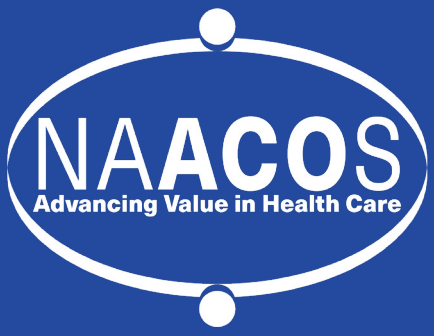

ACO Drivers for Success

September 2024

Table of Contents

NAACOS
Advancing Value in Health Care

Executive Summary

Often our health care system can feel like a daunting labyrinth that lets down those in need and mystifies even the most informed consumers. The promise of value-based care (VBC) is to provide patients a health care system that is less complex, more supportive, and focused on keeping patients healthy and delivering positive outcomes from care. For more than a decade, accountable care organizations (ACOs) have made great strides in fulfilling this promise by demonstrating a notable ability to improve quality and outcomes, lower costs – or at least slow their rate of growth, and increase patient and provider satisfaction.

Despite their success, the road for many ACOs has not been easy, with tremendous challenges and growing pains along the way. For early adopters, there was no road map. Those ACOs showed their commitment to value by improvising, taking risks, and staying on the path even when perilously close to failure. That drive and commitment yielded positive results. When ACOs are successful, the shared savings earned is a direct investment in transformation and improving patient care and outcomes.

This paper shares lessons learned from the early days of adoption through today. The National Association of ACOs (NAACOS) conducted in-depth interviews with the leadership teams of high performing ACOs and reviewed literature on ACO strategies. Five key strategies emerged as a consistent theme for success. In sharing these themes, we hope to further ACO adoption and success, and ultimately accelerate care transformation and improve the experiences of everyone involved in and affected by our health care system.

Key Strategies for Success

Working across payers.

Achieving a critical mass of VBC patients across multiple payers creates stronger incentives than managing accountable care for just one business line or a subset of the population. ACOs found that their transition to VBC gained momentum when they had arrangements across different payers. However, navigating VBC across payers can be challenging due to inconsistent policies and program designs, so streamlining these aspects is beneficial. Interviewees highlighted the importance of shared goals and trust with payers, along with the need for timely data to identify necessary clinical changes and patient needs. Payers should also facilitate the transition from fee-for-service (FFS) to VBC, potentially through upfront funding or ongoing care management fees.

Building a high-value culture.

Creating a high-value culture requires strong visionary leadership and a commitment to accountable care. Providers need to shift from reactive to proactive population health care, prioritizing patient needs. ACOs encourage new leaders to focus on the vision of value and

communicate how VBC enhances patient outcomes and provider satisfaction. Successful leaders explain the reasons for transitioning to accountable care and build organizational support. Engaging both primary care and specialist physicians is essential, as is educating all staff involved in patient care. Financial incentives should align with VBC goals and ACO performance. Trust in leadership and a culture of continuous learning are vital. ACOs also stress the importance of health equity in building a high-value culture. Once established, maintaining a high-value culture requires ongoing effort.

Leveraging data and tools.

In short, data drives transformation. Timely and informative data is essential for accountable care, helping ACOs identify variations in clinical patterns, quality gaps, and care needs. Initially, many ACOs struggled with data management and optimization, but they have since improved by combining multiple data sources and developing analytical solutions. Some ACOs partner with vendors, while others build in-house capabilities, each with its own advantages and challenges. Regardless of the approach, internal expertise is necessary to manage data and evaluate findings effectively. It's crucial to ensure that data is transparent, accurate, and consistent. ACOs should present only relevant data to avoid overwhelming providers and ensure that it serves as a helpful tool rather than an extra burden. Finally, findings should be actionable and aligned with VBC priorities.

Implementing successful clinical interventions.

Transforming clinical care is central to VBC. ACOs highlight the crucial role of primary care providers and the move toward team-based care, which allows for more patient interaction and better care coordination. Many ACOs allocate more funding to primary care and team approaches that encourage shared responsibility. Care teams include various professionals, such as social workers, dietitians, and pharmacists, and increasingly integrate behavioral health while addressing social determinants of health (SDOH). Expanding access to primary care helps reduce unnecessary hospital visits, providing patients with better options to improve their health. ACOs also focus on smooth transitions of care for patients seeing multiple providers across different settings. They often start by transforming primary care and, as they advance, work to enhance specialist care to manage total cost of care (TCOC) and improve quality and outcomes.

Effectively engaging patients in care.

ACOs aim to build strong, trusting relationships with patients to provide personalized and coordinated care. Positive connections based on trust and open communication are crucial. ACOs educate patients on how to manage their health differently, such as using a 24/7 nurse triage line or extended office hours instead of going directly to the emergency room (ER). Access to care is vital for changing behaviors and engaging patients. ACOs also seek to understand patients' preferences and health goals to tailor care effectively. Care teams collaborate closely with families and caregivers, promoting a high-value culture that shifts how they treat patients. Additionally, ACOs are increasingly delivering care outside traditional medical settings, driven by technology and patient preferences.

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Background

Over a decade ago as Medicare value-based payment was in its infancy, there were spirited debates about how to best change provider reimbursement to unlink payment from volume and align it with patient outcomes and experiences of care. The Center for Medicare and Medicaid Innovation (Innovation Center) was established during that time and began to test dozens of payment and care delivery models, with new programs continuing to launch today. ACOs were – and are – a pillar of payment reform and have enjoyed bipartisan support.

Medicare has been a leader in adopting value-based and accountable care and in recent years doubled down on the promise of these models. In 2021, the Centers for Medicare and Medicaid Services (CMS) set an ambitious goal to have the vast majority of Medicaid beneficiaries and 100 percent of Traditional Medicare patients in accountable care relationships with providers who are responsible for quality and TCOC by 2030.[1] The agency notes the importance of accountable care to achieving its goals of advancing health equity, supporting high-quality, person-centered care, and promoting affordability and sustainability. The vast majority of other payers have also embraced accountable care. This is culminating in a critical tipping point with VBC models as a central driver of care transformation as opposed to a peripheral experiment.

The foundation of accountable care is to keep a population healthy by coordinating across providers, including those in various settings or of different specialties. Accountable care more effectively engages patients and rewards providers based on high-quality, efficient care. It also reduces waste in our health care system, which contributes to the exorbitantly high cost of health care. In fact, according to a 2022 Journal of the American Medical Association (JAMA) study, the estimated cost of waste in the U.S. health care system ranged from $760 billion to $935 billion, accounting for approximately 25 percent of total health care spending.[2] Reducing waste not only saves money for taxpayers and patients burdened by increasingly high cost-sharing, but it also frees up capacity for patients who have greater need. With a focus on keeping people healthy and preventing waste, ACOs can generate savings to reinvest in care delivery transformation.

One of the most notable VBC benefits is care delivery transformation, which changes health care to focus on keeping people healthy rather than solely treating them when sick. While a basic notion, health care siloes and payment structures in past decades misdirected providers from prioritizing those goals. The system was instead contributing to a disjointed, reactive "sick care" approach that rewarded providers for how many services they delivered as opposed to how healthy they kept patients. Accountable care continues to spur true care delivery transformation, and for it to be successful long-term, it must happen across all patients, providers and payers.

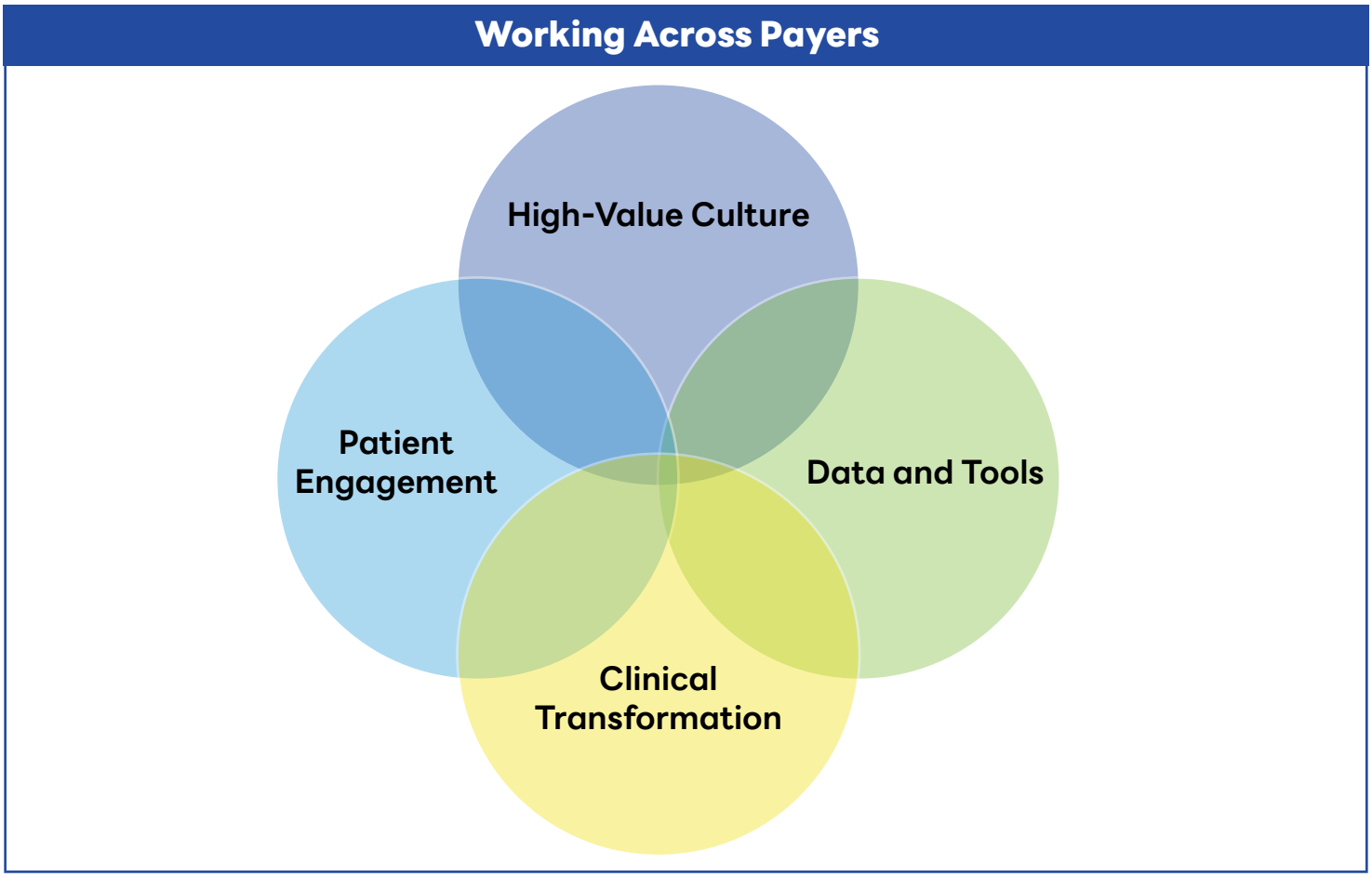
> **"By 2021, 44% of traditional Medicare beneficiaries enrolled in Parts A and B were in a care relationship with providers accountable for quality and total cost of care."[3]**
>
> *Accelerating care delivery transformation — the CMS Innovation Center's role in the next decade*
> New England Journal of Medicine Catalyst

Key Drivers of ACO Success

This section walks through interrelated pillars of ACO success: working across payers, high-value culture, data and tools, clinical interventions, and patient engagement. Each is necessary for ACO success. That said, when pressed to prioritize what new ACOs should focus on first, ACO leaders chose creating a high-value culture, followed by data which drives the clinical innovations that ACOs prioritize. Clinical innovation enables better access to care and care redesign to support patient needs, which is why ACOs recommend clinical innovations be in place to drive better patient engagement. ACOs shared different approaches with expanding their accountable care work across payers, with some gradually expanding VBC across payers and others implementing it more quickly. Regardless of their pace, all agreed that making accountable care changes across payers and patient populations is foundational for long-term ACO success.

Working Across Payers

Achieving scale or hitting a tipping point for when accountable care is the core of care delivery and payment can be a long process for ACOs and other VBC entities. However, leaders interviewed underscored that they gained critical momentum in their VBC work when they hit that tipping point. Many began with Medicare then expanded that work to other payers, though that was not the case for all. While the specific progression varied, those interviewed noted that hitting a critical mass of VBC patients across payers provides stronger incentives to widely implement population health strategies compared to when their organization was only focused on accountable care for one line of business or a subset of the population.



ACOs noted challenges with differences in accountable care arrangements across payers. There are many barriers to aligning accountable care arrangements, including operational barriers and legal issues such as anti-trust laws. Dealing with different program design and methodologies creates confusion and complexity, which is why many ACOs and other VBC entities try to align those across payers when possible. On the other hand, in some instances they may prefer more flexibility or favorable policies when available and would prioritize inconsistency to obtain benefits. For example, an ACO reported receiving different data sets from payers, providing detailed information allowing them to see issues across payers. This identified opportunities to address care gaps for certain patient groups. Therefore, consistent data may be easier to manage, but the benefits of additional data were preferable. This issue, and many more, are discussed in the playbook highlighted on this page.

Key Driver Of Success: Be Payer Agnostic With Population Health

> **Many ACOs felt their success really took off when value-based work was core to the organization and not a peripheral focus. There became a sense of accountable care being engrained in their organizational identity. As one ACO executive commented, "We have a mentality that we won't turn back from value-based care. This is who we are, it's what we do."**
>
> Mary D Strasser, MHL, Senior Vice President Population Health, Essentia Health

ACOs noted the importance of having positive relationships with payers to successfully partner on accountable care. It's crucial to have shared goals and a high level of trust. Additionally, those interviewed emphasized the need for payers to provide informative data in a timely manner, use transparent methodologies, and allow flexibility with aspects of the arrangement such as how and when to assume risk. Commercial payers have increasingly embraced accountable care, providing new opportunities for ACOs and other VBC entities and reinforcing broader health care transformation.

Experienced VBC entities work hard to negotiate favorable changes to support population health, with some noting they won't partner with payers they view as unfavorable from a VBC lens. Many have population health leaders with payer backgrounds, providing a valuable perspective on payer strategy and contracting. ACOs discussed the need to work with payers to establish a path from FFS to VBC, with funding playing an especially important role in the early stages. Payers can support the transition

RESOURCE SPOTLIGHT

A Playbook of Voluntary Best Practices for VBC Payment Arrangements

NAACOS, AHIP and the AMA collaborated on this action-oriented playbook informed by real-world multi-stakeholder experiences.

To further efforts to streamline, align, and scale VBC arrangements, this playbook delineates voluntary best practices on key payment domains such as the development of patient attribution methods, establishment of financial benchmarks, and methods to ensure risk adjustments appropriately reflect the health of the attributed patient populations. This publication is a rich resource that sheds light on what works from the perspective of VBC entities, health plans, hospitals, physicians and other clinicians.[4]

by providing up front resources and/or ongoing per capita funds. Another common approach is paying for care management through various services or a more general fee. These options, or a combination thereof, help smooth the transition from FFS to value.

VBC is changing how payers think about administrative issues such as prior authorization. In a FFS environment, payers see a greater need for tools such as utilization management, but those aren't necessary in an accountable care arrangement that incentivizes proper utilization for optimal outcomes. One ACO shared how they convinced a payer to limit use of prior authorization given the ACO was at-risk for TCOC. Other payers in the area followed suit, thus lessening a major headache for all involved and reducing administrative costs.

> **"We don't want our doctors thinking of patients and their payer. We really want to change care, design, and delivery at the entire practice level. Not patient by patient. This concept of being payer agnostic across our system is core to us and is very important."**
>
> Mark Gwynne, DO, President, UNC Health Alliance

An ACO executive shared that as their success with quality and savings grew over time, payers took notice and increasingly approached them to initiate new VBC arrangements. Multi-payer models are also on the rise and are developed to promote proliferation of VBC. Leaders from OneCare Vermont, the sole participant in the Innovation Center Vermont All-Payer ACO Model, noted that the initial challenges associated with such broad collaboration were worthwhile and the approach is "one of their hallmarks of success".[5] Being in an all-payer model, they spent a long time getting agreement on and narrowing down quality measures, which others longingly commented was a goal they shared. Multi-payer models have not been without their challenges. For example, other Innovation Center models, such as Primary Care First, struggled to attract and retain commercial payers in certain geographies. These models aim to transform care for an entire area and its patients. With laudable goals and the promise of what multi-payer models can deliver, all stakeholders should continue to collaborate on these.

Building a High-Value Culture

Visionary leadership and engagement throughout the organization

Culture is affected by many factors and often hard to change. It permeates an organization, influencing overall strategy and goals as well as how daily responsibilities are carried out. Many ACOs point to creating a high-value culture as their top recommendation for those new to the transition to value. A key to building culture is to shift the mindset of delivering sick care to proactive, population health care. Many ACOs emphasized visionary leaders as crucial for shifting that mindset. This was especially true in the early days when the scope of change was daunting for many ACOs interviewed, and those

> **"Analyze your culture and determine if your organization and employees are in a place where they're going to embrace this and do the hard work it takes... You really need that engagement across the organization to be successful."**
>
> Amy Ready, RN, Director Of Population Health, Billings Clinic

committed to the value transition met skepticism from others. In fact, ACOs noted that one of their biggest initial challenges was dealing with naysayers who preferred to maintain the status quo. Among other impediments, critics pointed to funding concerns and failures of health maintenance organizations (HMOs) in the 1990s as examples of why ACOs wouldn't work.

> **"Don't focus too much on the naysayers. Every developing ACO has them. A leader's time is better spent on those who are supportive of value-based care and then working to grow that coalition of the willing."**
>
> Stephen Nuckolls, MAC, Chief Executive Officer, Coastal Carolina Quality Care, Inc.

Successful leaders clearly articulate their vision and explain why it is necessary and worthwhile. Brevity is helpful, and one ACO succinctly shared their vision was simply "to transform health care with coordinated, integrated care." Many ACOs commented that successful leaders explained why they were moving to accountable care and how it would improve the lives of patients and providers. Some ACOs pursued patient-centered medical home (PCMH) accreditation as a means to change their culture. That sharpened their focus on improving patient care through stronger primary care.

> **"Lead with the vision of value - how it improves patient outcomes and how doctors' lives can be better."**
>
> Mark Gwynne, DO, President, UNC Health Alliance

ACOs affiliated with broader health care organizations, such as health systems, highlighted the importance of VBC being a core focus of the larger organization. For example, UNC Health Alliance, which is part of a broader health system, faced struggles when the ACO was outside of core operations for the academic medical center and the physician entities across the system. They felt they were pushing against aspects of the health system which created tension and challenges. Following decisions to focus more on VBC, ACO efforts became a core pillar of the organization, leading to system-wide change and notable success over time. Today, the ACO plays a prominent role alongside faculty and community practices, is part of the organizational chart, and is fully represented as an operating unit. As the population health enterprise of UNC Health, they also have broad accountability for initiatives that extend beyond the ACO's scope.

ACOs emphasized strong physician leadership, urging new ACOs to include physician leaders from the beginning and to work hard educating all providers about accountable care goals. This fosters buy-in and creates champions within the organization, which spurs value-based culture. It's important to engage specialists as well as primary care physicians. Overall, physician engagement is a key driver for ACO success. Once strong leadership and champions are in place, ACOs should work to garner support across the organization. This includes clinicians and non-clinicians, with ACOs noting the important role that medical practice staff play addressing patient needs quickly and adjusting provider schedules when necessary. Successful ACOs discuss the importance of value when they interview potential employees to make sure they will be a good fit. Unfortunately, most medical schools and other clinical education do not emphasize VBC and population health. Therefore, ACOs must fill this gap by educating providers about what it means to practice medicine consistent with accountable care goals.

It may be more challenging to get support for VBC from specialists or non-medical staff. As recommended by one ACO executive, it's imperative to explain to them why they need to change their behavior. It may be easier for them to tell a patient to go to the ER on a Friday afternoon, but if it's not truly necessary the patient can greatly benefit from the specialist staying late to see them. This requires the administrative staff and providers to do things differently, which is a hallmark of accountable care.

ACO IN FOCUS: Citrus Engages Medical Practice Staff Through Meaningful Rewards

Citrus ACO, a relatively small physician-led ACO in Florida, had success garnering physician support for VBC. However, they struggled with buy-in at some levels of the organization. Wavering support among non-clinical medical practice staff caused them to think creatively about how to improve engagement. They did so by creating bi-annual events to recognize achievements by the ACO practices, such as the highest Annual Wellness Visit (AWV) completion rate or best use of Transitional Care Management (TCM) services. They don't host run-of-the mill lunches with small gift cards. Instead, they have big, special, fun events with notable rewards including large flat screen TVs, paddleboards, and $500 or $1,000 gift cards exclusively for medical practice staff, not clinicians. The recognition and rewards have gone a long way to effectively incentivize staff who play a critical role in the ACO and can sometimes be overlooked. The approach has increased engagement and improved performance metrics that benefit patient care and contribute to shared savings. It's also driven healthy competition and improved employee retention.

Emphasis on addressing health equity

A high-value culture includes many components, including those discussed above and those featured in the list on this page. ACOs and health care providers, along with payers and policymakers, have been increasingly focused on addressing health disparities and integrating health equity into their work. This is a core component of culture for many ACOs and is a focus of new payment models, such as the ACO REACH Model. In fact, a few MSSP ACOs commented that the equity components in the REACH Model are so appealing they might be a reason to switch into that program.

A handful of the ACOs interviewed highlighted how they are proud of their

DRIVERS OF HIGH-VALUE CULTURE

- Visionary leadership dedicated to population health
- Committed to continuous learning and improvement
- Focused on patient outcomes
- Willing to take risks
- Prioritizes health equity
- Learns from mistakes
- High level of trust
- Aligns financial incentives to VBC goals
- Continuously strives to improve quality
- Emphasizes collaboration
- Willingness to adapt
- Positively works with stakeholders to change
- Emphasizes transparency
- Team-based
- Selective partnerships
- Fosters healthy competition

organization's increasing focus on equity and how it became core to their ACO's mission. For example, one ACO explained that 2022 was their first year with deep dives into addressing health disparities. A key payer partner designed financial incentives to reduce disparities by focusing on hypertension, diabetes, and colorectal cancer screenings. The ACO aligned those incentives into their value contracts. They also examined quality and whether they were able to close disparity gaps. Overall, they were highly effective, aligning the financial incentives to outcomes and focusing their quality improvement strategy on disparities. As their ACO executive explained, "We can actually address disparities. It's not some mythical thing that's impossible to do. If we use what we know works and prioritize disparities, it makes a real difference."

Addressing health equity is a growing priority for ACOs

> **"A person born into one neighborhood can have a life expectancy more than 20 years lower than a person born into an adjacent one, which can be the result of a confluence of individual-level and community-level factors, including access to health care. The design and implementation of value-based models and programs can have a meaningful impact toward addressing these and other disparities and promote value-based practices among providers treating rural and other underserved communities."**
>
> *Update On The Medicare Value-Based Care Strategy: Alignment, Growth, Equity*, Health Affairs Forefront

Health equity touches many aspects of accountable care and is therefore discussed again in later sections of this paper. Many payers are finding new ways to tie equity to VBC models. As detailed by CMS leaders, Medicare is leveraging VBC models to address equity, by launching new models and revising existing models.[6]

Funding the value transition

Strong leadership requires more than just convincing others of the importance of VBC, it also necessitates investing to build that future. ACOs devoted money and resources to prepare them for VBC. For example, updating or implementing EHRs, investing in education, purchasing analytics capabilities, attending ACO conferences and networking events, hiring new staff, and more. ACOs noted one of their biggest early challenges was the upfront investment needed to become an ACO. That, coupled with the uncertainty of shared savings and waiting nearly 18 months to receive those payments. Those interviewed commented on how challenging it was to make a business case for the initial year or two of participation because of the funding, uncertainty, and delay of shared savings.

Financing these initiatives can come from a variety of sources. Many ACOs leveraged value-focused FFS opportunities in the beginning, such as chronic care management (CCM) and TCM in Medicare. With some payers, ACOs negotiated monthly care management fees to provide revenue streams for VBC infrastructure. These predictable funds were also helpful to assuage concerns from chief financial officers (CFOs) or others worried about lost revenue from reduced utilization in a TCOC model, which is a common concern among hospital-based ACOs.

Some ACOs were fortunate to receive funding from Medicare through the Advanced Payment ACO Model (2012 to 2015) or the ACO Investment Model (AIM) (2015 to 2018). Both provided

upfront and ongoing payments to participating MSSP ACOs for investment in care redesign and infrastructure to support the value transition. The programs were largely designed to support rural, smaller, and/or physician-led ACOs that lacked funds needed to become an ACO. The programs later recouped shared savings, if earned by the ACO, to repay the investments. Numerous ACOs credited these programs as vital to their ability to become successful. Further, the larger of the two programs, AIM, generated an estimated $381.5 million net reduction in Medicare spending after accounting for payment of AIM funds and ACOs' earned shared saving.[7] Further, 63 percent of AIM ACOs indicated in a CMS survey that the program funds were critical to their formation.[8] Beginning with the 2024 performance year, MSSP ACOs may be eligible for funding for care improvement for underserved beneficiaries through CMS's Advance Investment Payments (AIP).[9] Because the business case is more challenging in the early years, ACOs should look for available funding. Ideally the business case should grow stronger over time to reinforce culture and long-term viability.

As illustrated by the earlier equity example, part of that ACO's success was aligning the financial incentives with the goal of addressing health disparities. The lesson of connecting financial incentives to ACO goals is important and extends to many VBC priorities. Therefore, part of high-value culture is to link ACO financial performance, both in the short- and long-term, to organizational goals. That link should be clear, direct, and strong. Setting the right financial incentives can lead providers to be high performing. For example, as opposed to keeping financial distribution methodologies at arms' length from quality performance or shared savings, ACOs recommend clearly linking financial distributions to performance on quality metrics and contributions to shared savings. That provides a stronger incentive than something less direct, such as only having to attend quarterly meetings. Aligning performance to shared savings distributions is a best practice that successful ACOs increasingly focused on over time. Therefore, they highlighted this advice for new ACOs after reflecting on their own journeys and noted they wished they had pursued this earlier.

Shifting funding to new priorities is challenging when those funds are redirected from other priorities. A few ACOs noted how they moved resources to primary care. For example, one ACO addressed challenges redistributing money to primary care by working those changes through provider committees and trying to get different perspectives on how best to accomplish their goals. This was part of their strategy for creating a TCOC culture, and years later they noted this was a good long-term shift for their ACO.

Assuming risk and developing a business-minded culture

Risk-taking is another component of high-value culture, with many forms of risk. This includes changing previous care patterns, adjusting compensation plans, or investing in new technologies or priorities, among others. Of course, a widely scrutinized part of the ACO journey is when and how to assume financial risk for the ACO's assigned population. Nearly all the ACOs interviewed started in a shared savings-only model and moved into risk after developing a positive track record over time. Losses in early years created uncertainty, which was eased by not having to cut a check for shared losses. Assuming risk can be a major turning point for an ACO, and that pivotal point requires steadfast commitment and leadership. Among Essentia Health's top leaders, the CEO was the key advocate driving their ACO to assume risk. He set the direction and many of the ACO's leaders later commented that the decision was a turning point for the ACO, which elevated their commitment and eventually performance results.

ACO risk is a particular challenge for health care organizations with a financially conservative culture, especially if that predates the ACO. That hurdle can apply to other financial decisions such as changing compensation or moving to capitated payments. ACOs with a more risk-averse culture may also shy away from perceived compliance risks, which is difficult in ACO programs with evolving rules that leave gray areas for interpretation. It can be easier to create a new culture in a nascent organization than to change ingrained culture. This can be an advantage for the many new ACOs and health care organizations forming and competing with long-standing organizations. That said, regardless of their age, successful ACOs learn to adapt more quickly than was necessitated by health care organizations in the past.

A few ACOs interviewed pointed to their business-minded culture as a driver for their success. This made it easier to implement changes to support ACO performance and to pivot when something wasn't delivering desired results, even if the concept had merit. Citrus ACO commented about how well their providers adapt to improve efficiency with Medicare spending and maximize benefits from program rule changes, thus bolstering their ACO's success. Citrus uses data-driven evaluations for deciding whether a potential new ACO practice performs up to their standards. Further, if after two years a new participant hasn't sufficiently changed their practice patterns and/or quality to positively contribute to ACO savings, they may be removed from the ACO.

In contrast, other ACOs commented that their providers were wary of making changes solely to drive ACO shared savings. For example, providers in those ACOs shied away from improving risk score data through complete and accurate coding, which was a strategy many ACOs are more comfortable with. Business savvy ACOs also emphasized tips such as focusing on changes that provide the biggest return and fully understanding program methodologies to maximize results. These strategies help generate savings to reinvest in other priorities such as care transformation and analytics. Citrus ACO executive Derek Pauley explained, "We run our ACO like a business. If we work with our physicians very closely, we can keep the success going. We focus on being innovative and having a great management team that works closely with providers and staff at all levels to really drive results. That's worked for us."

Some larger ACOs operate under a single Tax ID Number (TIN) and don't have as much flexibility in full-TIN models such as MSSP compared to models with TIN-NPI level participation." That affects their culture by requiring them to maintain underperforming providers. For many ACOs their TIN structure was already in place and is difficult to change. This presents challenges for more diverse sets of providers operating under a larger TIN, such as a sizeable multi-specialty practice, health system, or an academic medical center. For the latter, their ACO executives also face challenges such as being a referral center for patients with complex and/or costly conditions. These patients often travel farther to benefit from the high level of expertise. After receiving care, which often results in them being attributed to the ACO, they return home leaving the ACO without adequate opportunity to manage their care long-term. This dynamic leads to higher patient turnover year to year and is difficult for ACOs. Shifting to prospective assignment may help ACOs in this situation.

Continuous improvement and sustaining VBC culture

Focusing on learning and continuous improvement is another hallmark of high-value culture. ACOs report that developing an ongoing cycle of examining data and care patterns, focusing on improvement, and adapting based on the results became an important underpinning of their

value-based culture. This can be done in a variety of ways. For example, one ACO discussed their success with physician-led collaboratives that brought primary care and specialist providers together to seek innovative ways to improve quality and outcomes on conditions including cancer, urgent care, cardiovascular care, and pediatrics. Many ACOs use analytics to identify areas for improvement and once a change is made, they look for another opportunity. One ACO noted they developed an "engine of improvement" focused on iterative testing, changing, and improving. A physician leader from that ACO shared, "All we do is turn that engine toward what we define as priorities," and noted how this spurred broad physician engagement across the ACO.

It is challenging to create a high-value culture, and sustaining it can be equally difficult. Many ACOs noted that it requires diligence to maintain VBC culture as people can slip back into old habits over time or as new employees join the ACO. Therefore, ACOs continued education on what VBC is, how it supports patients and providers, and what it means to day-to-day operations. Some ACOs discuss VBC during employee interviews, including those at all levels and not just for clinicians. They want to ensure new staff understand this important part of their culture. ACOs work to think creatively about continued engagement and how to incentivize ongoing participation, with some paying for meeting attendance or making events more social to promote camaraderie.

Another aspect of sustaining culture is to selectively choose new partners, which can be new practices joining the ACO as discussed above or collaborating with those outside of the ACO. In interviews, ACOs shared mixed stories of partnerships. Some said they faced challenges bringing new providers into the ACO and ultimately parted ways. Seasoned ACO executives urged new ACOs to very carefully vet and select new partners when growing their ACO. One ACO shared that an aspect of their success has been to set a very high bar for any new partners or participants, highlighting that they prioritize protecting their culture and success over growing the ACO. While there are many positive stories of partnership and growth, it should be done carefully in a way that reinforces high-value culture and doesn't dilute it. This topic is further discussed in the sections on data and tools and clinical transformation.

Environmental factors that influence ACO culture

The concept of leveraging diverse professional culture is discussed above, but a related component is managing broader environmental aspects that affect ACOs. Cultural aspects can dramatically vary for ACOs in the same market, but the broader environment in which they operate is more consistent. ACOs noted environmental factors influencing them such as being in a rural area or a more conservative or liberal part of the country.

ACOs in rural areas face unique challenges based on a wider geographic spread, tighter profit margins, and staff/clinician shortages. To reach patient minimums, they may be tied to larger health systems that serve as referral centers for patients with complex health needs. Patients in these areas may have to drive hundreds of miles to receive care, especially specialty care. Billings Clinic in Montana explained challenges such as having fewer nursing homes and shortages of home health, resulting in patients spending more time in the hospital. They recognized that some services remained hospital-based and therefore more expensive because of limited capacity to shift them to ambulatory settings. ACOs commented on the need for greater VBC implementation in rural areas. They noted that while some critics say VBC isn't suited for rural settings, they feel it is a good fit because they don't have enough patients to fill beds and remain profitable in a FFS model. Being an ACO is a creative alternative that will help them evolve and provide care more effectively in a rural setting.

The political environment in a geographic area also influences culture. ACOs in more liberal parts of the country report having more openness to government involvement in health care but face greater skepticism of for-profit entities. The reverse is true in more conservative areas, and a frontier state ACO noted patients are less willing to share their health data. These environmental factors are bigger than ACOs but are important to recognize so ACOs can develop strategies to work more smoothly in their area regardless of the political climate.

Leveraging Data and Tools

Value-based culture cannot succeed without information to drive transformation. Data enables ACOs to identify variations in care patterns, quality gaps, and how much care is needed. ACOs use data to illustrate why providers need to change their behavior, thus reinforcing the shift to VBC. Obtaining and successfully utilizing data is a challenge for ACOs, but as one ACO executive noted, "Without data and actionable analytics, you are just spinning your wheels." Analytics are of critical importance throughout an ACO's evolution, and ACOs use of data evolves over time. This section discusses the evolution as well as challenges and strategies to best leverage data and other tools to support VBC.

Challenges and Best Practices for Data

> **"We couldn't be the transformational agent we want to be without data."**
>
> Gary M Jacobs, MPA, Executive Director, VillageMD Center for Government Relations and Public Policy

In the early years, many ACOs felt overwhelmed by data and weren't sure where to start. As one leader commented, they had a "pipes and duct tape approach. We were just piecing it together and figuring it out." However, those early struggles were worthwhile given the promise of robust clinical and claims data, which created new opportunities to identify care gaps and areas of improvement. One ACO executive shared mixed feelings about navigating data in the early years saying, "data is a blessing and a curse." ACOs noted early challenges such as ensuring they were receiving the right data elements in a timely manner, figuring out how to best filter and combine disparate data sets, and turning data into digestible, actionable information to focus clinicians. ACOs also faced skepticism from some providers about their performance data. Having ACO participants on different EHRs was also a challenge for many. For those using the same EHR, there were still hurdles due to different versions of the same EHR or customization nuances. To address this, some ACOs required participants to be on the same EHR version to more easily transfer data and align analytics.

ACOs also struggled to find and retain high caliber staff who were adept at managing data to support the ACO. Staff turnover created knowledge gaps, especially when losing key employees involved in building or customizing platforms. This convinced many ACOs to better document details of their analytics and create some redundancy among staff. ACOs reported expanding their data and analytics programs over time and investing to hire or contract with those with specific expertise such as actuaries. A few ACOs emphasized giving analytics a prominent seat at the table of the ACO's leadership. One noted their analytics team has a role in leadership equal to those of finance and operations. ACOs' use of data drives decisions and influences actions for the whole organization.

ACOs bring together a variety of data to form a complete population health picture. Data from claims, EHRs, state health exchanges, hospital EDT feeds, eligibility verification systems, and more are all helpful sources. One executive reminds newcomers to make use of publicly available data in addition to the ACO's data. For example, CMS data on county expenditures to show the ACO's relativity to their region or data from state-based Health Information Exchanges (HIEs). While not perfect, these sources add pieces of information to the picture an ACO is trying to see.

DRIVERS FOR SUCCESS: DATA AND ANALYTICS

- Transparent
- Accurate
- Consistent
- Informative
- Timely
- Actionable
- Tied to individual and ACO priorities
- Comparative
- Easily understood
- Combined across payers
- Used to improve clinical care

Many ACOs start by focusing on claims data, which is detailed and actionable. As Coastal Carolina Quality Care CEO Stephen Nuckolls emphasizes, "You have to dive into the data and truly know your costs." He and other ACOs use data to identify gaps in care, such as missed screenings or unfilled prescriptions. Once gaps are identified, providers can work with patients to close those. ACOs also look at variations of care compared to a standard of care and track data over time. They develop a baseline, examine what happens with a particular intervention, and then evaluate the results based on outcomes, quality, and cost. This evidence-based approach determines whether interventions are successful.

ACOs often get different data sets from different payers. Among others, payers provide claims data and contract- or model-specific data as well as performance feedback. Data can be very granular or higher level, both of which can be helpful. Unfortunately, the lack of data standardization makes it hard to seamlessly share data for VBC. This challenge and potential solutions are detailed in *The Future of Sustainable Value-Based Payment: Voluntary Best Practices to Advance Data Sharing*, a joint publication from AHIP, the AMA and NAACOS.[10]

Given the notable challenges managing data across payers, high-performing ACOs work to avoid clinicians having to go into numerous portals or systems. VillageMD's internal analytics team addressed this by making data comparable across traditional Medicare and Medicare Advantage (MA) so providers can look at the same data across payers. They pull in as much raw data as possible across payers and use Tableau for visuals.

Successful ACOs recommend advocating for robust access to detailed and timely data from payers. OneCare Vermont was able to negotiate direct file feeds from payers who wouldn't have given them that information in a FFS model but were willing to do so in a VBC arrangement. ACOs face challenges when data is not available, impeding their ability to make clinical changes. There are barriers to certain data, such as that related to mental health and substance abuse. NAACOS continues to advocate for expanding access to this data.

Much of the focus for ACO data has been on claims and clinical information, but there is growing emphasis on data around social determinants of health to better identify and address

patient needs. Many ACOs collect individual data from patients and when possible, use that to connect them with available social services. As more data becomes available across a population, it can be used to identify trends and address broader issues such as availability of needed services in a particular area.

ACOs faced challenges working with vendors, especially in the early years. With VBC programs in their infancy, vendors were learning how to best support ACOs, leaving some to feel certain analytics vendors weren't adequately equipped to support ACOs. Sophisticated software or expensive platforms may not be necessary in the beginning. One ACO commented, "don't assume you need expensive analytics." Others noted that "simple is better" when starting out with ACO data. Many reported using Excel and basic charts to convey data to providers, such as that related cost variation. ACOs also use Tableau for visuals, and many ACOs leverage their EHRs and use dashboards and alerts to flag needed interventions.

ACO IN FOCUS: OneCare Vermont works across payers.

OneCare Vermont, which operates in a multi-payer model, had to integrate multi-payer data and provide comprehensive reports to various audiences. Early on they struggled to integrate the data across payers and provided reports payer-by-payer through different portals, which created barriers. They have shifted to more real-time data focused on key population health priorities. They are pushing data out in a more action-oriented way. Soon their providers will be able to drill down to patient level data and click on actions items. For example, clicking to see the list of patients who need colorectal cancer screening in the next three months. They hope this patient panel approach will be more successful than a fragmented payer-based approach.

Today there are a myriad of vendor solutions for data and much more expertise in the industry. This complexity underscores the need to properly vet vendors to ensure they can really deliver what an ACO needs.

It's critical that ACOs have the right expertise and capacity to evaluate vendors, ask thoughtful questions, and work on implementation. The ACO should also have staff adept at pushing and pulling data, evaluating what the vendor provides, and mapping to other ACO systems. Regardless of whether using ACO staff or vendors, it is critically important that those using data are properly trained and educated to interpret data. This expertise is imperative for drawing appropriate conclusions that guide ACO actions.

ACOs emphasize that it can take many years to find optimal data solutions, either through partnerships with vendors or growing their own internal capabilities. For example, one ACO that provides custom analytics to clinicians shared that they spent nearly seven years building those capabilities. As ACOs advance, they develop solutions to quickly digest and interpret data to identify utilization patterns and inform optimal care at an efficient cost.

Advanced ACOs use data warehousing and develop predictive algorithms to identify high-risk patients. For example, Health Choice Care has their own data warehouse that combines data and produces custom analytic reports. Reports started in Excel and became more advanced. They shifted from developing reports in a largely manual way to automating some of the development. This allows their analytics team to focus more on the analysis of the data. Sophisti-

cated ACOs also learn to layer data. For example, Essentia Health sends all their claims and enrollment data to a vendor that adds benchmarking tools, groups' clinical data, and flags situations such as potentially avoidable ED visits. This gives a bigger picture for the entire population.

Regardless of the process to create data reports, ACOs strongly emphasize that data must be transparent, accurate, and actionable. Without those pillars of ACO analytics, providers won't have confidence in the data and will be less likely to change their behavior. ACOs should be prepared to walk providers through their data and answer tough questions about the patients included, the evaluation methods, recommendations, and more. Many ACOs are transparent about provider-level and ACO participant-level performance across the ACO. By knowing others' performance, individuals and participants are more incentivized to improve. Data should be shared on a regular basis and should be highly relevant to an individual physician as well as tied to the overall ACO goals. It's also important to show performance changes over time, which can be throughout the performance year as well as year-over-year.

Do not put out incomplete or inaccurate data to physicians. While obvious, spending extra time on quality assurance is worthwhile to build provider trust in the data which drives clinical changes. ACOs should encourage providers to explore the data and ask questions. Many ACOs share that their physicians challenge them, which is a sign of engagement.

To be actionable, ACOs should focus on what matters most and try not overwhelm providers with too much information, especially early on as providers become accustomed to quality and utilization evaluations. One ACO noted they prefer an "elevator pitch" approach to initiate a conversation, sharing clear and concise data points with providers in simple charts that show their performance relative to peers. To encourage ongoing attention to data, ACOs should present it in a consistent manner.

ACOs that span large areas use deep dives into data to identify differences in clinical patterns and gaps in care across markets. This allows them to flag outliers and create customized solutions for a particular area. For example, VillageMD's data showed two states had relatively high post-acute care spending and another state spent three times the average on specialist care. Knowing this allowed them to effectively tailor their strategies.

ACOs evaluate data over time which can reveal unusual spikes in spending. Some spikes may make sense, such as for a new treatment, but other anomalies may be cause for concern. For example, in 2023, ACOs noticed significantly higher Medicare spending for two catheter codes. The Institute for Accountable Care (I4AC) analyzed Medicare claims for these two codes and discovered a nearly 20-fold increase in just two years, with spending increasing from $153 million in 2021 to $3.1 billion in 2023.[11] The impact of the high catheter spending varied greatly from region to region and may have gone unno-

Key Lesson: Data Should Help Prioritize Changes

ACOs should use data to help simplify providers' days. It's important that clinicians not view data as an added burden or chore but as a tool to help them prioritize changes. Clearly showing relevant and meaningful data drives providers to think more carefully about their practice patterns. That can lead them to ask more questions, promote discussion, and improve performance in support of the ACO's goals.

ticed for years without the diligence of ACOs examining data trends. ACOs flagged this issue for NAACOS which led a successful advocacy effort urging Medicare to remove catheter expenditures from ACO financial calculations and to determine if the spending was fraudulent, which it turned out to be. ACOs have similarly identified and reported other fraudulent activity, such as that related to home health or durable medial equipment, prosthetics, orthotics, and supplies (DMEPOS) abuse.

Risk Score Data

Another important use of data is knowing if providers are properly capturing risk scores to accurately reflect underlying patient risk profiles. ACOs stratify by risk to identify patients with the highest needs, which allows ACOs to allocate resources accordingly. Some ACOs shared that there is often more benefit focusing on the rising risk patients, to prevent them from getting sicker, as opposed to the very sickest patients whose conditions are less likely to change. Risk data also plays a critical role in ACO financial calculations, and many ACOs use tools and technology to make clinical documentation easier. One ACO shared how early on they didn't fully understand the importance of accurately capturing the severity of illness among their patient population. They hired a clinical documentation specialist to improve accuracy, which they noted was "absolutely critical" to turn things around. Another ACO cautioned, "our risk adjustment program wasn't up and running until it was too late." They saw the MSSP risk scores go down, which hurt their reconciliation and they subsequently left the MSSP.

Health Choice Care advises using caution when having discussions with providers about risk score data. If they haven't traditionally focused on coding and accurate risk scores, they may be skeptical. It's important to carefully discuss the need for accuracy and supporting documentation in VBC. ACOs should continue to monitor risk score data over time to ensure providers don't slip back into old habits of not properly coding. ACOs use ongoing data and education to maintain buy-in and tie risk score accuracy to their overall ACO goals.

ACOs use data for risk stratification, and ACO methods vary significantly in their level of sophistication. Next Generation ACO Model evaluations found that 43 Next Generation ACOs (NGACOs), or 87 percent, described using risk stratification to identify high-cost, high-risk beneficiaries for more intensive care management services.[3] More sophisticated ACOs develop the ability to risk-stratify patients prospectively. NGACOs reported specifically identifying beneficiaries for intensive care management based on characteristics such as past patterns of high utilization, recent inpatient stays, frequent ED visits, predicted high spending, risk of hospitalization, and having multiple chronic conditions.[3]

Data-driven ACO Initiatives

ACOs use the strategies described above to drive their data initiatives, which result in a myriad of clinical interventions. ACOs evaluate efforts over time, retaining and improving those that show promise and sunsetting those that don't deliver their intended results. This combination of data-driven evaluation and continuous improvement is a foundational element of ACO success. The interventions described below were shared by ACO executives in their interviews for this paper.

- **Ochsner Accountable Care Network** identified significant spend in medically administered Medicare Part B drugs for the treatment of wet age-related macular degeneration. Further analysis revealed variation with how patients were being treated both within the group practice and community. Ochsner partnered with retina specialists to establish an evidence-based care pathway and appropriate therapy plans for these patients, which generated average savings of greater than $5,000 per patient from the prior treatment plan without compromising quality of care.
- **OneCare Vermont** mines available data to focus on addressing health equity issues. They use a combination of their claims and other data to identify opportunities and share information about disparities to close gaps. Examining food insecurity flags led them to initiate a joint program with an FQHC that identified 900 patients appearing to be food insecure. They initiated an outreach program and connected them to food benefit programs in their area.
- **Coastal Carolina Quality Care's** analysis of treating iron-deficient anemia showed spending deviations. Looking into the data further, they discovered many patients were receiving a costly injectable treatment totaling $2,000, which had a six percent profit margin. The ACO's leaders and hematologists discussed an equally effective off-label treatment that only cost $200 but wasn't covered by Medicare. The hematologists established a standard of care to start with the less expensive treatment, which the ACO paid for. This approach contributed to shared savings and patients were happy with their outcomes and avoiding higher cost-sharing.
- **Health Choice Care** data showed that a large portion of inpatient admissions were associated with falls. They discussed the findings with clinical leaders to determine how they could improve efforts around fall risk among their patient population. They adopted a Center for Disease Control program to improve workflows and mitigate fall risks.
- **UNC Health Alliance's** analytics team discovered an unusual uptick in ER visits and ICU admissions for ESRD patients in a certain region, spiking during or right after the weekend. The data prompted them to dig deeper. They discovered that patients in a rural area were routinely missing dialysis appointments on the weekends because they didn't have rides. This led to fluid overload and other complications. UNC Health Alliance addressed this need through a transportation benefit, which was a highly successful initiative to improve access to needed care and avoid complications.

Implementing Successful Clinical Interventions

Having a high-value culture and effectively using data supports the work detailed in the next two sections: implementing successful clinical interventions and effectively engaging patients in their care. These are at the heart of care transformation. Providers deliver care differently in ACOs, because they can spend more time with patients and work in

> **"Providers will be able to deliver more integrated care across settings and engage in more comprehensive and longitudinal care as a result of accountable care relationships and participation in total cost of care models."**
>
> *Innovation Center Strategy Refresh*
> Centers for Medicare & Medicaid Services

team-based environments better suited to effectively coordinate care. ACOs emphasize proactive care and keeping people healthy to avoid unnecessary care. Many of the clinical interventions discussed in this section wouldn't make sense in a traditional FFS environment. When looking narrowly at a particular initiative, it may lose money on its own, but in a broader accountable care context it can generate overall savings and/or improve quality. While a lot of attention is given to whether ACOs save money, it's important to highlight quality improvement, which is a foundational element of equal importance. This section discusses how ACOs transform care delivery, the challenges they face, and success stories of clinical change.

Primary and team-based care and care management

As noted in another publication on factors that distinguish high-performing ACOs, "primary care may be the lynchpin of accountable care".[12] Many ACOs highlight that primary care providers (PCPs) are the quarterbacks of care. When they have the support of care teams, more time with patients, and tools such as data, they can deliver better care than when operating in an uncoordinated volume-based FFS model.

As noted in the section on high-value culture, many ACOs redistribute funding to primary care. For example, OneCare Vermont had a comprehensive payment reform program to support independent primary care. Some ACOs, such as Billings Clinic, valued PCMH accreditation as an effective way to transform primary care. Through that process, they tackled many improvement initiatives, such as enhancing primary care delivery, integrating behavioral health, and embedding pharmacists and social workers into PCP offices. Other ACOs successfully participate in primary care models that operate in junction with ACO models, such as Comprehensive Primary Care Plus (CPC+) or Primary Care First (PCF) in Medicare. Shifting to a team-based approach fosters a culture of shared responsibility and accountability. Care teams communicate more frequently and effectively; many have regular meetings to discuss patients, goals, and their roles within the team. Essentia identified team-based primary care as important for coordinating care at all levels across their organization, which they noted is a key driver of their success. Over time many ACOs expanded their care teams. For example, UNC Health Alliance used VBC revenue to extend care teams by embedding social workers, dieticians, pharmacists, and more. They prefer to have these professionals embedded as it fosters trust with the PCPs.

Care redesign was a challenge for some ACOs in the early years. One ACO shared that was more challenging for them than implementing changes to improve quality. They struggled with changing care patterns for certain high-cost conditions, such as low back pain, but were more successful with others, such as with joint surgery. One of their ACO executives commented that consistency with clinical transformation helped "create the muscle memory" for behavior change among providers.

Care redesign can focus on simple changes or entail a major overhaul of diagnosis, treatment, and documentation. For example, VillageMD did an overhaul of treating patients with Chronic obstructive pulmonary disorder (COPD) and Congestive heart failure (CHF). After reviewing medical records, they were concerned patients were not properly diagnosed. That stayed part of their medical records for years, affecting treatment and outcomes. The ACO had doctors change the test to diagnose COPD and created a new team-based care pathway. They implemented new medication protocols to provide rescue inhalers for patients who were going to the ED for difficulty breathing. They also saw patients more frequently and improved patient education.

Care teams use a variety of care management programs, which bring preventive care to the forefront. ACOs emphasize prevention for a myriad of conditions. For example, Essentia offers a pre-diabetes program for their patients. Screenings such as those for colon and breast cancer are also key to early detection and treatment.

Right care, right setting, right time

As the concept of ACOs began to take root, many supporters highlighted how ACOs would provide the right care, in the right setting, at the right time. While that is a basic notion, the complexity, rules, access impediments, and other pitfalls of our health care system have repeatedly prevented this optimal treatment. For example, patients go to the ER because they lack access to primary care, or they remain in a hospital due to insufficient nursing home capacity or lack of home health services.

This is costly in many ways, both to the system as a whole and to patients who typically prefer to be at home or in a lower care setting when appropriate. A 2019 Department of Health and Human Services (HHS) Office of Inspector General (OIG) report highlighted how ACOs leverage expanded access to primary care to avoid hospital use when possible and utilize telehealth to improve care coordination and care transfers.[13] These strategies were echoed by ACOs contributing to this paper. For example, it's imperative to give patients more options after regular business hours, such as through 24/7 nurse triage lines and urgent care. Coastal Carolina Quality Care expanded their urgent care center to add what many refer to as an "intensive clinic" staffed by ER physicians and sometimes hospitalists. Patients can stay there for a few hours or receive treatment for a few days. The ACO used shared savings to invest in this, providing more access for patients and contributing to TCOC reductions. This, coupled with other strategies, helped them lower their hospitalizations per 1,000.

ACO IN FOCUS: Coastal Carolina's Primary Care Transformation

Coastal Carolina Quality Care changed their primary care offices by developing care teams to alleviate burdens on physicians. More delegation and support enabled PCPs to slow down and spend their time more meaningfully. The ACO incentives to improve care and slow the growth in costs resulted in the group recruiting more physicians and reducing the panel size of many by 20-30%. New care management programs focused on the sickest and most complex patients as well as those struggling with frequent ER use. They reached out in between visits and managed those patients more closely to reduce care gaps. They also improved access through extended primary care office hours, noting that patients won't change their habits unless you give them a better path. Coastal Carolina notes their primary care transformation and patient engagement strategies are their leading drivers of success.

Health care is a highly regulated industry, and certain payment rules can prevent patients from receiving care in the right setting. This is especially a challenge with Medicare, and ACOs are afforded meaningful waivers to help mitigate some of the rules that limit their discretion or pose challenges to cooperation amongst health care providers. For example, qualifying ACOs may use a waiver to provide telehealth services for patients in their home regardless of meeting geographic criteria in place under normal Medicare FFS rules. Many ACOs use this flexibility to engage patients and provide greater access to convenient and timely care. Another notable waiver allows ACOs to place Medicare beneficiaries into a skilled nursing facility (SNF) without having a prior hospital stay of 3 days or longer, as is typically required.

OneCare Vermont credits their use of waivers as a driver for success, commenting that waivers "give our provider partners flexibility and freedom from some burdensome requirements and allow us to better address critical health care needs." ACOs are afforded flexibility through waivers because they are incentivized to efficiently manage TCOC, which disincentives unnecessary over utilization that these payment rules are intended to curb. OneCare Vermont Chief Medical Officer, Dr. Carrie Wulfman, notes that their use of waivers is successful because it is coupled with other strategies, in particular "boots on the ground and providing patient care that is really meaningful for our population."

> **"An ACO approach supports patients being in the best care setting. I like to call it the Goldilocks approach. They shouldn't be getting too high a level of care that is unnecessary, and costs more than it should. And, patients shouldn't be sent home when they need a higher level of care, in which case you aren't giving the patient optimal care. So, you have to make sure the accuracy of the care setting is just right – every time."**
>
> Sidney Raymond, MD, Chief Medical Officer, Ochsner Accountable Care Network

Care transitions and post-acute care

ACOs focus on transitions of care, conducting "warm handoffs" to improve transitions and support patients as they move through the continuum of care. Care transitions are especially important for hospital and post-acute care. For example, Health Choice Care, an ACO comprised of federally qualified health centers (FQHCs), was concerned about "extremely high" ED utilization and an increase in readmission rates, which are cost drivers. They established a formal transitions of care program, benefitting from HIE alerts and enhanced contact with patients. The program gathers clinical documentation from the hospital and does triage, medication reconciliation, and screenings. They emphasize addressing patient needs at their health centers to avoid ED visits and unnecessary hospital use. This program has worked well and raised awareness with patients and providers. ACOs emphasize the importance of connecting with patients while in the hospital to engage with them before they leave. Pre-discharge visits help care teams and patients work together on a care plan and flag potential issues before they arise.

ACOs carefully evaluate post-acute care needs and work to get patients home when appropriate. That can be accomplished more easily with in-home support such as home health, remote patient monitoring, or patient tools such as blood pressure monitors. Because ACOs are accountable for care furnished across the care continuum and Medicare patients retain full choice of providers, ACOs must work collaboratively with providers outside of the ACO. One ACO set up a gainshare model and penalties for readmissions to create the right incentives. ACOs use data to evaluate partners that play vital roles in care transitions and post-acute care, such as SNFs, home health, palliative and hospice care providers. Some ACOs embed ACO staff in SNFs to enhance care coordination. Overall, improving care transitions and use of hospital care, as well as having meaningful partnerships with post-acute care providers can yield savings and improve quality and outcomes.

Engaging with specialists

> **"CMS Innovation Center models often encourage strengthening partnerships with providers across the care pathway to support patient care through total cost of care approaches in population- and episode-based models."**
>
> *Accelerating care delivery transformation — the CMS Innovation Center's role in the next decade*
> New England Journal of Medicine Catalyst

Many ACOs begin with transforming primary care. As they become more advanced, they increasingly focus on improving specialist care as a means for managing TCOC and improving quality and outcomes. Depending on the type and structure of the ACO, specialists may be part of the ACO or outside of the ACO. Both are important in a TCOC model, but there are unique challenges collaborating with specialists outside of the ACO. Research shows that most specialty care that Medicare ACO patients receive is provided by clinicians outside of the ACO.[14] ACOs noted the importance of selecting efficient, high-quality partners and working collaboratively with them as they play an important role in patient care pathways.

A 2024 study by the I4AC, published in the American Journal of Managed Care, finds engaging specialists in VBC is a top priority for ACOs, but they face challenges doing so.[15] The study notes that specialists account for approximately 70 percent of spending for outpatient office visits in our country, and they frequently prescribe expensive diagnostic services, procedures, and drug regimens. The growth of specialist referrals and visits underscores the need for better alignment with ACO goals to improve quality and efficiently manage health care spending. Unfortunately, the I4AC study found that less than 10 percent of ACOs reported high levels of specialist

ACO Strategies to Effectively Engage Specialists

1. Advocate for payers to provide informative data on specialist costs and outcomes.
2. Analyze the quality performance and resource use of specialists.
   - NAACOS and the I4AC offer complimentary episode spending reports to member ACOs based on Medicare data, enabling ACOs to assess specialist performance and identify partners and clinical improvement opportunities. Learn more here.
3. Share relevant data with specialists and collaborate on implementing care improvements.
4. Utilize financial incentives to motivate specialists, such as incentives for performance on cost measures, clinical outcomes, and patient satisfaction survey results.
5. Prioritize which specialist to work with.
   - ACO respondents to the I4AC survey referenced above noted they "were most interested in improving alignment with cardiologists (83%), orthopedists (57%), and oncologists (34%)."
6. Focus specialist referrals on those who demonstrate a commitment to VBC and are responsive to ACO priorities of high quality and cost management.
7. Encourage PCPs to utilize specialist e-consults with high-performing specialists.

engagement in VBC initiatives. These findings are based off feedback from a survey of over 100 Medicare ACO leaders. They identified common challenges including FFS payment structure, lack of data to evaluate specialist performance, and insufficient bandwidth.

ACOs interviewed for this paper echoed challenges engaging specialists and establishing new partnerships to lower TCOC and emphasized this is a priority. For example, one ACO has been trying to get retinal specialists involved for years but continues to face roadblocks and is concerned about increased admissions. An ACO executive noted that positive collaboration with specialists "expands the medical neighborhood." One strategy is to establish gain sharing models with specialists to better align incentives. Billings Clinic has had success embedding care management teams within certain specialty offices such as cardiology and neurology to support care improvement. Payers, including Medicare, have increasingly emphasized the need for better integration of specialists into ACOs and there is growing use of "shadow bundles" for shorter episodes or targeted treatment.

Behavioral health, mental health and SDOH

As discussed in the section on high-value culture, ACOs are increasingly focused on tackling health disparities to improve population health. For this paper, ACOs shared their work addressing SDOH, mental health, and behavioral health. Unfortunately, many challenges remain. For example, one ACO with a commitment to these issues noted that their patients face long waits to see behavioral health providers and despite increasing patient demand, the behavioral health network and capacity in their area haven't changed much in the last decade.

Billings Clinic shared that one of their strategies has been to use social service care managers to enhance their work on SDOH. They help address needs like affordable housing. Their ACO has embedded behavioral health counselors within the primary care practices. They found that supporting patients' behavioral health needs helps patients avoid higher levels of care.

> **"We've talked about integrating behavioral health with primary care for two decades, and now we are actually doing it. That's a direct function of our ACO."**
>
> Mark Gwynne, DO, President, UNC Health Alliance

Billings Clinic also enhanced their primary care work by connecting patients to therapists for needed support and treatment. They note that normalizing mental health and treatment has been a spillover effect of their ACO work. OneCare Vermont rewards their PCPs for doing mental health screenings of all their patients and even more so if they integrate mental health screenings into primary care. ACOs underscore the importance of seamless transitions for patients who need mental health services. These examples highlight the growing commitment to improving outcomes through treating social needs and enhancing behavioral and mental health.

Clinical interventions with a strong ROI

For ACOs to effectively prioritize how to allocate limited resources, they must factor in the return on investment (ROI) of various clinical interventions. This is challenging to do and is a major hurdle for new and inexperienced ACOs. Citrus ACO noted that some ROI calculations are easier than others, and ACOs should look for "low hanging fruit" as they get started. For Citrus, one of those opportunities was to shift certain surgeries and procedures from the hospital outpatient department (HOD) to Ambulatory Surgery Centers (ASCs). While the physician fee for surgery remains constant, the ASC facility fee was half that for the same surgery in the HOD. Citrus ACO

executive Derek Pauley recommends evaluating data for site of service changes that would be clinically appropriate. Below are additional examples shared by ACOs of clinical interventions that yielded a positive ROI.

Clinical Interventions with strong ROI

- UNC Health Alliance was very concerned about high ED utilization rates (1,400 per 1,000) in a particular part of North Carolina. Specifically, the higher ED utilization was for a population of around 200 patients suffering from COPD who were driving more than 50 percent of the ED visits in their county. UNC dug into this to understand why. They found insufficient access to oxygen for acute flare ups as well as a lack of primary care in the area. To address these needs, the ACO brought more primary care to the area and redesigned care protocol when patients went to and left the hospital. They also worked with local home health agencies and DME companies and even collaborated with the local public health agency to improve tobacco cessation. This comprehensive plan improved outcomes for patients, generated savings and reduced their ED utilization rates to 800 per 1,000.
- Coastal Carolina Quality Care was concerned about how its patients were being treated for bone mineral density loss. They discovered that many were receiving a $22,000 treatment that had alternatives. They implemented protocol to double check with rheumatologists whether it would be appropriate to support bone health through a much less expensive yearly treatment. Specifically, they began using evidenced-based protocol that starts with oral bisphosphonates and injections of zoledronic acid before moving to more expensive medications which include Prolia. They also increased the number of patients being treated for osteoporosis and enhanced educational efforts for patients to prevent falls and minimize fracture risk.
- Ochsner Accountable Care Network focused on improving their outpatient case management. They looked at the highest risk individuals, those in the top 3 percent, who are most likely to go to the ED. They encouraged them to enroll in a program designed to reduce admissions. An important component of their work was supporting patients by addressing their SDOH and/or DME needs. Another key to their success was to look at readmissions in a different way than they had in the past. As opposed to organizational level data for a hospital, they drilled down to patient level data. That showed when patients were going to other hospitals for follow-up care, which was a problem they worked to address through this program. Overall, they successfully lowered admissions and readmissions, thus lowering costs meaningfully.

Effectively engaging patients in their care

Many of the clinical interventions discussed in the preceding section rely on ACOs effectively engaging patients to meet their unique needs. As noted in an issue brief from the Alliance for Value-Based Care, "When asked about their health care preferences, consumers overwhelmingly say that they want more personalized care, in which physicians and other clinicians listen attentively and work to identify the root causes of their health problems."[16] VBC enables physicians and other clinicians to spend more time with patients, allowing them to build deeper

relationships and enabling more personalized, coordinated care. Because patient engagement is so closely tied to high-value culture, data, and clinical interventions, this section recaps important strategies for engaging patients and includes patient engagement drivers for success not yet discussed.

> **"Change sometimes happens broadly, driven by leadership and commitment, but it also happens one patient at a time, and one interaction at a time."**
>
> Jessica Martensen, MBA, RN, FACHE, Vice President Population Care Management Programs, Essentia Health

Examples of what "patient engagement" means to ACOs

- Having strong, positive relationships with patients based on trust, collaboration and open dialogue.
- Communications and/or education about key ACO initiatives or services to support patients such as care coordination or clinical reminders.
- Efforts to solicit feedback from patients and incorporate patient perspectives in the ACO's initiatives, including involving patients in ACO governance or advisory committees.
- Use of waivers or incentives to engage patients in their clinical care, or other tools ACOs employ to involve patients in creating and committing to treatment plans.
- Communications and/or education to patients about the ACO or about VBC broadly.

Improving patient access and awareness

One of the most meaningful ways to engage patients is to give them better alternatives to the fragmented care they may have received in the past. Working with patients to teach them what to do when they are sick takes diligence and thoughtful outreach. ACOs that successfully educate patients can build stronger relationships over time. As noted previously, changing provider behavior is hard and takes time and commitment. The same is true for patient behavior. When physicians have more time with patients and care is delivered in an accountable, team-based manner, it supports strong relationships. Providers in ACOs should also improve their own awareness as it pertains to patient preferences and health goals.

Relationships built on trust and communication

At its heart VBC is patient-centered, but there remain a variety of patient engagement challenges. ACOs need to have a deep understanding of their patients to more effectively tailor care to their needs. In addition to patients, ACOs must work closely with families and caregivers. Deeply knowing patients is a challenge for ACOs that have high turnover, which can happen for reasons such as treating patients who move or switch providers because of health insurance changes. Despite challenges, ACOs need to do all they can to build relationships with patients. One basic strategy is to spend more time with patients. As noted earlier, Coastal Carolina Quality Care's success enabled them to recruit more physicians which reduced the panel size of many physicians by 20 to 30 percent. This allows more time to engage with patients and more closely manage them.

Care teams are critical to building relationships, and care coordinators are often a patient's main point of contact. When patients consistently interact with the same person, it promotes trust which is key to effective collaboration and getting optimal care. As one ACO executive noted, "patient engagement is really about meeting patients where they are at. If you don't have a personal, trusting relationship with a patient, you can tell them to do something but maybe they can't. Such as afford medication, get a ride to a follow up appointment, or change their diet. This is why you need personal connections and trust between patients and providers."

Real Patient Story

Richard, a senior with pulmonary fibrosis, was on a phone call with Sandra, his ACO care advisor, when she noticed he was struggling to speak and his breathing had become labored since their previous talk. Drawing on her years of experience as a registered nurse and care management specialist, Sandra urged Richard to call 911 immediately. While Richard didn't initially think he needed to go to the ER, he trusted Sandra after working with her through the ACO's Complex Care Program. Richard called 911, and he was diagnosed with a pulmonary embolism—a blood clot in the lungs that could have been fatal. Later, Sandra received a call from Richard's daughter, who was grateful. When asked what might have happened without Sandra, Richard was clear: "I might not be around today." In the months after his potentially fatal health scare, he continued to work with Sandra to actively manage his disease and better understand when his condition may require urgent medical care.

Effective communication requires trust, as discussed above, but ACOs may also need to overcome other communication barriers, such as language or cognitive barriers. One ACO noted that they had poor patient outcomes at a particular medical practice. They realized that the many patients didn't speak English, so they hired a translator, which strengthened patient relationships and improved outcomes. This example illustrates another point - to ask the right questions. Without doing so, ACOs can't know what is or isn't working or how to adapt to patient needs and circumstances. For example, VillageMD improved how they communicated with patients with CHF about monitoring their weight. They emphasized the importance of doing so effectively and consistently. In another example, Health Choice Care listened to feedback from elderly patients who wanted to receive care in a geriatric location as opposed to a health center with mixed ages and lots of pediatric patients. The ACO took this feedback and opened three locations with a geriatric focus.

Engaging patients outside of traditional medical care settings

The high-value culture of ACOs causes them to think differently about treating patients. It's not enough to treat those who come to see ACO providers in a traditional health care setting. ACOs increasingly deliver care outside the traditional medical setting, a change driven by technology and patient preferences. For example, Coastal Carolina Quality Care launched a palliative care program where care managers, as well as sometimes physicians or physician assistants, go into homes to help patients who can't get to the office. This is particularly helpful for patients suffering from conditions such as dementia. This initiative has been well received by patients and their families. In another example, Essentia needed to reach patients in their homes, especially to assess home safety levels and review medications. The payers serving the area weren't willing to fund this, so Essentia launched a community paramedics program for home assessments. If the paramedics saw issues, they helped address those needs which then prevented adverse health events.

Educating patients about accountable care

In the early years of ACOs, there were concerns that ACOs would disrupt patient-provider relationships. This unfounded worry was borne from negative experiences of other health care arrangements, such as some failed HMOs. Because of the concerns, ACOs didn't properly educate patients about the benefits of accountable care. This is changing and work is needed to grow awareness among consumers and patients about what VBC is and the important role ACOs play in improving health care. Successful ACOs are increasingly doing that. Many began by emphasizing additional ACO benefits and services, such as extra clinical support and coordination across clinicians in different settings and fields of expertise. ACOs note that it is helpful to emphasize the benefits of establishing a primary care relationship, managing chronic diseases, and seeking the right care in the right setting to avoid an ER visit when appropriate.

Meeting nonmedical needs

Research shows up to 80 percent of patient outcomes are influenced by social, behavioral, and environmental factors.[17] Therefore, ACOs need to prioritize understanding and addressing nonmedical needs. While important, this can be a complex and challenging area. ACOs are increasingly working to collect information on nonmedical needs and find solutions to address them though more needs to be done. ACOs are incentivized to tackle these issues as part of their population health strategy. Many ACOs provide patients with services like housing, food, and transportation assistance.

In partnership with Blue Cross Blue Shield of North Carolina, UNC Health Alliance is conducting a large, randomized control trial across their network addressing food insecurity. They screen for food insecurity and test interventions that will help with management of chronic diseases such as hypertension and diabetes. Part of their training is how to ask questions in a sensitive and appropriate manner.

OneCare Vermont has a Longitudinal Care Program that funds home health agencies to provide ongoing care for individuals who no longer meet the Medicare requirements. This is a tremendous support to patients who have continued medical needs and sometimes social needs. The ACO provides wrap around services, and this program has led to significant declines in ED utilization and readmissions.

Obtaining patient feedback through governance and committees

Medicare ACOs are required to have beneficiary representatives on their Boards of Directors to ensure patient needs and preferences are considered. Many ACOs working with payers other

Real Patient Story

After Brenda's home was severely damaged, she felt so overwhelmed that she missed her annual wellness visit with her doctor. Rather than mark her as a "no-show," a patient care navigator with Summit Health, part of VillageMD, followed up with Brenda, because the navigator knew how integral the results from her annual lab work were to managing her diabetes. After Brenda explained her situation, the care manager worked with her to book new appointments. The care manager notified her provider's office of Brenda's circumstances so they could better support her in the future.

As a result of her coordinated care, Brenda was able to get back on track with her medical visits. Today, Brenda is grateful for the deeper connection between her and her healthcare provider, which helps her better manage her health.

than Medicare are required to, or choose to, involve patient volunteers in a variety of ways, such as establishing a patient advisory committee or similar group to gather feedback on communications, educational efforts, and more. There are growing opportunities for ACOs to meaningfully engage with the patients and communities they serve. ACOs benefit from engaging with patients through volunteer opportunities by learning more about the community, feedback on ACO initiatives and communications, and a better understanding of patient needs and preferences. ACOs can learn more about how to successfully recruit and work with patients through this NAACOS resource.

Spillover Effects & Community Benefits

ACOs' care transformation efforts and other initiatives discussed in this paper have directly benefited many patients, but their reach extends even further. ACOs shared rich stories of spillover effects and community benefits that wouldn't occur in a traditional FFS environment. Some benefits are broad, such as developing a sophisticated use of data, changing culture to prioritize patient needs, and giving more of a voice to front line clinicians. Other benefits are narrow, such as creating a transportation benefit for patients in a particular community to support their health needs. All are important as they wouldn't happen in the absence of the ACO.

As noted in the Working Across Payers section, high performing ACOs enact clinical changes for their entire patient population. This creates a positive spillover effect for patients who receive accountable care services but aren't covered by an ACO contract. As UNC Health Alliance Chief Operating Officer Robb Malone noted, "We have payer agnostic approaches, and the halo of doing good work pays off for all patients across payers." In another example, Ochsner Accountable Care Network implemented their outpatient case management program across payers, leading to a reduction of hospital readmissions for all patients, regardless of payer. This is likely one of the most notable spillover effects from ACOs and underscores their pivotal role in system-wide transformation. This has also contributed to a slowdown in Medicare spending.

In fact, Medicare has saved $4 trillion over projections over the last decade. As noted in a New York Times article on the spending slowdown, Harvard professor of health policy and medicine, David Cutler, states "Without a doubt, this is the most important thing that has happened to the federal budget in the last 20 years."[18] According to The Congressional Budget Office, this is in part due to better management of chronic diseases such as hypertension, diabetes and cardiovascular disease.[19] The Alliance of Value-based Care responded to the New York Times article by pointing out that ACOs have played an important role in slowing health care spending. This VBC spillover effect is likely to continue for decades to come, thus relieving pressure on the strained federal budget. Savings have also accrued at the state level. For example, ACOs in Indiana have transformed post-acute care delivery to get patients home faster as opposed to having longer stays in nursing homes. This has led to an overall decrease across the state in the time patients spend in nursing homes, which frees up capacity for those who genuinely need that care and easing the state Medicaid budget.

Implementing accountable care across payers can result in easing policies designed to curb overuse of health care services in a FFS environment. By aligning provider incentives to use care more efficiently, it relieves the need for guardrails such as prior authorization or limits on services such as physical therapy or home health. This reduces administrative burdens for providers, patients, and payers, which is a positive spillover effect for all.

Shifting to a population health mentality can also change how providers view their role in their community. Instead of focusing on treating patients who come to see them, they proactively work to keep the population healthy. Coastal Carolina Quality Care exemplified community engagement following a hurricane. Care managers were worried about their patients struggling with health needs and the ramifications of the hurricane which caused significant flooding in the region. They developed a plan to check on patients in their homes by taking care packages to support them following the storm. This allowed the care managers to determine who needed additional help and patients were touched at the outreach.

Identifying fraud and abuse is another important spillover effect of ACOs. Because ACOs carefully analyze claims data, they are uniquely positioned to identify spending anomalies that could be fraudulent. As noted in the Data and Tools section, ACOs were instrumental in identifying fraudulent Medicare billing for catheters earlier this year. Because ACOs have close relationships with patients, they also hear about schemes in the community that may otherwise go unnoticed. ACOs step in when patients are misled about receiving "free" items or services. For example, one ACO heard concern from patients who were getting "free" healthcare screenings in church parking lots across their community. The company was billing Medicare for AWVs but would soon leave for another town without any capacity or desire to provide ongoing care, nor would they share the AWV information with the patients' PCPs. The ACO educated patients about this and encouraged them to get AWVs from their PCPs instead. Another company would offer free cases of Ensure to patients for signing a form, which turned out to be for receiving additional services that were never provided but were billed to Medicare. The ACO reported this fraud to the Office of Inspector General. This spillover effect bolsters oversight of health care spending and protects consumers, taxpayers, and payers.

NAACOS and many ACOs advocate that payers remove fraudulent spending from ACO calculations. ACOs noted that another spillover effect is to be more engaged in policy and advocacy. ACOs such as VillageMD and Essentia emphasized their advocacy engagement noting that their business and mission are at stake if payers such as Medicare don't get the policies right. Therefore, they are heavily involved in advocacy efforts, which they say wouldn't be the case without their ACO. These and other ACOs advocate for more favorable policies to support VBC implementation, and they educate policymakers and their staff on what ACOs are and how they benefit patients. There is endless need for this education and advocacy, and many ACOs work in conjunction with NAACOS and other leading associations on this work.

ACOs highlighted other spillover effects and community benefits, such as improved provider satisfaction, emphasis on addressing social needs, better screening for mental health, transportation benefits, and emphasis on caring for patients in their homes when possible. Readers can learn more about these and other benefits in earlier sections of the paper.

Advice for new ACOs and clinicians joining ACOs

1. **Evaluate your culture and readiness.**
   As a precursor to participation, providers should evaluate their readiness to commit to joining or becoming an ACO, as well as the readiness of their organization. As discussed in greater detail in the section on Building a High-Value Culture, it's imperative to understand what an ACO is and how participation necessitates meaningful changes. Education is needed to ensure understanding and buy-in of core concepts, which should be at all levels of the organization before beginning VBC contracts.

2. **Have strong, committed leadership.**
   ACOs need strong, committed leadership to champion the VBC transition and need to foster clinician buy-in of accountable care. Building trust and support among physician leaders is especially important so that they vocalize their support during the ups - and downs - of the journey to value. It's also important to have a strong management team. That could be developed internally or by bringing in outside expertise. The key is that running a successful ACO not only takes commitment, but it requires a lot of time and expertise.

3. **Understand accountable care methodologies.**
   There are many facets of ACO agreements, including patient attribution, financial benchmarks, risk adjustment, quality evaluations, overlap with other VBC initiatives, and more. Each is complex, and they combine to influence ACO success. It's essential to have an in-depth understanding of program design and methodologies; not doing so can spell disaster for new ACOs. One ACO noted that learning program complexities was their biggest challenge early on, and many emphasized the steepness of the learning curve. New ACOs and providers joining ACOs should take time to dig into the program methodologies as early as possible and when evaluating new opportunities.

4. **Start with the basics; don't try to tackle too much.**
   New ACOs face a myriad of priorities and goals. Successful ACOs advise carefully identifying a few key priorities for the first year or two and not trying to tackle too much. It's important to maintain discipline by prioritizing key goals and not get distracted. ACOs should also focus on really understanding their pre-participation performance to have an in-depth understanding of baseline performance. This helps identify areas for improvement. ACOs often face a litany of quality measures across payers, making it nearly impossible to focus on them all. Successful ACOs recommend prioritizing three or fewer and really working to improve performance on those.

5. **Prioritize changes that provide the biggest return.**
   New ACOs can often generate savings through a few simple or meaningful changes, such as tackling costly treatments with clinically equivalent alternatives. For example, one ACO saw savings from changing the treatment for iron-deficient anemia by using a $200 replacement for a $2,000 treatment which hematologists

said was equally effective. Without VBC, the incentive would have been to continue the more costly treatment. The bottom line is to pick a few priorities with notable impact on savings in the beginning and add to those in future years.

6. **Be transparent and accurate with provider data.**
   As discussed more in the section on Leveraging Data and Tools, accuracy and transparency are critical with data, especially for new ACOs that may be sharing performance data for the first time. Many experienced ACOs faced pushback from providers when they initially saw data, thinking their performance was better or questioning the validity. If data is wrong, incomplete or lacks transparency, it undermines the ACO and breeds uncertainty. As one ACO executive cautioned, "As soon as you hand over a report to a doctor, and they find something wrong, your credibility is crushed." For these reasons, it is imperative to have strong quality assurance and to be ready to explain the sources and methods used. It's also helpful to provide data in a consistent manner, and it should be tied to specific problems the ACO is working to solve.

7. **Know your patient population.**
   While this is basic, many ACOs gave this advice. It's essential to have detailed knowledge of the patient population so care teams can effectively manage care and engage with patients. ACOs should focus on initial patient lists and determine how best to adapt priorities as those change over time. ACOs may have a choice of prospective or retrospective attribution, which is often secondary to voluntary patient selection. Best practices on attribution can be found in A Playbook of Voluntary Best Practices for VBC Payment Arrangements.

8. **Design changes with workflow in mind.**
   ACOs should give careful, upfront consideration to how changing clinical patterns, quality improvement, and use of analytics, among others, integrate with workflow. While various workflows adapt with the transition to value, new ACOs should do their best to seamlessly incorporate changes into optimal workflow. If not, well-intended changes may not be adhered to by those responsible for them. That could be due to a lack of buy-in for concepts, or simply because of disruptions that hadn't been considered.

Conclusion

While this paper details challenges and best practices for ACO success, there are many others to consider. The COVID-19 pandemic took a tremendous toll on our health care system. Some ACOs noted its lingering effects and commented that the pandemic stalled their VBC momentum. One ACO executive illustrated this point, saying, "COVID turned everything upside down, creating complete turmoil." Rural ACOs interviewed for this paper put more emphasis on COVID challenges, sharing examples of harmful staffing shortages, lack of administrative bandwidth, challenges with changing pandemic policies and protocols, and more.

Changing market dynamics present challenges and opportunities, and the health care industry has navigated an uptick in mergers and acquisitions in recent years. While they can present new, promising opportunities for partnership, they can also take a toll by affecting everything from organizational culture to daily operations. One ACO shared their challenge with a joint venture, which their executive said was "like the Red Sox and Yankees trying to figure out how to do a joint venture with each other." Thankfully they bridged their differences to effectively work together, but that isn't the case for all. New entrants and disrupters can create upheaval in the market and competition for traditional health care organizations, but also provide innovation and fresh thinking. Technology, including Artificial Intelligence, is also a major opportunity and challenge and will be a key focus for ACOs in the coming decade. ACOs and other VBC entities need to effectively navigate the evolving market and leverage innovation and technology.

> **"ACO work isn't for the faint of heart. It's not a side business. It takes steadfast commitment, money, resources, and diligence. It also requires an understanding of what your goals truly are as an organization and then wholly committing to those goals."**
>
> Gary M. Jacobs, MPA, Executive Director at VillageMD Center for Government Relations and Public Policy

ACOs also face upheaval from a shifting policy landscape, with new VBC programs and evolving rules. They must devote considerable time and resources to keep up with changes and adapt to them. These sometimes happen quickly and may include implementation uncertainty. While ACOs have largely enjoyed bipartisan support, changing administrations and leadership result in varying attitudes and policies governing ACOs. Many commented they would like to see more consistency and stability. ACOs that have seen success for years face hurdles stemming from that success, with increasingly challenging financial targets. Some very high performing ACOs questioned their ability to meet future goals, noting that they would consider leaving programs without fair targets. This consideration is especially important in light of increasing ACO risk.

Another issue, which is a challenge and an opportunity, is the low level of understanding consumers have about VBC and ACOs. In the early years, many didn't discuss the role of the ACO as it caused confusion for consumers. Over time, it became apparent that more education was needed to increase awareness and explain the important role that ACOs play in furnishing patient-centered care. Consumer testing has shown that the term "value" isn't well received when it comes to health care. CMS and others, including NAACOS and the Alliance for Value-Based Care,

have taken steps in recent years to help the public understand VBC and ACOs. There are more patient-facing resources available such as this NAACOS factsheet but more needs to be done.

To accelerate VBC progress and growth, it will take a cross-stakeholder effort from providers, payers, and policymakers, and educating patients about accountable care should be a top priority. These stakeholders also need to work together to align accountable care concepts and methodologies to ease burdens and complexity. Efforts are underway, including those highlighted in the previously referenced *Playbook on Voluntary Best Practices for VBC Payment Arrangements*.

Policymakers are a key stakeholder and should enact changes to retain ACOs and attract new ones, especially in underserved areas. They should also address long standing impediments, such as ratcheting benchmarks, and minimize regulatory burdens, especially those that don't make sense in a TCOC environment. Many ACOs are active in advocacy and their perspectives help inform NAACOS's policy recommendations, which are available on this webpage.

In conclusion, ACOs started as an ambitious effort to fix long-standing flaws of our health care system and align provider incentives more with promoting health as opposed to delivering reactive care. This bold experiment hasn't been easy, and challenges remain, but ACOs have made tremendous strides. If the dedication and hard work shown by ACOs in the past decade are any indication of health care's future, it's very promising that our country can have the health care system that we all want and deserve.

NAACOS
Advancing Value in Health Care

NAACOS and the ACOs contributing to this paper hope that the lessons detailed here will help others on their accountable care journey.

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