

ISSUE BRIEF

PERSPECTIVES FOR
THE HEALTHCARE INDUSTRY

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The Future of Accountable Care Organizations

HOW TO CREATE INCREASED SHARED
SAVINGS WITH PAYERS

EXECUTIVE SUMMARY

Medicare, Medicaid, private health plans and employers see the shifting of risk to providers as a way to improve outcomes and lower costs. The Medicare Shared Savings Program (MSSP) in the Patient Protection and Affordable Care Act (Section 3022) was the impetus for 343 provider organizations to organize themselves into accountable care organizations (ACO) to assume risk with Medicare enrollees. Their results since 2012 have been mixed: per U.S. Department of Health & Human Services (HHS), fewer than one in five produced savings that could be shared between Medicare and providers in the ACO. For most, the costs of organizing and implementing the ACOs were higher than anticipated and care coordination via their clinically integrated network problematic.

Despite these disappointments, ACOs will not disappear. Payers, wary of anticipated health cost increases in the coming decade, see these clinically integrated networks as a platform for negotiating bundled payments as a new contracting vehicle. And the sponsors of these ACOs - hospitals, medical groups, and their business partners - remain committed to the ACO model despite early setbacks for many.

This evolution from ACO 1.0 to ACO 2.0 features the marriage of ACOs and bundled payments. It is what payers want. And it is where bigger savings shared by providers can be optimized if implemented effectively.

GLOSSARY

Accountable Care Organization (ACO): A clinically integrated group of providers that accepts financial risk for the management of a patient population.

Bundled Payments: A contract between a payer (Medicare, Medicaid, employer, plan) and provider that requires all anticipated services for an episode of care be included in a single payment, with risk for costs and clinical outcomes borne by providers.

Clinically Integrated Network (CIN): A clinically integrated network is a group of clinicians and allied health professions who agree to a formal set of standards for diagnosing, treating and coordinating care for a patient population, sharing risk for clinical outcomes (safety, outcomes, adherence to evidence-based care).

Medicare Shared Savings Program (MSSP): Section 3022 of the ACA created a national demonstration program wherein clinically integrated provider networks, together with their business partners, may assume risk for the management of at least 5,000 Medicare fee-for-service enrollees and share in savings if quality is achieved at 90% or higher on 33 measures.³

TRANSITIONING FROM ACO 1.0 TO ACO 2.0

The transition from ACO 1.0 and ACO 2.0 for most organizations will be necessary but challenging. In ACO 2.0, risks will be greater requiring advanced actuarial capabilities and meticulous attention to care coordination. Relationships between and among physicians will change as risk is shared among tighter networks of high-performing practitioners in the acute and post-acute settings around patient populations covered in bundled payment programs. The scope of regulatory oversight will widen, publicly accessible data about the performance of the ACO will be readily available and the effectiveness of patient engagement magnified.

ACO 1.0 focused primarily on the efforts of clinically integrated networks buoyed by well-organized primary care networks. ACO 2.0 adds specialists and post-acute providers to the mix, requiring new calibration for incentives to align specialists and post-acute providers with primary care. Bundled payments, we believe, will be integrated into traditional ACO 1.0 structures so that patient populations requiring acute interventions are managed within the construct of the clinically integrated network.

ACO 2.0 will evolve fast in most markets because payers, including Medicare, private insurers, employers and Medicaid, see the need to expand risk taken by providers to higher cost populations. As the shift from fee-for-service to value-based purchasing accelerates, it is inevitable that providers – doctors, hospitals, long-term care providers, retail health – will migrate from ACO 1.0 to ACO 2.0. Some will succeed; many will fail.

BACKGROUND ON ACO 1.0:

The concept of accountable care is not new. Medicare experimented with risk-based contracting with large medical groups in its Physician Group Practice Demonstration Program (initiated in April 2005) with mixed reactions.¹ In many markets, private insurers and large employers have implemented risk-based contracts with providers, ranging from programs targeting chronic disease management to direct-contracts for specific, high-cost acute interventions (i.e. hip replacement, open heart surgery).² Medicare ACO activity, begun in 2012, created momentum around the concept of risk sharing by providers and value-based purchasing by payers. These early efforts had varying results (*Exhibit A*).

While results from these programs were diverse, policymakers were nonetheless confident that shifting financial and clinical risk to providers – doctors, hospitals and allied health professionals – was a necessary reform if the costs of the health system were to be managed. As a result, Section 3022 in the Patient Protection and Affordable Care Act was included, along with other demonstration and pilot programs, to encourage “clinically integrated provider networks” and their “business partners” to contract with CMS to manage clinical and financial risk for at least 5,000 Medicare fee-for-service enrollees for three years, with savings to be shared if the ACO scored 90% or higher on 33 quality measures.³

EXHIBIT A - HISTORY OF ACO 1.0

	PHASE 1 - PGP DEMONSTRATION 04/01/05 - 03/31/10	PHASE 2 - PIONEER ACO 01/01/12 - 12/31/14	PHASE 3 - MSSP 04/01/12 - ONGOING
Participants	10 large multispecialty groups representing approximately 5,000 physicians, mostly part of large IDCs	32 organizations began the Pioneer ACO program in 2012 Only 22 remain in PA 7 transitioned to MSSP	360 ACOs in 47 states
# of Beneficiaries	220,000	670,000	~5,000,000
Beneficiary Assignment	Retrospective based on majority of the patient's office or other OP services were provided by the PGP group	Elect either prospective or retrospective beneficiary assignment	Retrospective based on majority of PCP services by PCP physicians
Savings Criteria	Attain spending growth rate > 2% lower than comparison populations were eligible for shared savings, where local market area was basis for comparison	Specific payment arrangement for a Pioneer ACO will be negotiated in the ACO's contract with CMS, but benchmark based on weighted prior 3-year average of actual expenditures for each of ACO's aligned beneficiaries	50% savings after exceeding minimum savings rate (60% if shared downside risk) compared to 3-year average of actual expenditures for aligned beneficiaries
Results	All organizations improve quality Above 1/5 of organizations qualified for sharing in the \$135M generated in savings over the 4-year period	\$147 million in total savings. 12 of 32 shared in savings. Only one ACO shared in losses All Pioneer ACOs successfully reported quality metrics and showed improvement in results	Initial results include, that of 114 MSSP ACOs, 54 kept costs below budget benchmarks and 29 of those saved more than 2%, thus qualifying for shared savings. The 29 saved \$250M, of which half returned to ACOs

Results for these ACO 1.0 efforts have been mixed. Per the Center for Medicare and Medicaid Services (CMS), some ACOs created and shared in savings, but most fell short.

“Last year, the ACOs had higher-quality and better patient experience than published benchmarks. This year, the ACOs improved significantly for almost all of the quality and patient experience measures demonstrating that these organizations improve care. ACOs in the Pioneer ACO Model and Medicare Shared Savings Program (Shared Savings Program) also generated over \$372 million in total program savings for Medicare ACOs. At the same time, ACOs qualified for shared savings payments of \$445 million. The encouraging news comes

from preliminary quality and financial results from the second year of performance for 23 Pioneer ACOs and the first year of performance for 220 Shared Savings Program ACOs.”⁴

But a closer look at the data shows that most ACO 1.0 participants failed to generate savings thus disappointing participating providers who envisioned bonus sharing:

- Medicare Shared Savings ACOs: only 53 of the 320 participating ACOs; the majority failed to generate savings and some faced exorbitant losses in the millions.
- Pioneer ACOs: only 11 of the 23 produced savings, and some dropped out of the program altogether.

LESSONS LEARNED IN ACO 1.0:

Interviews with leaders of successful ACO 1.0 efforts point to five consistent themes.

1. **Being a first-mover ACO is an advantage.** Successful ACOs are playing a long ball. They bet that payers – government, commercial – will eventually shift all risk to local providers, and they recognized that a commitment to clinical integration will improve outcomes and efficiency, goals sought whether risk is shared with payers or not. Early movers invested heavily in board and medical staff education as they embarked on their journey and considered their ACO strategy central to their long-term solvency as an organization. ACO 1.0 sponsors are committed to active participation in risk-sharing contracts with payers, even though savings to date have been less than anticipated. They believe the shifting of risk from payer to provider is not a fad; it is a trend that is likely to gain momentum requiring every provider organization to equip itself accordingly. They believe their ACO 1.0 effort was preparatory for expansion into other provider-sponsored risk opportunities.

“We have found that being the first-mover in the marketplace is a strategic advantage to a health system. A key tenet for Fairview, in 2008, was to be a market maker – the deal maker, not deal taker. It was a big risk, but has huge advantages when you’re able to set up the first shared savings contract with a commercial health plan that thereafter dictates the rest of the marketplace. Those health systems that courageously pursue care model and reimbursement model redesign in parallel will align the incentives to reward the transition from volume to value. To truly drive disruptive innovation, you need a level of education within your board, the strength and perseverance of leadership, and the resolve within the culture that this is the right work to be done before you start talking about ACOs. You need to nurture the culture to ensure the organization recognizes the importance of this work. Too many organizations get into this work as a sideshow, rather than the main show.”

/ MARK HANSBERRY, FAIRVIEW HEALTH SERVICES,
MINNEAPOLIS, MN

2. **Costs to manage risk are significant.** Assessing risk is key. Creating an effective and scalable population health/clinical integration infrastructure requires a significant investment of capital, time and resources. Off-the-shelf information technologies with a registry function are useful, but staffing required to capture and report quality measures, identify and interdict avoidable costs, coordinate care across specialties and facilities, and comply with regulators are significantly higher than anticipated. Most organizations invested a minimum of

\$2M to \$5M to ramp up; most diverted capital from other programs or partnered with an outside business partner to defray costs. As a result, managing risk for a population of fewer than 20,000 covered lives is challenging if costs are to be scaled efficiently. It is a necessary investment to assess an ACO’s performance risk before embarking on the ACO journey: signing up physicians is no predictor of success, especially if the attributed population in the ACO carries high risk.

“A surprise, of course, is what it costs to set up and operate a set of functions that cut across the entire organization, changing the way care is delivered and relationships among clinical staff, allied health professionals, post-acute providers and patients themselves are structured and maintained. And data, data, data. That’s key to the entire effort.”

/ ERIC BIEBER, M.D., UNIVERSITY HOSPITALS, CLEVELAND, OH

3. **Managing physician expectations and behavior is difficult, especially if the ACO loses money and physicians see no shared savings.** The potential that participating physicians might share in savings is alluring. But for most physicians, complete autonomy is “best practice” and shared risk with anyone a non-starter. The reality in ACOs is that referral patterns change, collaboration with peers and allied health professionals around evidence-based care coordination is required, and costs associated with capturing data to comply with payer requirements is borne by the doctor directly. The complexity around team-based compensation arrangements with physicians accustomed to individual production-based income alone is constant pressure. And all these activities are carried out in the intensifying spotlight of physician transparency: the release last spring of the Medicare Physician Database has sparked unparalleled attention on physician prescribing and diagnostic testing patterns, self-referral and patient experiences. And the mixed results reported by CMS suggests that most ACOs might face disappointed physicians.

“Much is written about physician leadership, but it can’t be overstated. Physicians are intelligent professionals. They push back if not kept informed about a change, and require solid evidence of its reality before lending support. The ACO represents change. By requiring clinical integration, it flies in the face of clinical autonomy. And by assuming risk for savings and measurable outcomes, it represents what many physicians conclude is a compromise of their professional standards. Understanding that certain process-of-care outcomes are measurable and variation in practice patterns may be appropriate or inappropriate is a start. And engaging physicians at every level of governance is an absolute necessity for a successful ACO. There is likely no such thing as a non-physician led ACO.”

/ ERIC BIEBER, M.D.

4. Contracting effectively with payers is essential to sustainability.

Medicare and Medicaid contracts carry unusual risk due to the complexities in these patient populations, and the role government plays as a payer. Health insurers representing individuals and groups have distinct expectations: each plan is unique in reporting requirements and risk tolerance. Large employers contract for specific patient populations sometimes attaching narrow network or reference pricing to their contract specifications that deviate from an ACO's structure and incentives. Leaders in ACO 1.0 efforts place a premium on managed care contracting expertise, believing win-win scenarios with most payers are difficult at best. The attribution model for Medicare enrollees requires meticulous risk scoring to assess the ACO's capability to manage its financial downside. With non-Medicare populations accessed through private health plans, the negotiation between the ACO and plan is fraught with risk unless carefully negotiated. And key decisions – like who managed the drug component, or how “avoidable readmissions” and outliers are managed – require professional guidance. Sophistication in negotiating contracts with payers, and in compliance with the requirements in each, is underestimated by most ACOs. As their scope of contracting expands to other models like bundled payments, the assessment of risk necessary to negotiate a contract in which savings can be produced and shared with payers will become even more vital to the ACOs sustainability.

“The attribution of lives by commercial health plans has been problematic from the start. An ACO must be able to proactively identify and risk-stratify their patient population in order to effectively manage the clinical and financial risk inherent with shared savings contracts. In addition, ACOs must have dedicated staff and sophisticated population health tools that are integrated into the clinical work flows to manage patient diagnoses and treatment adherence aggressively. Contracts with payers that limit the ACO's ability to do these well will no doubt result in losses for the ACO and negligible savings for the payer.”

/ MARK HANSBERRY

5. Patient care management is tough. How patients behave, whether they adhere to treatment recommendations, what they understand about their role, what resources they use (whether necessary or not) factor into an ACO's success. In ACO 1.0, patient care management is focused primarily on avoidance of acute events, adherence to routine testing and visits, and health coaching to ensure better outcomes. In ACO 2.0, more complex patient populations will widen the scope of patient engagement risk requiring more sophisticated care teaming around care coordination, medication management and others. Managing

patient behavior is key to the creation of shared savings: in most ACO 1.0 efforts, patient engagement milestones were met as quality metrics were achieved. In expanding an ACO into more complex, high cost populations, the ability to manage patient behaviors is more vital to shared savings, requiring closer coordination among a wider array of providers.

“The success or failure of an ACO comes down to two key dynamics: accurate diagnosis and treatment that's coordinated well, and management of patient behavior to improve outcomes and lower unnecessary utilization. The former has been the primary focus of efforts to implement electronic health records, reduce error, and apply evidence to practice. The latter patient engagement has not gotten the same level of attention in most organizations. In a successful ACO, the two are co-dependent and equally important. Ironically, we know much more about the first than the second.”

/ ERIC BIEBER, M.D.

In most cases, ACO 1.0 was not pursued as a financial strategy; rather, it was an effort to “tiptoe” into risk-sharing arrangements with local payers strategically. It afforded a provider organization the impetus to organize physicians, post-acute providers and allied health professionals around broadening market recognition that fee-for-service payments are prone to overuse and costliness. So ACO 1.0, in most communities, represents a strategic move by providers to accept risk in contracts with multiple payers. And for payers, it opens the door to other ways risk can be transferred; bundled payments, we believe, will be the focus of the transition from ACO 1.0 to ACO 2.0.

LOOKING AHEAD: ACO 2.0

Payers will increasingly accelerate the transition from fee-for-service payments to value-based purchasing. They fear higher costs for hospital care, drugs and professional services and see the shift from volume to value as a permanent change they can propel via their contracts.

In ACO 1.0, populations were managed using a clinically integrated network with a significant complement of primary care providers. The savings from managing cholesterol more aggressively are a significant part of their calculus, but in ACO 1.0, the high costs associated with care between providers treating a complex condition involving a hospital stay – like a joint replacement – were not addressed as directly as they'd like. Bundled payments, as it turns out, are a complement to ACO 1.0 in that its focus is on the high cost populations that require more intense services that, if better coordinated, generate huge savings. So, ACO 1.0

MedPAC Recommended Bundles⁶

1. Major joint upper extremity
2. Amputation
3. Urinary tract infection
4. Stroke
5. Chronic obstructive pulmonary disease, bronchitis/asthmae
6. Coronary artery bypass graft surgery
7. Major joint replacement of the lower extremity
8. Percutaneous coronary intervention
9. Pacemaker
10. Cardiac defibrillator
11. Pacemaker Device replacement or revision
12. Automatic implantable cardiac defibrillator generator or lead
13. Congestive heart failure
14. Acute myocardial infarction
15. Cardiac arrhythmia
16. Cardiac valve
17. Other vascular surgery
18. Major cardiovascular procedure
19. Gastrointestinal hemorrhage
20. Major bowel
21. Fractures femur and hip/pelvis
22. Medical non-infectious orthopedic
23. Double joint replacement of the lower extremity
24. Revision of the hip or knee
25. Spinal fusion (non-Cervical)
26. Hip and femur procedures except major joint
27. Cervical spinal fusion
28. Other knee procedures
29. Complex non-cervical spinal fusion
30. Combined anterior posterior spinal fusion
31. Back and neck except spinal fusion
32. Lower extremity and humerus procedure except hip, foot, femur
33. Removal of orthopedic devices
34. Sepsis
35. Diabetes
36. Simple pneumonia and respiratory infections
37. Other respiratory
38. Chest pain

Continued on the following page.

and ACO 2.0 are the best of both worlds (*Exhibit B*): using a clinically integrated network of providers intent on shared risk, the maintenance and management of a population's health can stabilize costs over time, and the big ticket items involving costly hospital stays can be more efficiently managed through bundled payments.

EXHIBIT B - PAYER PERSPECTIVE ON ACO 1.0 VS. 2.0

	MEDICARE	MEDICAID	PRIVATE INSURERS	LARGER EMPLOYERS
ACO 1.0 Focus	<ul style="list-style-type: none"> • Chronic disease management 	<ul style="list-style-type: none"> • Primary care 	<ul style="list-style-type: none"> • Chronic care management 	<ul style="list-style-type: none"> • Preventive Health • Chronic Care
ACO 2.0 Focus	<ul style="list-style-type: none"> • Bundled payments for high-cost acute events • Post-acute coordination 	<ul style="list-style-type: none"> • Expanded primary care (dental, mental health) • Dual eligibles case management 	<ul style="list-style-type: none"> • Complex, chronic care, bundled payments 	<ul style="list-style-type: none"> • Bundled payments, narrower networks

Integrating bundled payments into the chassis of the ACO is strategically necessary to address growing payer demand for lower costs and provider expectations for shared savings. Consider the following:

Medicare will expand its bundled payment program (Bundled Payments for Care Improvement initiative – BPCI) to include potentially dozens of acute populations (see *MedPAC sidebar*). At the same time, it will intensify its efforts around chronic care management among seniors, with increased focus on formulary design, medication adherence and the role of supplements and off-the-shelf therapeutics. And, among seniors 75+, ACOs will be required to share risk with post-acute providers, including hospice, skilled nursing facilities (SNF), long-term acute care (LTAC) and others involving tightened controls for medical management and complicated coordination with family members (see *Medicare Bundled Payment Initiative callout on the following page*).

- Medicaid will build on ACO 1.0 efforts to improve access to primary care, leveraging a holistic model that includes dental, mental and ophthalmic care along with health coaches and nutritionists to manage populations. Separately, states will contract with ACOs for dual eligible populations on a Per Member Per Month (PMPM) basis, requiring dedicated case management and social services capabilities. And states will contract with ACO 2.0 CINs for high-cost populations requiring sophisticated medical management protocols and predictive analytics to identify populations most at risk.
- Private insurers' ACO 2.0 expectations will vary somewhat plan to plan, but generally require an ACO 1.0 to add bundled payments for high-cost acute populations to current chronic care efforts. In these, plans are likely to press an ACO's credentialing to limit physician participation to a subset of specialists, posing an administrative challenge to the ACOs medical leadership as physician expectations of inclusion in all contracts continue.

- Large employer focus on ACO 2.0 will increasingly focus on a trifecta offering: preventive and chronic services provided on a Per Employee Per Month (PEPM) basis, and acute services priced at a bundled rate based on a narrow network-reference-pricing based negotiation. Inevitably, large employers will accelerate use of bundled payments as they see opportunity to contract directly with the ACO. Each of these payer groups is migrating from ACO 1.0 to ACO 2.0, but in different ways and for different reasons. It requires expanded capabilities beyond what most ACO 1.0 efforts have demonstrated to date.

Medicare Bundled Payment Initiative: On January 31, 2013, CMS announced the Bundled Payments for Care Improvement initiative (BPCI), whereby organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher-quality, more coordinated care at a lower cost to Medicare. Four models are available to qualified applicants:

1. Retrospective hospital acute care hospital stay only
2. Retrospective hospital acute care hospital stay only plus post-acute care
3. Retrospective post-acute only
4. Acute-care hospital stay only

There are 48 episodes of care from which applicants may choose.⁵

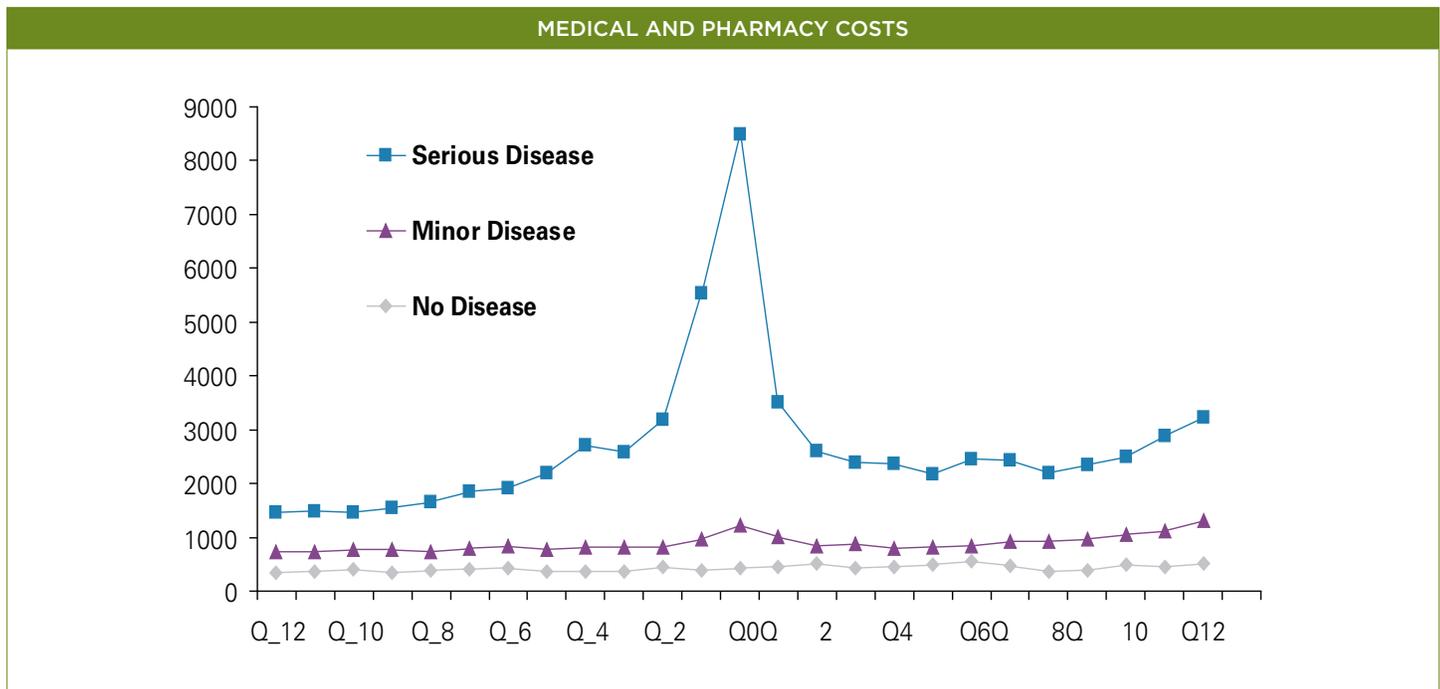
39. Medical peripheral vascular disorders
40. Atherosclerosis
41. Gastrointestinal obstruction
42. Syncope and collapse
43. Renal failure
44. Nutritional and metabolic disorders
45. Cellulitis
46. Red blood cell disorders
47. Transient ischemia
48. Esophagitis, gastroenteritis and other digestive disorders

ACO 2.0 CAPABILITY REQUIREMENTS

The distinctions between ACO 1.0 business imperatives and ACO 2.0 are derived from two trends: the likelihood that greater numbers of payers will use risk-based contracts in negotiations with providers, and the certainty that required reporting measures of savings and outcomes (quality) will expand exponentially. For instance, in the MSSP program, 33 measures are used to calculate quality scores and CMS has already announced that additional measures for this program will be added next year.³ It requires analytics specific to each bundled payment population as illustrated on the following page (*Exhibit C*).

EXHIBIT C - COST PREDICTION ANALYTICS

(SOURCE: TONY BENEDICT, CPIM, CBPP, CIO, VICE PRESIDENT SUPPLY CHAIN, TENET/ABRAZO HEALTHCARE)



But to marry ACO 1.0 with bundled payments, several changes must be made to a traditional ACO (Exhibit D).

EXHIBIT D - KEY DISTINCTIONS BETWEEN ACO 1.0 AND ACO 2.0

CORE COMPETENCIES	ACO 1.0	ACO 2.0
Governance & Leadership	Physician leadership with business partners	...plus narrowed networks of allied health professionals, pharmacists, and post-acute providers willing and capable of sharing substantial risk
Clinical Integration	Care management guidelines and adherence oversight for chronic populations, select acute	...plus additional acute and post-acute populations in narrow networks: requires 'carving in' provider teams around each bundle
Regulatory Compliance	Annual disclosures (federal): structure, incentives, FTC-DOJ for anti-competitive behavior, CMS (quality, safety)	...plus state disclosures and scope of practice constraints plus ongoing federal guidance about safe harbors, market saturation, anticompetitive behavior
Payer Contracting	CMS, national insurers: primarily low risk around upside savings and FFS fee schedules	...plus Medicaid (states), large employers ...assumption of upside and downside financial risk requiring more sophisticated actuarial analytics and predictive models to assess clinical and financial risk
Care Coordination	Evidence-based practices in ambulatory environment, pharmacy, lab	...plus acute and post-acute environments

CORE COMPETENCIES	ACO 1.0	ACO 2.0
Outcome Measurement	Process measures primarily captured in a registry function	...plus functional status and outcome measures in bundled payments (up to 48 bundles in CMS possibly) based on predictive analytics to assess clinical risk
Patient Engagement	Health coaching, self-help tools	...personal health records, social media, online connectivity
Physician Participation	Primary care driven	...plus specialists, pharmacists, mental health professionals, and post-acute providers
Risk Mitigation	Provider credentialing and private inurement	...plus adherence to evidence-based practices, increased exposure to conflicts of interest, increased visibility of physician clinical performance

Clearly, ACO 2.0 is more complex. The management of bundled payments around medical populations, for whom post-acute management is key, like hip replacements, assures that ACO 2.0 will require connectivity with facilities and professionals outside their normal spheres of operation. The significance of medical management and patient adherence to their therapeutic regimen requires engagement with retail pharmacists and use of sophisticated technologies for tracking. And the challenge of addressing physician participation in ACO 2.0 will be a daunting task:

"Today, as networks become more selective, we believe there is more solid legal ground to exclude a physician at the outset than to go through an expulsion and possible lawsuit later, not to mention the heartache of going through a long performance-improvement process. An exception is if you're excluding a physician for purely economic reasons, such as a participating physician not wanting a local competitor in the network. That's a risky proposition."

/ JOHN KIRSNER AND DAVID MORRIS, JONES DAY

KEY TAKEAWAYS:

For providers, the transition from ACO 1.0 to ACO 2.0 is a necessary step in responding to the market's demand that risk be assumed by doctors, hospitals, physicians, post-acute and allied health professionals. But to evolve from ACO 1.0 to a high-performing ACO 2.0 that effectively manages risk for financial and clinical results for larger and more complex populations, three considerations are key:

- 1. Assessment:** Are local payers driving the market to ACO 2.0? Are the economics of the market (utilization, enrollment, rates) sufficient to justify the risk? Are actuarial assumptions about populations under risk contracts sound and finances adequate to fund downside risk? And which bundled payment programs in what order are integrated into ACO 1.0? What capital is required to implement ACO 1.0 and 2.0, and is a business partner necessary? **Key takeaway: do your homework – a bad contract to assume risk is worse than no contract. Do your homework up front.**
- 2. Organization:** How will your high-performing networks be defined, constructed and incentivized to share risk in a clinically integrated model? How will you select from all providers to create narrow networks constructed to achieve optimal savings and quality? How is governance structured to be compliant to laws? **Key takeaway: pick your partners carefully. It's better to have a few of the right players in the front row than lots of players in the back row.**
- 3. Implementation:** How will utilization, outcomes and patient experiences be measured and improved systematically? How is each discrete patient population managed? How is utilization coordinated and tracked? How and where are savings optimized that enhance quality? How are underperforming providers addressed? How is adverse selection in patient populations handled? Where are the addressable savings in the scope of the populations under contract? **Key takeaway: execution is everything. Having physician leaders who drive ACO 2.0 and systems in place to measure and monitor savings and outcomes is key.**

Payers want to see ACOs survive as the vehicle whereby they shift risk to providers. Providers may elect to sit on the sideline and participate opportunistically, or engage their market proactively through the ACO 2.0 model that adds bundled payments to its contracting mix.

To optimize shared savings, and to energize the support and efforts of ACO provider participants, ACO 2.0 is the route to go. But without adequate foresight (assessment), effective structuring (organization) and focused execution (implementation), shared savings will not be realized and losses will mount.

ENDNOTES:

1. "[Medicare Physician Group Practice Demonstration](#)," Center for Medicare and Medicaid Services, July 2011
2. Medicare Shared Savings Program, Section 3022 Patient Protection and Affordable Care Act, March, 2010
3. [Medicare Shared Savings Program Quality Measure Benchmarks for 2014 and 2015 Reporting Years](#), supplemental document to Medicare Shared Savings Program, cms.gov
4. "[Medicare ACOs continue to succeed in improving care, lowering cost growth: Pioneer ACO Model and Medicare Shared Savings Program ACOs show continued quality of care improvements and additional Medicare savings](#)," Center for Medicare and Medicaid Services, September 16, 2014
5. "[Bundled Payments for Care Improvement Initiative Fact Sheet](#)," Center for Medicare and Medicaid Services, January 30, 2014; Bundled Payments for Care Improvement Initiative Fact Sheet," Center for Medicare and Medicaid Services, July 31, 2014
6. "[Bundled Payments for Care Improvement \(BPCI\) Initiative: General Information](#)," Center for Medicare and Medicaid Services

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