care services. Federal regulators appear to be considering revisions to 42 CFR Part 2.<sup>40</sup> Changes to the regulations could help patients with substance use disorders get better-coordinated care from their providers, who may not otherwise be aware of full patient histories because of current data-sharing regulations. ACOs can use foundation support to work toward interoperability of EHRs and other methods of facilitating information exchange among providers, including physical, behavioral health, and long-term care providers, as well as social service agencies and community-based organizations.

### 3. Facilitating multi-payer ACOs

If ACO arrangements are expected to truly change the way providers do business, over the long run multi-payer alignment and participation will be critical. Payers and providers must work together to identify the program elements where alignment is crucial, and, conversely, areas where payer variability is acceptable. For example, it would be beneficial to establish a measurement set of common conditions that cut across patients served by most payers, while allowing certain quality metrics to vary due to conditions prevalent in payer populations (e.g., Medicaid patients may need prenatal care, but Medicare patients rarely do). Additionally, aggregating data across ACO models is difficult due to risk adjustment and benchmarking that vary widely among ACO programs. Several federal initiatives, including the Health Care Payment Learning and Action Network (LAN) and the SIM initiative, are promoting alignment across health reform models, but there is still much work to be done. Research into the impact of multi-payer ACOs would help elucidate the pros and cons of alignment and specialization. Finally, policymakers or funders can help foster these developments by funding multi-payer ACO pilots or providing funding opportunities for ACOs to develop the infrastructure to take on these complex care coordination efforts.

### 4. Refining risk adjustment across populations and services

As ACOs assume greater financial accountability, improvements to risk-adjustment will be especially important. More sophisticated risk-adjustment mechanisms will help with potential adverse selection problems, where providers may avoid treating high-need, high-cost patients due to fear of driving up costs in a total cost of care calculation. In addition, if these methods account for social determinants of health, regional costs, and other non-medical factors, ACOs may be better positioned to enter into prospective, risk-based, or population-based payment arrangements. Risk-adjustment will also be critical for accepting global payments across large populations, as even a one-cent difference in payment could mean a large difference in population-based ACOs that serve hundreds of thousands of patients across multiple payers. In particular, precise risk adjustment will help ACOs stratify their high-need, high-cost patients, build tailored interventions to suit these needs, and efficiently allocate personnel and resources to provide the right level of care for each patient. Policymakers, researchers, and funders can help providers improve risk-adjustment techniques to include different populations and services by supporting research into these areas and investing in actuarial modeling. Efforts that are more

basic might involve investing in actuarial consultants to develop advanced risk-adjustment tools, while more far-reaching activities could entail pooling aggregate data from patients across the country to discover the most important factors affecting health to more effectively calibrate risk adjustment models.

## 5. Managing market consolidation

As market consolidation continues, policymakers, researchers, and funders may want to explore ways that ACOs drive or counteract this phenomenon. While it is not known what the exact effect consolidation will have on health care markets, and whether this effect will be positive (improved efficiency and coordination) or negative (increased costs and less patient choice), there is likely to be a large effect on these markets and the driving role ACOs can play in creating provider market power.<sup>41</sup> While the federal government may have already begun to discourage further hospital mergers through provisions in the Medicare Access and CHIP Reauthorization of 2015,<sup>42</sup> the impacts of ACOs on this trend should be explored by researchers positing future outcomes of actual or potential mergers. This could be done through an economic study with a national scope or an in-depth analysis of a state, city, or regional market. Once this information is obtained, federal, state, or local policymakers may want to take steps to regulate consolidation based on the research findings, or possibly help providers and payers prepare for the new market dynamics.

## 6. Encouraging greater patient engagement in care

ACOs are tasked with providing more effective patient-centered care, and encouraging patients to engage in their own care is a perfect opportunity to do this. While ACOs are using many methods to engage patients, many admit they need to do a better job in this area, especially in issues related to addressing cultural and ethnic disparities. Researchers and foundations can support these efforts by determining what methods of patient engagement are working and helping to spread such models. Further, policymakers can support changes in ACO quality measurement standards to include metrics that assess health outcomes that are important to patients. While many ACOs already measure patient experience metrics, these measures usually gauge satisfaction with the care delivery process, not outcomes. By measuring patient-reported outcome metrics, ACOs may be able to gain a more accurate picture of their patients' true experience with the health care system.

## 7. Improving measurement of ACO success

Policymakers, researchers, and funders can help measure ACO success more accurately by supporting rigorous studies on ACO progress. Research efforts could conduct randomized control trials of ACO interventions or across interventions for subpopulations or to address health disparities. In addition, further research on whether ACO providers are better equipped to implement such interventions than other providers may be worthwhile. ACO impact may also be more effectively measured if outcome measures were more reliable. While there are currently efforts underway to address shortcomings in statistical analysis and improve comparative outcomes research at the Patient-Centered Outcomes Research Institute and the Dartmouth

Institute for Health Policy and Clinical Practice, it may still be worthwhile for policymakers and foundations to invest in research in this area.

As mentioned earlier, standardizing ACO measurement practices so performance can be compared across states, regions, payers, and populations can help the field. Potential areas of improvement include standardizing: (1) benchmarking techniques for savings and quality; (2) quality metrics; and (3) prospective and retrospective attribution guidelines. However, since ACOs are still a relatively new concept, standardizing processes at this point may be premature and inhibit the development of promising practices and innovation. Due to this tension, it may make sense to invest in evaluation techniques that strategically analyze ACO results, such as filtering results on many different outcome metrics to determine which are most salient.

## The Future of ACOs

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ACOs continue to proliferate and ACO results continue to roll in. These trends show no signs of subsiding, and though not all ACOs have made measureable strides toward the Triple Aim, many have improved quality and patient experience while simultaneously reducing costs. As this momentum continues to build, there are many opportunities to support this work. Since not all ACOs have been successful, targeted research and investment could help identify differences between successful ACO models and those that struggle. These findings could generate lessons to guide future ACO activity and encourage replicability or standardization across models. In addition, since the comparative efficacy of particular ACO models has not been proven, policymakers and funders should not be afraid to forge ahead on innovative ACO model enhancements, such as multi-payer alignment, population-based ACOs, and subpopulation-focused ACOs. As providers and payers continue to work toward ACO arrangements that improve quality, reduce costs, and enhance patient experience, policymakers, researchers, and foundations can help them reach these goals by providing key support for these initiatives.

### ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop better models of organizing, financing, and delivering health and health care services, especially for people with complex needs. For more information, including additional ACO-related publications, visit [www.chcs.org](http://www.chcs.org).

## ENDNOTES

- <sup>1</sup> D. Muhlestein. "Growth and Dispersion of Accountable Care Organizations in 2015." *Health Affairs Blog*. March 31, 2015. Available at: <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>.
- <sup>2</sup> Institute for Healthcare Improvement. "IHI Triple Aim Initiative." Available at: <http://www.ihf.org/engage/initiatives/tripleaim/pages/default.aspx>.
- <sup>3</sup> Centers for Medicare & Medicaid Services. "Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014." August 25, 2015. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html>.
- <sup>4</sup> Ibid.
- <sup>5</sup> J. Lloyd, R. Houston, and T. McGinnis. "Medicaid Accountable Care Organization Programs: State Profiles." Center for Health Care Strategies. October 2015. Available at: <http://www.chcs.org/resource/medicaid-accountable-care-organization-programs-state-profiles/>.
- <sup>6</sup> Ibid.
- <sup>7</sup> D. Muhlestein, op cit.
- <sup>8</sup> C. Colla, V. Lewis, S. Shortell, and E. Fisher. "First National Survey of ACOs Finds that Physicians are Playing Strong Leadership and Ownership Roles." *Health Affairs*. June 2014. Vol .33 No. 6. Available at: <http://content.healthaffairs.org/content/33/6/964.full.pdf+html>.
- <sup>9</sup> Centers for Medicare and Medicaid Services, op cit.
- <sup>10</sup> Centers for Medicare & Medicaid Services. "Where Innovation is Happening. Available at: <https://innovation.cms.gov/initiatives/map/index.html#model=pioneer-aco>.
- <sup>11</sup> T. Tu, D. Muhlestein, S.L. Kocot, and R. White. "The Impact of Accountable Care: Origins and Future of Accountable Care Organizations. Leavitt Partners. May 2015. Available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2015/rwjf420213](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420213).
- <sup>12</sup> J. Lloyd, op cit.
- <sup>13</sup> CHCS interview with Blair Childs of Premier, Inc. November 6, 2015.
- <sup>14</sup> Centers for Medicare & Medicaid Services. "Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014." August 25, 2015. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html>.
- <sup>15</sup> S.L. Kocot, F. Mostashari, and R. White. "Year One Results from Medicare Shared Savings Program: What it Means Going Forward." The Brookings Institution. February 7, 2014. Available at: <http://www.brookings.edu/blogs/up-front/posts/2014/02/07-results-medicare-shared-savings-program-kocot-mostashari>.
- <sup>16</sup> D. Introcaso and G. Berger. "MSSP Year Two: Medicare ACOs Show Muted Success." *Health Affairs Blog*. Available at: <http://healthaffairs.org/blog/2015/09/24/mssp-year-two-medicare-acos-show-muted-success/>.
- <sup>17</sup> Centers for Medicare & Medicaid Services. "Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014." August 25, 2015. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html>.
- <sup>18</sup> J.M. McWilliams, B. Landon, M. Cherner, and A. Zaslavsky. "Changes in Patients' Experiences in Medicare Accountable Care Organizations." *N Engl J Med*. October 30, 2014. Available at: <http://www.nejm.org/doi/full/10.1056/NEJMs1406552>.
- <sup>19</sup> Centers for Medicare & Medicaid Services. "Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014." August 25, 2015. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html>.
- <sup>20</sup> Ibid.
- <sup>21</sup> J.M. McWilliams, et al., op cit.
- <sup>22</sup> M. Petersen and D. Muhlestein. "ACO Results: What We Know So Far." *Health Affairs Blog*. May 30, 2014. Available at: <http://healthaffairs.org/blog/2014/05/30/aco-results-what-we-know-so-far/>.
- <sup>23</sup> T. Tu, et al., op cit.
- <sup>24</sup> Colorado Department of Health Care Policy & Financing. "Creating a Culture of Change: Accountable Care Collaborative 2014 Annual Report." 2015. Available at: <http://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>
- <sup>25</sup> Minnesota Department of Human Services. "Minnesota's Medicaid Reform Initiative Saves \$61.5 Million in 2<sup>nd</sup> Year." June 19, 2015. Available at: <http://mn.gov/dhs/images/IHP%2520second%2520year%2520results%2520NR.pdf>.
- <sup>26</sup> State of Vermont Governor's Office. "Medicaid Shared Savings Programs Helped Avoid \$14.6 Million in Costs in 2014. Available at: <http://governor.vermont.gov/node/2474>.
- <sup>27</sup> Oregon Health Authority. Oregon's Health System Transformation: 2014 Final Report. June 24, 2015. Available at: <http://www.oregon.gov/oha/Metrics/Documents/2014%20Final%20Report%20-%20June%202015.pdf>.
- <sup>28</sup> M. Evans. "Hennepin Health Saves Money by Housing, Employing Patients." *Modern Healthcare*. November 3, 2014. Available at: <http://www.modernhealthcare.com/article/20141103/BLOG/311039997>.
- <sup>29</sup> R. Scheffler. "Accountable Care Organizations: Integrated Care Meets Market Power." *Journal of Health Politics, Policy, and Law*. Vol. 40, No. 4. August 2015. Available at: <http://ihpp.dukejournals.org/content/early/2015/06/09/03616878-3149964.full.pdf+html>.
- <sup>30</sup> New Jersey Division of Medical Assistance and Health Services. Proposed New Rules: N.J.A.C. 10:79A. May 6, 2013. Available at: <http://www.state.nj.us/humanservices/providers/ruleprop/RuleProposals/PRN2013054DHSDMAHS1079A.pdf>.
- <sup>31</sup> T. Williams. "ACO Contractual Arrangements in California's Commercial PPO Market." Integrated Healthcare Association. May 2015. Available at: [http://www.ihf.org/pdfs\\_documents/resource\\_library/RWJF-ACO-Case-Study-ACO-Contracts-Issue-Brief-Final-20150515.pdf](http://www.ihf.org/pdfs_documents/resource_library/RWJF-ACO-Case-Study-ACO-Contracts-Issue-Brief-Final-20150515.pdf).

- <sup>32</sup> S. Corlette, J. Volk, R. Berenson, and J. Feder. "Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care." Georgetown University Center on Health Insurance Reforms and The Urban Institute. May 2014. Available at: [http://www.rwif.org/content/dam/farm/reports/issue\\_briefs/2014/rwif413643](http://www.rwif.org/content/dam/farm/reports/issue_briefs/2014/rwif413643).
- <sup>33</sup> R. Mahadevan and R. Houston. "Supporting Social Service Delivery through Medicaid Accountable Care Organizations: Early State Efforts." Center for Health Care Strategies. February 2015. Available at: [http://www.chcs.org/media/Supporting-Social-Service-Delivery-Final\\_0212151.pdf](http://www.chcs.org/media/Supporting-Social-Service-Delivery-Final_0212151.pdf).
- <sup>34</sup> M. Evans. "Dartmouth-Hitchcock Exits Medicare's Pioneer ACO Program." Modern Healthcare. October 20, 2015. Available at: <http://www.modernhealthcare.com/article/20151020/NEWS/151029984>.
- <sup>35</sup> Department of Health and Human Services. "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule." Federal Register Vol. 80 No. 110. June 9, 2015. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2015-06-09/pdf/2015-14005.pdf>.
- <sup>36</sup> S.L. Kocot, R. White, and M. McClellan. "The Revised Medicare ACO Program: More Options...And More Work Ahead." *Health Affairs Blog*. June 16, 2015. Available at: <http://healthaffairs.org/blog/2015/06/16/the-revised-medicare-aco-program-more-options-and-more-work-ahead/>.
- <sup>37</sup> CHCS interview with Madeline Rivera of Maimonides Medical Center, January 6, 2015.
- <sup>38</sup> J. Yegian. "A Large Community Health Center Adapts to a Changing Insurance Market." Integrated Healthcare Association. May 2015. Available at: [http://www.iha.org/pdfs\\_documents/resource\\_library/RWJF-ACO-Case-Study-AltaMed-Issue-Brief-Final-20150508.pdf](http://www.iha.org/pdfs_documents/resource_library/RWJF-ACO-Case-Study-AltaMed-Issue-Brief-Final-20150508.pdf).
- <sup>39</sup> Health IT.gov. "Meaningful Use Definition & Objectives." Available at: <https://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>.
- <sup>40</sup> Department of Health and Human Services. "Confidentiality of Alcohol and Drug Abuse Patient Records." Federal Register Vol. 79, No. 91. May 12, 2014. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10913.pdf>.
- <sup>41</sup> R. Scheffler, op cit.
- <sup>42</sup> M. Sanger-Katz. "Prices Are Higher When Hospitals Buy Doctors' Practices. That's Set to Change." *The New York Times Online*. October 28, 2015. Available at: <http://www.nytimes.com/2015/10/29/upshot/doctors-who-work-for-hospitals-charge-more-thats-set-to-change.html?emc=eta1&r=1>.