New ACO Playbook: Three Touchstones for ACO Viability

written by Theresa Hush | May 13, 2021



Some believe that an ACO's leadership structure predicts its success. They point to differing savings results for physician-led versus hospital-led ACO shared savings models (MSSPs) to

make their case. In particular, they make the argument that future Value-Based Care (VBC) policies should benefit the growth of successful physician-led ACOs, protecting them from policies that force them into Risk.

There are significant flaws to tying ACO structure to the viability or value of the model, however, or in discrediting ACOs which don't yet produce those savings but may have other important characteristics for the long term. In a more competitive health care environment, the value of ACOs is not only the amount of savings generated, but the model's ability to grow and expand Value-Based Care. That ability is not just a function of structure, but also of the ACO's assets. In most hospital-led ACOs, Fee-for-Service incentives certainly continue to reward volume, and hospitals will promote internal referrals to specialty and ancillary services; but these referrals may also result in better coordination of care, clinical decision-making, and more choices for patients. The methodology to determine ACO savings captures none of these nuances.

If we tie ACO structure to viability of the Medicare ACO program itself, we must ask this question: Are smaller, lower revenue, physician-led ACOs capable of leveraging sustained support for ACOs as a Value-Based Care model? This is unlikely. Physician-led ACOs have left the program in greater numbers because of discomfort with increasing levels of Risk. But a more important takeaway is that physician practices themselves are choosing other VBC models—against Medicare ACO participation and for other programs.

To generalize from successes by ACO structure is misleading and

distracting. There are hospital-led ACOs with significant physician leadership, ACOs with blends of hospital and physician ownership, and the pure physician-led ACO consisting of one small group or a federated group of primary care practices. ACO models exist along a spectrum that includes both the owner/leaders of the organization and leverage through market penetration.

ACOs Are Losing Status as the Most Prominent Provider-Led VBC Model

ACOs no longer stand alone as the most prominent Value-Based Care model for providers. In its first year of operation, Primary Care First (PCF) attracted 827 participating practices, compared to a current volume of 477 Medicare ACOs. Dropping numbers of ACOs and competitive health care participation models should signal a reassessment of the criteria by which we—and providers—are assessing ACO viability.

Value-Based Care has moved forward in both private and governmental insurance markets. As the private market developed its own ACO-like agreements with providers, it opened opportunities for providers to build strategies for growth and community connections in concert with Value-Based Care. The pandemic launched additional expectations of needed changes in health care and highlighted health care equity as a priority. Investment opportunities prompted expansion of investment-backed physician organizations that are eager to participate in Risk.

To Be Viable, ACOs Must Achieve Business Success

Achieving formula-based savings targets won't guarantee success for future VBC models. The Medicare ACO shared savings plans were generated by law and regulation to stimulate provider activities to improve health care. The market matured. Now we must examine the viability criteria for ACOs under a changed and newly competitive environment. Even if the ACO models continue, they must be able to retain both participating physicians and patients.

In 2019, McKinsey & Company outlined seven characteristics of successful alternative payment models. Focused on policymakers as well as ACOs, it's worth a review. But being "successful" first requires a viable, cohesive plan for staying in business amidst competition. ACOs that meet these three essential criteria will compete more successfully in Value-Based Care:

1. Growth Orientation

A small ACO can produce high savings from historical spending, and this will sustain the model for a while. But it is not compelling enough. Organizations that are on a path to growth as well as savings will have greater impact. The growth must include both higher volume of business for providers within the ACO, by contracting with commercial payers, Medicare, and Medicaid, as well as higher growth of new patients. A larger patient base provides the potential for greater engagement and collaboration among physicians, depth of clinical services, and more efficient clinical pathways.

Growth protects the ACO in a risk environment, especially if

the ACO can draw younger and healthier patients into services. Expansion makes the ACO not only more important to participating physicians, but also gives it leverage with specialties and facilities, and creates the basis for more ACO investment.

Some ACOs are limited geographically or by participation, and cannot grow. These organizations are, indeed, more vulnerable under financial risk and susceptible to patient leakage.

From a Medicare VBC perspective, programmatic growth is essential to vibrancy and savings success of the ACO initiative. Otherwise, even five percent or more in savings for a small number of ACOs is not worth the cost of the initiative, and the program will begin to deteriorate or be replaced.

2. Data and Technology

Some ACOs lack the resources and infrastructure to go beyond the basics of coordinating care. Data and technology are required to understand what is driving costs and how to create interventions at the physician and patient level.

Current efforts to delay changes in Medicare ACO quality reporting only serve to hamper the tools that ACOs have to compete, to establish clinically-driven programs to improve outcomes and reduce costs, and to involve physicians in their results.

Every viable business measures its success through analytics, no matter how small. The more at stake, the more data is required. EMRs have come a long way, and larger ACOs with one EMR have an advantage in data analytics. But the core EMR

purpose is point-of-care improvements; thus the ACO may require additional technology arrangements to help with cost analysis and condition-based bundles, specialty payments, and revealing cost variation by procedures and conditions.

3. Consumer- and Patient-focused Strategies that Can Fortify ACO Leadership and Change Efforts

These include:

- Building community connections and capacity for services not provided within the ACO, such as behavioral health services;
- Adoption of remote clinical monitoring like devices and patches to improve understanding of patient status;
- Efforts to improve collection of patient social and economic risk data;
- Promotion of cost transparency by ACO providers;
- Support to practices for informed decision-making initiatives.

ACOs have often been perceived as entities that can operate in the back office on behalf of their participants. Those administrative functions are essential. But as new payment models and programs emerge from payers and providers, we need more energy and value from ACOs. That’s the formula for viability as well as success.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Markus Spiske