Accountable care 2.0

How to maximize value from ACO arrangements
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Accountable care organizations (ACOs) are sure to become fixtures in the emerging U.S. healthcare landscape. But so far, few of the 600 or so ACOs in existence today have achieved significant cost savings or measurably improved patient care. There are various reasons for this underachievement: poor understanding of the sources of value (e.g., total cost of care savings), lack of targeted care management approaches to capture value, significant gaps in capabilities to manage populations, and muddled operating models.

At least some of these failures are due to growing pains. There’s been a flurry of deal making, but Strategy& believes it’s time for “accountable care 2.0” (AC 2.0) — a next generation of accountable care that shifts the emphasis from business development to operational excellence. By evolving to a new data-driven, financially sound, capability-based approach, the industry can capture the value inherent in ACOs and make them financially sustainable.

AC 2.0 has five parts, and each endeavors to answer a critical question: identifying value drivers (“Where is the money?”), choosing the care management approach (“How do we reduce the total cost of care?”), defining capabilities (“What capabilities do we need to succeed?”), designing the operating model (“How do we organize ourselves to succeed?”), and enhancing the financial model (“How can we structure contracts to share opportunity and risk appropriately?”).
The Affordable Care Act (ACA) is in the process of transforming healthcare in the United States, but its progress and success will depend on the effectiveness of new healthcare delivery models such as accountable care organizations (ACOs), which policymakers hope can improve the quality of care while also introducing greater efficiencies and lowering costs.

Given that the ACA specifically encourages the formation of ACOs — groups of providers and suppliers of services that work together to coordinate care for the patients they serve — there’s been considerable excitement and deal making. Today, more than 600 ACOs are in operation (in both the commercial and Medicare markets). More than 75 percent of hospital executives say they are likely to form or join ACOs in the near future, according to a recent survey. More than 120 new ACOs were introduced in the latest round of the Medicare Shared Savings Program in December 2013, the largest wave to date.

Despite this flurry of activity, however, most ACOs have not achieved meaningful cost savings or greatly improved the quality of care. For example, fewer than half of the 114 hospitals and doctor groups that began ACOs under the health law in 2012 managed to slow Medicare spending in their first year, according to a report released in January 2014 by the Centers for Medicare & Medicaid Services (CMS). In fact, only 29 saved enough money to qualify for bonus payments from Medicare, which is a major incentive to forming an ACO in the first place.

Much is at stake for providers. Forming an ACO is a big capital investment that puts the reputation of providers on the line and can distract from day-to-day operations. But the opportunities are huge, and some ACOs are succeeding even in these early days. Palm Beach Accountable Care Organization, for instance, was one of the 29 ACOs cited by CMS as qualifying for a bonus. It saved US$22 million, netting it and Medicare $11 million each. Elsewhere, UPMC has generated $65 million in savings during the last five years, and payor–provider ACO collaborations such as AdvocateCare in Illinois have reportedly cut hospital readmissions by more than 25 percent.
Generally, however, ACOs have not performed well, and we have identified several causes:

- An unclear strategy to create value and be sustainable in the long term (in fact, one survey found that 20 percent of ACOs are unsure of their long-term strategy)
- Poor understanding of the sources of value (e.g., total cost of care savings)
- Lack of targeted care management approaches to capture value
- Significant gaps in the capabilities necessary to manage populations
- A muddled operating model that juggles the old fee-for-service business model and the newer value-based payment business model
- High investment costs that make it difficult to structure a financial arrangement between the provider and the payor

For the industry to improve outcomes, we believe it’s time for “accountable care 2.0” (AC 2.0) — the next generation of accountable care that shifts the emphasis from business development to operational excellence. By evolving to a new data-driven, financially sound, capability-based approach, the industry can capture the value inherent in ACOs and make them financially sustainable.

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Identifying value drivers is a three-step process that uses data and analytics to answer the question “Where is the money?” By highlighting areas of excessive medical costs and other waste in the system, as well as areas to better optimize value, this sets the priorities and agenda for the remainder of the AC 2.0 methodology.

The first step is to create a medical spending baseline for a given target population, in order to uncover the drivers of costs and potential savings. The cost of care typically varies across three dimensions — disease category, health status, and care setting. Understanding these characteristics of the target population can help an ACO quantify the potential cost savings and help focus intervention efforts. For instance, if a certain disease is prevalent or if the delivery of care is particularly fragmented, the cost of care is higher.

The second step is to identify value drivers based on external benchmarks. Through a detailed analysis of external best practices and benchmarks, an ACO can identify the high-cost components of medical spending and pinpoint the high-cost outliers, or “hot spots,” in its own population. These hot spots often represent prime opportunities to capture value.

The third step is to identify value drivers based on internal ACO cost variability — such as within a facility or among practitioners. When combined with operational metrics, these internal comparisons can reveal the true cost drivers and identify opportunities for medical cost savings.
Choosing the care management approach

Once the high-cost drivers and sources of value have been identified, an ACO must then answer the question “How do we reduce the total cost of care?”

We have identified three approaches for care management in AC 2.0. All three focus on treating patients holistically, including behavioral and/or social needs — particularly for more complex population segments — to reduce costs without reducing the quality of care.

*Targeted intervention* is designed to provide care management for specific disease states. It brings value through unifying resources to decrease specific causes of healthcare costs.

*Care bundles* are integrated “products” for well-defined care episodes/conditions (e.g., knee or hip replacements), combining care, financing, and engagement across the care continuum with a direct focus on the consumer. These care bundles decrease cost variability for the specific set of services and thus make possible a predetermined package price.¹

*Population management* involves comprehensive care and overall health. This brings value through disease prevention, early detection, and avoidance of “overall potential costs” — particularly valuable for the patients with the highest medical costs and most complex needs.² Many of these patients have underlying behavioral and social issues; the new care model must address these issues, which can often be the gateway to reducing the overall medical costs of such populations.

Focus on treating patients holistically to reduce costs while potentially improving the quality of care.
Once an ACO has identified the value drivers and chosen its care management approaches, it must ask itself, “What capabilities do we need to succeed?” Most organizations fail to translate their ACO goals into capabilities and rely too much on existing tool sets. We believe there must be a direct translation from the value drivers and care management approaches into a holistic, advanced set of capabilities, which fall into five broad categories:

- ACO design and setup
- Care delivery and coordination
- Data aggregation and connectivity
- Quality management and incentives
- Payments and financial management

ACOs can obtain these five sets of capabilities through in-house development or by leveraging or acquiring third-party vendors, which now offer a variety of well-integrated products. There is no one-size-fits-all solution for how each capability should be sourced and which capabilities should be prioritized, because these decisions depend on a number of factors, such as the maturity levels of current capabilities, the availability of vendor solutions, and the extent of cultural change required to transform the organization into an ACO model (see Exhibit 1, page 9).
### Exhibit 1
Sample framework of ACO capabilities and sourcing strategy

<table>
<thead>
<tr>
<th>ACO design and setup</th>
<th>Care delivery and coordination</th>
<th>Data aggregation and connectivity</th>
<th>Quality management and incentives</th>
<th>Payments and financial management</th>
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<tbody>
<tr>
<td>Population identification and risk analysis</td>
<td>Population health management</td>
<td>Information aggregation</td>
<td>Reporting and analytics</td>
<td>Financial reconciliation and reporting</td>
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<td>Product development</td>
<td>Case management</td>
<td>EMR integration and support</td>
<td>Incentives structure</td>
<td>Claims and reimbursement</td>
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<td>Attribution</td>
<td>Disease management</td>
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<td>Contracting and network management</td>
<td>Utilization and referral management</td>
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<td>Reimbursement structure</td>
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![New capabilities and vendor solutions](#)

![Combination of new and existing capabilities/solutions](#)

![Existing capabilities/solutions to be leveraged or enhanced](#)

Note: This example represents our assessment of current capability maturity across major organizations establishing ACOs.

Source: Strategy&
Managing the complexities of an ACO is beyond the scope of most existing operating models. Thus, it’s critical that an ACO ask itself the question “How do we organize ourselves to succeed in the long term?” Requirements should include facilitating a tight-knit working relationship among providers, clarifying decision rights, engaging patients in ways that encourage them to manage their own care, and focusing on change management to overcome organizational obstacles. Getting the physicians on board is an essential imperative that all ACOs need to plan for.

These requirements call for a structured and comprehensive operating model framework (see Exhibit 2, page 11). Ultimately, each component in the framework must foster coherence and — most important — a performance-centric culture. Many organizations across all industries aspire to become more performance-centric. But in the healthcare industry, and particularly in ACOs, this represents a large-scale change and is particularly challenging, as many organizations will be required to continue operating in the traditional volume-based model while transitioning to value-based care. Depending on their mix of payors, contractual situations, and underlying economics, some providers will find it best to switch to value-based care for their entire business, while others will need to take a more calibrated approach, switching sites or service lines gradually as their situations evolve.
Exhibit 2
A strong ACO operating model
Enhancing the financial model

Setting up an ACO requires significant investment and risk on the part of providers, and in return they expect to share in the cost savings they generate for payors through bonus programs. But these bonus programs, inevitably, shift some financial burden to the payors, which in turn may try to push back on the size of bonuses and/or raise cost-saving targets. Given this dynamic, ACOs must ask themselves, “How can we structure contracts to share opportunity and risk appropriately?”

In the long run, payment models need to gradually evolve, moving from today’s fee-for-service mentality, with payors retaining the most financial risk, to a future in which providers share more risk and collaborate with payors on care, allowing for an appropriate division of financial benefits. (For example, providers could be paid a set amount per person regardless of whether that person seeks care during a set amount of time.) It is critical that ACOs evolve over time to share both upside and downside risk with providers, as upside-only arrangements may not create sufficient incentives for real change.

Until then, however, we recommend leveraging analytically rigorous financial modeling to create payment models that define the level of risk and value sharing among providers and payors, the methods of payment, and the mix and conditionality of payment methods. For example, the payor’s up-front investment might be negotiated in exchange for payment reductions over time. Financial modeling can also help address contract clauses like reinsurance, freezing the cost baseline for multiple years, and the treatment of “shock claims” that concern both payors and providers.

One way to mitigate the ACO investment is through a gradual self-funding approach driven by quick wins — instead of a more comprehensive approach that would demand a bigger up-front
investment. This involves prioritizing the investments based on the size of the cost-saving opportunities and the ease of assembling the necessary capabilities.

Early successes with these quick wins will help establish credibility with the skeptics and create needed momentum for the next set of investments. This prioritization process also helps an ACO to identify the potential opportunities that are too costly, and thus where it should not devote resources.
We believe that industry players that use the AC 2.0 approach will be able to better align investment to inherent value and thus reap significant benefits. Likewise, those ACOs that do not improve their approach to accountable care soon may fall behind and be outmaneuvered by more structured and thoughtful competitors that are planning for long-term success.
Endnotes


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