

THE ACO SURPRISE

THERE'S A COMMON BELIEF THAT MEDICARE'S ACO PROGRAMS
HAVE HAD LITTLE IMPACT. BUT A NEW SURVEY OF THE FIELD
REVEALS A VERY DIFFERENT STORY

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For many of us in the healthcare industry, the real potential game-changer in the Affordable Care Act was not the highly publicized provisions—the creation of insurance exchanges or its embrace of guaranteed issue, community rating, and regulated medical loss ratios. Rather, it was the way ACA opened the door to accountable care organizations (ACOs) in Medicare. Here at last was a development in US healthcare that would shift the focus to delivery and encourage provider organizations to compete on quality and price—something the traditional fee-for-service system has failed at rather spectacularly. We believed—and still do—that as this sort of competition is successfully introduced into the US system, it will inevitably spread, enabling and accelerating a movement toward healthcare that is priced and paid for in terms of value, not volume of services rendered.

But are ACOs the right way to create that impact? Almost from the start, there have been skeptics arguing that ACOs as conceived under the law would be unable to achieve significant savings—and even if they could, they would never achieve critical mass or significantly penetrate the non-Medicare world. Indeed, at first glance, Medicare’s ACO-based programs do not appear to be making substantial inroads. Several major players have thus far declined to participate. And when the Centers for Medicare & Medicaid Services (CMS) announced in July that it had signed up 89 new ACOs, with 1.2 million additional members, critics were hardly placated. After all, the 2.4 million Medicare patients covered by ACOs to date still amounted to only about five percent of Medicare beneficiaries.

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First glances can be misleading, though. We recently surveyed the scene, attempting to identify all existing ACOs and assess their current and potential impact, and we are no longer skeptics. In fact, we believe that though there is much work left to do, ACOs in a remarkably short period of time have become a substantial part of American healthcare, with the potential to catalyze lasting, positive change as they begin to deliver the results they promise.

THE 150 MILLION PATIENT QUESTION

First, how many ACOs are there and how many patients do they serve? The answer depends on how you define “ACO,” a notoriously slippery term. In the narrowest

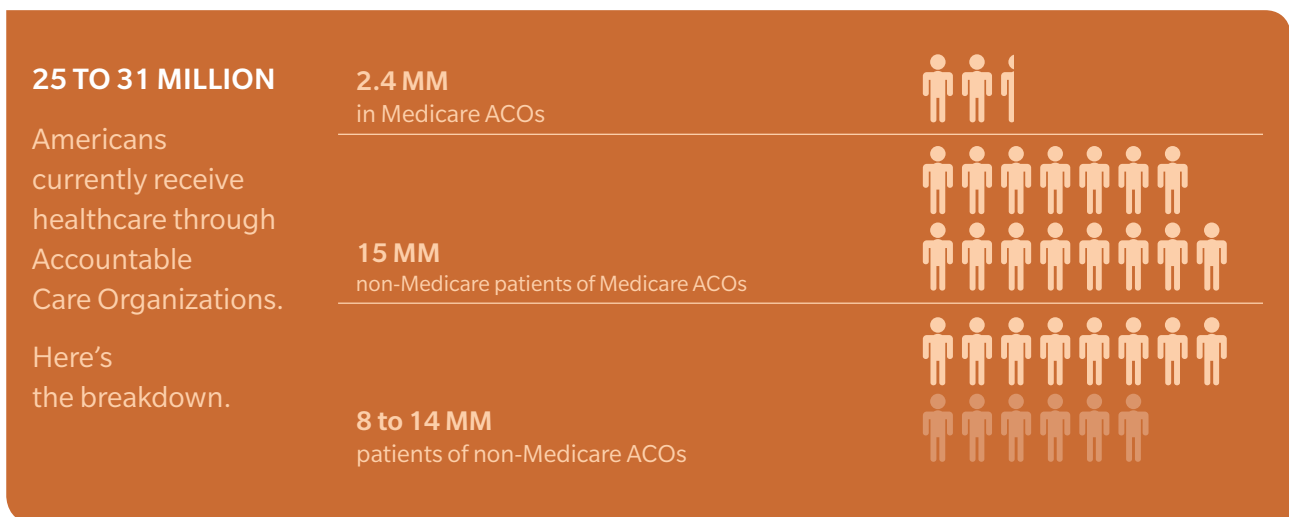
definition, only provider organizations enrolled with one of the Medicare programs qualify. But that isn't a very useful definition. In what follows, we'll use ACO as a catch-all term for providers participating in population-oriented, value-based care delivery and reimbursement models. That means we won't count providers that have only progressed to the level of piloting bundled payment programs (because they are not population-oriented) or those that just receive pay-for-performance or care-coordination payments (because they are not sufficiently value based). We will include only provider organizations that are working under value-based shared savings or risk arrangements on the total cost of care for one or more sets of attributed patients.

With that in mind, the math works like this:

Start with 2.4 million Medicare patients. Medicare's ACO patients are covered under a variety of programs, including:

- Six Physician Group Practice (PGP) Transition Demonstration organizations, which transitioned from the original PGP Demonstration, started in January 2011
- The 32 participants in the Pioneer ACO Model, announced December 2011
- The 27 organizations that, despite tight deadlines, successfully applied for the first round of the Medicare Shared Savings Program (MSSP), which started in April 2012
- The 89 second-round MSSP participants announced this past July. A significant number of these are new entities formed of independent physicians (with or without hospitals) coming together through some type of virtual aggregation

Expect those numbers to grow. More than 500 organizations have applied for the third round of MSSP, slated to begin in January 2013. If this round follows the same pattern as previous rounds, as many as 40 percent of the applications will be rejected—typically because of failure to meet the required minimum number of attributed Medicare beneficiaries. Even if this happens, the number of Medicare ACOs will more than double.



Additionally, many larger health systems, which have been slower to apply, have applied for the January 2013 start date, so the average number of patients per ACO may grow as well. When the third-round of MSSP participants is announced in January 2013, we anticipate not just more new participants but far more patients per organization, as many larger health systems, which have been slower to apply, finally join in. CMS has also been tinkering with the various shared savings programs to broaden their appeal and make them more financially attractive to specific types of healthcare providers. For instance, it expanded the Advance Payment Model, designed for smaller physician groups that couldn't afford the 18-month payment lag of the standard program. And 2,000 primary care physicians across 500 small to mid-sized practices will soon begin participating in CMS's Comprehensive Primary Care Initiative, which begins with large up-front care coordination payments and will layer in a shared savings model across CMS and private payers in its second year.

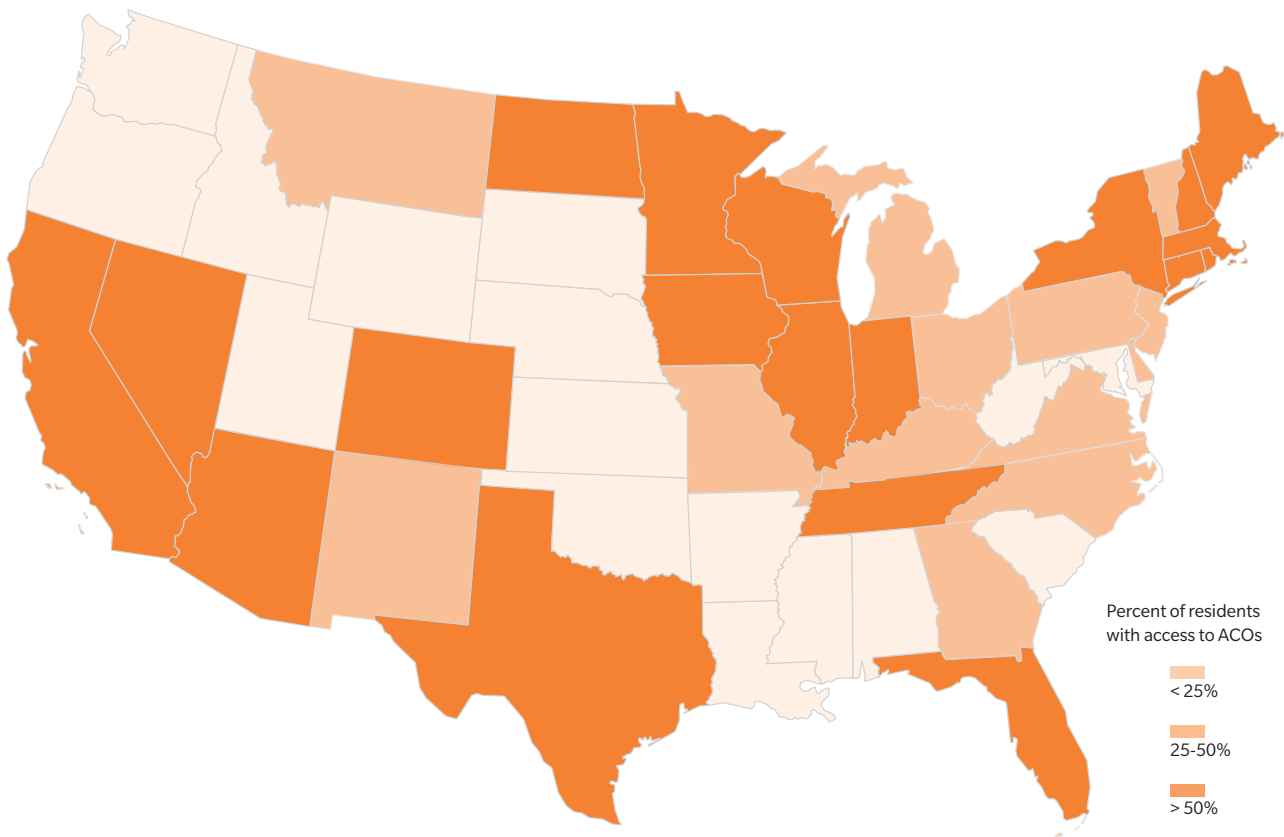
Add 15 million non-Medicare patients in Medicare-oriented ACOs. When a healthcare provider signs up for one of Medicare's ACO programs, it commits itself to a new way of delivering services and a new way of being compensated—a new model of healthcare delivery. And it is extremely difficult for a provider organization to apply that model to its Medicare patients and not to its commercial patients. In practice, virtually any provider that moves to a value-based contract with its most significant payer—Medicare—will eventually need to move all of its patients to value. It typically does not happen all at once, but it is clearly in the interest of an ACO to apply the same clinical model to all of its patients regardless of which insurance card they happen to carry and to be paid similarly as well. That is exactly what is happening with many provider organizations. We estimate that about 15 million patients in the commercial market are receiving their care through ACOs established under Medicare programs.

Add an additional 8 to 14 million patients in non-Medicare ACOs. While government-sponsored ACOs tend to take up much of the spotlight, there are roughly the same number contracting with private payers. Most national and regional commercial payers have begun to pilot ACO partnerships with select providers, and some providers are pursuing a conscious strategy of moving from fee-for-service to fee-for value by testing the concept first with a willing commercial partner or their own employee base first, and only then moving to Medicare. Some commercial payers have taken a relatively collaborative approach to Accountable Care models, giving providers the opportunity to test out new clinical models, often with some amount of advanced payment or enablement support before adopting CMS's models. For example, one of the largest ACOs, Advocate Health Partners in Chicago, has been in an Accountable Care arrangement with Blue Cross Blue Shield of Illinois since 2011 and brought its 2,237

physicians into an MSSP ACO for the July 1 start date. We estimate that non-Medicare ACOs account for 8 to 14 million patients.

For a grand total of. . . These three patient groups add up to 25 million to 31 million US patients receiving their healthcare through ACOs—or roughly 10 percent of the population. We would argue that this is remarkably quick growth for a new and complex form of payment and care delivery. But it is really only a fraction of the potential impact these provider organizations can have. The Medicare ACO programs were deliberately designed as a way to create a multipayer care delivery model that could compete in the open marketplace with fee-for-service, and it is reasonable to ask how many people live in markets where an ACO is one of their healthcare choices. The astonishing answer is nearly half of the US population. When we examine the landscape on the level of primary care service areas (PCSAs), 45 percent of the population live in PCSAs served by at least one ACO, with 17 percent in a PCSA served by two or more.

EXHIBIT 1: MORE THAN 40 PERCENT OF AMERICANS LIVE IN PRIMARY CARE SERVICE AREAS WITH AT LEAST ONE ACO



Note: ACOs defined as providers participating in Pioneer ACO, Medicare Shared Savings, a Medicaid ACO, PGP Transition, or in a shared savings/risk arrangement with a commercial payer

Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis

THE BEST—AND THE REST

What this means is that if the existing ACOs can produce substantial improvements in quality and cost, they are well positioned to drive rapid change in the marketplace. But can they? The question is especially important to ask because it is clear that many of the organizations that currently call themselves ACOs fall short of being “real” ACOs in some respects.

At present, this is true even in the CMS programs. In fact, it is likely the norm. Of the 89 providers approved as ACOs in the most recent round, only five are taking on both upside and downside risk. The remaining 84 could simply tweak their current models, run as predominantly fee-for-service enterprises, and hope for the best. If they create any savings, they get to share in them; if not, there’s no penalty. And it has to be acknowledged that though many ACOs have made progress in transforming their clinical processes, incentive models, and data tools and infrastructure, almost none have transformed all of them.

“Successful ACOs won’t just siphon patients away from traditional providers. They will change the rules of the game.”

This sort of incompleteness is to be expected in the early years of a complex transformation. And incompleteness has not prevented some of the first commercial payer ACO arrangements from having a significant impact on medical cost trend. The Blue Cross Blue Shield of Massachusetts Alternative Quality Contract achieved a 1.9 percent savings in its first year, while the ACO developed by Blue Shield of California, Dignity Health, and Hill Physicians was able to deliver a zero percent premium increase to CalPERS members in the first year of the ACO. Further, they have catalyzed change on a market-wide scale and that pace of change is only accelerating.

These aren’t average ACOs, but that’s the point. The averages won’t drive change, but the success stories—the ACOs that manage to gain an edge on fee-for-service providers will. There’s a reason we focus on the success stories—and why we recommend paying less attention to how well ACOs are doing on average and focusing instead on these success stories—and on the gap that separates them from other ACOs and fee-for-service providers. Successful ACOs won’t just siphon patients away from traditional providers and attract the attention of payers, employers, and partner organizations. They will

change the rules of the game in the regions where they operate, leading purchasers to expect lower costs, higher quality, and greater patient satisfaction. As that happens, there will be a race to adopt the best models. Providers that fail to do so—or that commit halfheartedly to real change, will stand no chance.

GETTING FROM HERE TO THERE

This dynamic means that there is a substantial advantage in being a first mover as your market shifts to ACOs. First movers will have the opportunity to partner with payers and shape an ACO arrangement that suits them. Once successful, they will be able to attract physicians and other critical provider partners through greater participation in the gain-share, along with more patients through higher value care. Fast followers

MEMO TO PAYERS AND OTHERS: IT'S TIME TO HELP

As the rules of healthcare change and the industry's economics evolve, other industry participants will have to keep pace—and some will need to assist providers.

Payers in particular need to step up and offer partnering, capital, and a whole lot of nudging. That will give them the opportunity to help shape the post-transformation playing field and let them put pressure on slower-moving providers. Ultimately, this gives payers better odds of survival in a changing system. The most obvious action payers can take is to create multiple value-based arrangements in each market, forcing providers to actually achieve savings if they want to compete effectively. Payers can look to early success stories to inform and refine these arrangements from both a reimbursement and a support standpoint, with an eye toward encouraging further successes.

Enablement companies should similarly take a proactive approach to ACOs. As the movement to value accelerates, these companies must develop offerings that actually help providers transform. Basic services will soon become commoditized, and ACOs interested in true transformation will need partners with the know-how to help them get there, as well as the capital and financing to accelerate transformation. If an enablement company can use organizational factors to identify providers likely to succeed and can set up at-risk partnerships with them, they can generate profits while developing a strong set of offerings to use with future providers.



will be left with a bit of a knowledge gap and likely some loss in share of both patients and physicians. Those that fail to act at all, choosing a wait-and-see approach or becoming an ACO in name only, will end up playing catch up to meet benchmarks set by their competitors.

To seize the first-mover advantage, though, it is essential to be a “real” ACO—one that is successfully blunting cost trend. To be successful, it is not enough to rebrand your physician network, or meet the application requirements of the MSSP program, or sign a commercial ACO contract. Rather, you have to change the way you deliver care: investing substantially more time and resource in the sickest patients, taking a proactive approach to heading off exacerbations of chronic diseases, and partnering with patients to help them stay well instead of caring for them only when they are sick. If you look past the ACOs in name only, and focus on those who are truly making transformational change, you can see who will redefine the basis of competition.

WHAT DOES REAL TRANSFORMATION LOOK LIKE?

What is the difference between an ACO in name only and an ACO that is truly poised to improve the quality of care, make patients healthier, and reduce costs? We think these four factors are a good indication:

- 1. You treat clinical transformation as the organizational priority.** It is visibly on the CEO’s agenda and not just another strategic initiative. You’re investing substantially in infrastructure—tens of millions of dollars, not tens of thousands. And you’re working to move to risk-based contracts across Medicare, Medicaid, and commercial payers to align incentives across your entire patient population.
- 2. You focus more on the AC than on the O.** You’re promoting true accountability across the organization. You’re identifying over- and under-utilization and eliminating both, while also shifting care to lower acuity settings regardless of parochial interests.
- 3. You’ve put patients at the center.** You’re ceasing to practice “body-part medicine” and instead focusing on patients’ overall health needs. You’re working to understand the clinical and social needs of the populations and sub-populations you serve.
- 4. You’re engaging physicians and other clinicians in a new way.** You’re getting physicians to commit to a model of care that is more patient-centric than physician-centric. You have a plan to dramatically change the way physicians are compensated in order to align incentives.



Of course, driving this level of transformation is easier said than done. It takes more than just resolve to act fast and with success—it also takes significant investment. But as the examples in Massachusetts and California, among other regions, have begun to show, it pays off. And there are ways to manage a transformation in stages. For example, an ACO might start with a focus on the sickest of the sick within the seniors population and develop the capabilities to effectively manage patients with multiple chronic conditions and complex psychosocial needs. In doing so, they'll have simultaneously built meaningful components of the tool kit they need to manage dual eligibles and complex commercial patients. As they further expand to other very expensive conditions such as oncology, heart disease, and renal disease, they'll have their hands around 45 percent of all healthcare spend. Add in an obstetrics model, asthma management, and a complex pediatric model, and they should be able to break even or maybe even make money on Medicaid. By prioritizing initial efforts around high-opportunity areas that require focused care coordination, ACOs can ensure that success across these areas will fund much needed additional investment in prevention, wellness, and consumer engagement to bend trend long-term.

The shift to accountable care is a massive opportunity, and many providers, payers, and enablement companies have already invested millions of dollars in transforming becoming, incentivizing, and supporting ACOs. We cannot ignore how the ACO movement has already earned the confidence of these sophisticated players across the healthcare system. They see more than just a buzz word or an impending government-sponsored trend; they see an attractive bottom line. They understand that value-based care is the standard of the future—and, in several of the most progressive regional markets, almost the standard of today. For those who intend to be part of tomorrow's market, it is time to move quickly, even for organizations that have already given up the chance to be first. The data are clear: The fight for tomorrow's healthcare market has already begun.

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