Growth and Dispersion of Accountable Care Organizations

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EXECUTIVE SUMMARY

Following the Patient Protection and Affordable Care Act's emphasis on Accountable Care Organizations (ACOs) and the announcement of the Medicare Shared Savings Program, an increased interest has emerged among providers and payers to create ACOs. To date, little has been published regarding the types and locations of organizations adopting principles of accountable care.

As part of an ongoing national study, Leavitt Partners identified ACOs from news releases, media reports, trade groups, collaborations and interviews through the beginning of September 2011. Also included were entities that either self-identified as being an ACOs or specifically adopted the tenets of accountable care including financial accountability for the health care needs of a population, managing the care of that population and bearing that responsibility at an organizational level. Leavitt Partners then mapped the market of each of these entities based on the States and Hospital Referral Regions (HRR) associated with the hospitals that each entity utilizes.

Of the 164 identified ACOs, the sponsoring entities included hospital systems, physician groups and insurers with a market presence in 41 states but less than half of all HRRs. Of these entities, 99 were primarily sponsored by hospital systems, 38 by physician groups and 27 by insurers.

To date, little has been published regarding the types and locations of organizations adopting principles of accountable care.

A clear movement is evolving within the health care industry towards the accountable care model of providing health services. Adoption of this model will vary greatly due to both regional differences as well as variations among the sponsoring entities.

INTRODUCTION

Since the 2010 passage of the Patient Protection and Affordable Care Act (PPACA), industry, media and national interest has grown in the concept of the Accountable Care Organization (ACO) [1,2]. With backing from the White House[3] and the conviction of Centers for Medicare and Medicaid Services (CMS) leadership that they will lead to better care, better results and decreased costs[4], Medicare has placed added emphasis on developing ACOs as part of the Shared Savings Program[5] and Pioneer ACO[6] demonstration projects. Additionally, private payers are experimenting with ACO-centric initiatives in an effort to increase the value they receive for the prices they pay by lowering the cost of care, improving the outcomes, or, ideally, both[7].

> What an ACO consists of … and how it achieves its aims is yet to be adequately defined, tested or analyzed.

While there are some specific requirements to participate in Medicare's demonstration programs, ACOs can take many different forms within and apart from Medicare. Since there are likely many models that will be able to achieve the same goals, there is little reason to define what an ACO is and, instead, the emphasis should be on identifying what an individual ACO does and then study the different approaches that can lead to the desired results. To this end, the loose definition of an ACO suggested by McClellan et al is the most fitting: an organization that seeks "per capita improvements in quality and cost" with some degree of accountability[8]. To clarify, an ACO must be, to some extent, financially accountable for the health care needs of a population, manage the care of that population and bear that responsibility at an organizational level.

While the "Accountable Care Organization" name is of recent devise[9], the concepts it embraces are not new to this period: management of and accountability for health care. From the earliest experiments with capitated payments to the most recent pioneer ACO demonstration programs, the goal of improving outcomes while providers manage some degree of risk has been approached in many different ways. To date, there is no consensus regarding which models are best, and the amorphous concept of what an ACO consists of, what it is expected to do and how it achieves its aims is yet to be adequately defined, tested or analyzed. Leavitt Partners Center for ACO Intelligence has begun to study the organizations that are attempting to achieve the aims of an ACO without limiting the approaches the organizations may take and hope to learn which, and to what degree, approaches are successful at improving the value of health care.

METHODS

Without mandatory accreditation[10] or some minimum requirement to become an ACO, Leavitt Partners has sought to pinpoint ACOs by identifying two types of organizations: those that self-identify as ACOs and those who have been specifically identified as adopting the tenets of accountable care. Leavitt Partners has used news releases, media reports, trade groups, collaborations, interviews and contacts within organizations through the beginning of September 2011 to identify 164 ACO entities, including those that are actively bearing risk and coordinating care and those that are implementing such programs. Initial review shows large variability between ACO organizations: some organizations have been bearing risk and coordinating care for decades, while others have newly adopted the ACO model and are in an implementation phase; some ACOs are started by hospitals and others by physician groups or insurance companies; some are large integrated systems and others are smaller and primarily variations on the patient-centered medical home. Starting with this initial list, Leavitt Partners will continue to track these and future ACOs over time and evaluate the effectiveness of different approaches to achieving the goals of improving care and lowering cost. This paper addresses the geographic growth of ACOs in the United States and summarizes the types of organizations that are implementing the ACO model. This information is useful as it indicates the regions which should expect initial ACO growth and describes the types of entities that will drive the initial creation of ACOs.

RESULTS

Summary of Results

1) Dispersion of accountable care organizations varies significantly by market. There is extreme variation in the present growth of accountable care organizations with some markets having multiple ACOs with others having none. Much ACO growth appears to be a reaction to other organizations in the market: when one institution forms an ACO, its competitors often follow suit.

2) Certain regions of the United States are devoid of accountable care organizations. While ACO growth is extensive in some regions, others have no current ACO activity. Poorer and rural regions in particular have little ACO growth.

3) Hospitals and hospital systems are the primary backers of ACOs. Nearly two-thirds of ACOs identified were started by hospitals or hospital systems. Insurers and Physician Groups, though, are also adopting tenets of accountable care and are backing ACOs throughout the country. The multitude of entities creating ACOs have led to many different models of providing care for a patient population.

4) Significant investment in the accountable care model exists independent of the Medicare Shared Savings Program. Though the Medicare Shared Savings Program final regulations have been released, implementation is still in its infancy. Regardless, ACO growth is growing independent of Medicare as multiple entities throughout the country are already operating under accountable care payment contracts.

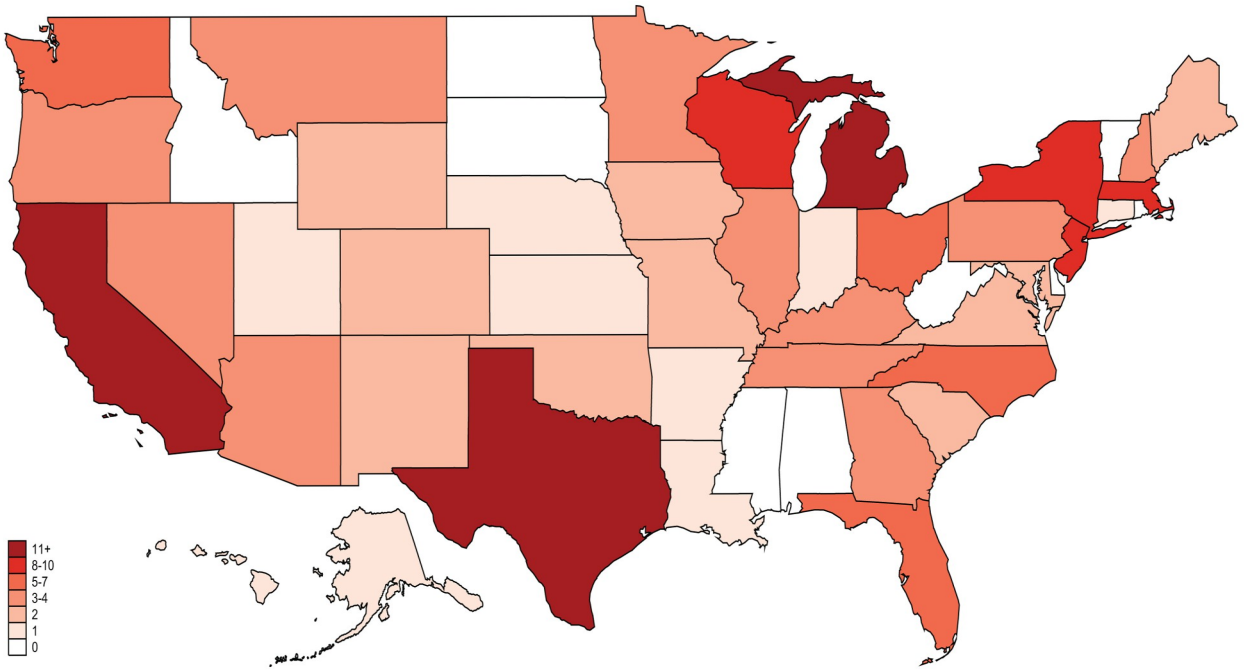
5) The success of different accountable care models is yet unproven. The overriding goal of accountable care organizations is to lower costs, improve care, or both. While there are many different models of providing accountable care, which approaches are most successful at realizing an ACO's goals is still unclear.

ACOs by State

Health care delivery in America is still primarily a cottage industry with few national health care providers. Most health service providers are regional and are focused around one market area, whether because of the simplicity of dealing with one state law, the difficulties in expanding beyond a relatively small footprint or for other reasons. Figure 1 depicts the dispersion of ACOs at the state level. Leavitt Partners classified state coverage based on the location of hospitals affiliated with the ACO. Where ACOs cover multiple states, both states were depicted on the map. When the geographic boundaries were unclear, as was often the case with large insurance companies, those ACOs were not included on the map; of the 140 ACOs mapped, 127 did not extend beyond one state.

Generally, states with larger populations are associated with more ACOs, though the trend in the South, through the plains states and into the mountain west is toward fewer ACOs. There are also noticeable outliers such as Montana, the 45th most populous state, which has the same number of ACOs (three) as Illinois and Georgia, the 5th and 9th most populous state, respectively.

FIGURE 1. ACO DISTRIBUTION BY STATE



ACOs by Hospital Referral Region

An indicator of competition among providers is the number of ACOs in Hospital Referral Regions (HRRs). Developed by the Dartmouth Institute for Health Policy, the 306 HRRs are regional health care markets where patients are referred for tertiary care[11,12]. Multiple ACOs in a single HRR is indicative of markets where health care providers within the regions may be competing for the same patients. Figure 2 shows the number of ACOs by HRR, determined by the location of hospitals affiliated with the ACO. When an ACO covers multiple HRRs, all were included on the map. When an ACO covers a poorly-defined region or is nearly national in scope, as is the case with some insurance company sponsored ACOs, the ACO was excluded from this map.

The smaller size of HRRs shows the trend of entities creating ACOs in narrower regions than the state map suggests: While only nine states do not have ACOs, less than half of all HRRs (144 out of 306) have an ACO. This clustering within HRRs suggests that competing health systems are simultaneously creating ACOs. This may arise from providers in a market who seek to match or copy what a competitor is doing or it may be indicative of previously-integrated systems that are better prepared to become ACOs. Additionally there likely are market-specific reasons that have previously affected the growth of health care entities in different areas of the country which differently affect market-level ACO growth.

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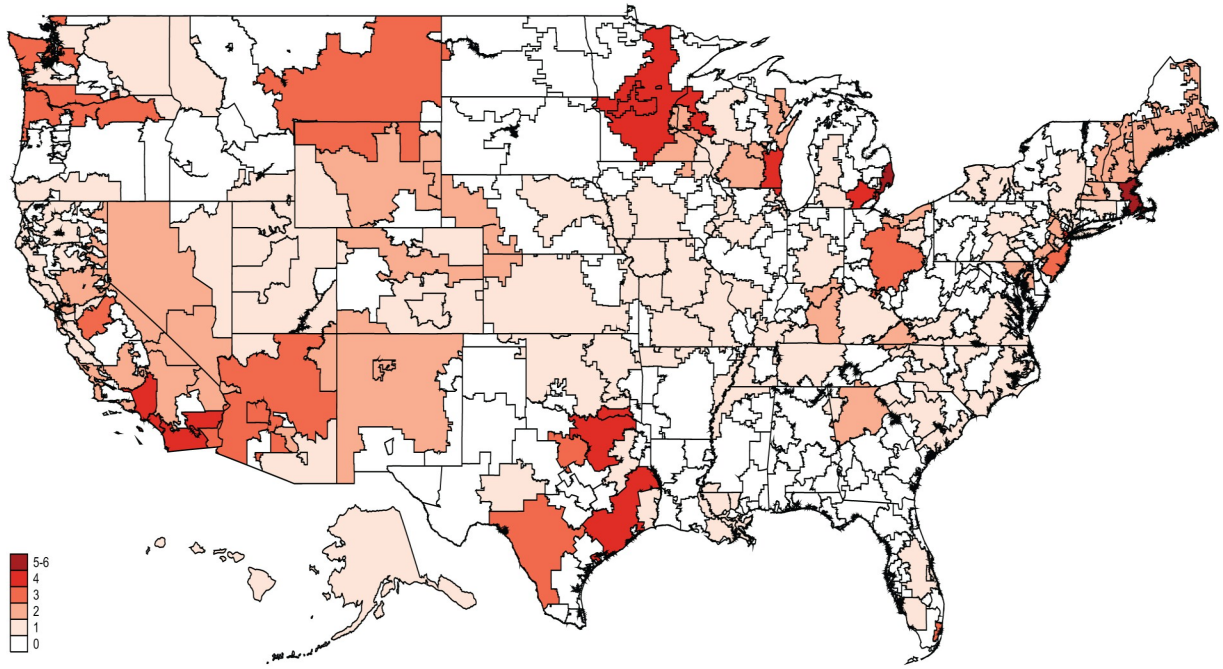
Another interesting aspect of this map is the dearth of ACOs in the Southeast and Appalachian regions which consistently rank as the least healthy areas of the country[13] with a high prevalence of obesity, heart disease, diabetes and other chronic diseases[14]. Accordingly, it would seem that these regions stand to benefit the most from coordinated care[15]. The reason for the lack of ACOs in these regions is unclear.

FIGURE 2. ACO DISTRIBUTION BY HOSPITAL REFERRAL REGION



ACO Sponsoring Entity

There is a clear trend toward hospital systems sponsoring ACO development, as they accounted for more than 60% of all sponsoring entities.

Traditional approaches to coordinated care have been structured around hospital systems or payers affiliated with hospital systems. ACOs, though, can be started by any entity that is able to cover a large number of lives and bear some form of risk for that population. Leavitt Partners defined the sponsoring entity as the organization that is primarily responsible for the ACO. In evaluating the sponsoring entity, each entity was defined as a hospital or health system, an independent physician association (IPA) or as an insurer. In actuality, some ACOs were started by organizations that do not clearly fit into one of these three categories and others were formed as joint ventures. In seeking to simplify the classifications, each organization was classified by the entity that was predominantly responsible for the ACO's creation and grouped the ACOs based on the state where the sponsoring entity is headquartered. Table 1 shows the breakdown of the number of ACOs formed by each sponsoring entity. There is a clear trend toward hospital systems sponsoring ACO development, as they accounted for more than 60% of all sponsoring entities.

FIGURE 3. ACOs BY SPONSORING ENTITY

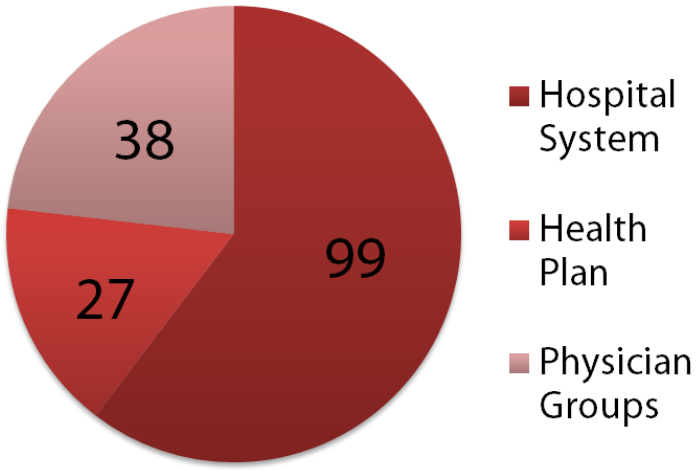


TABLE 1. ACO SPONSORING HEADQUARTERS BY STATE

State	Hospital System	IPA	Insurer	Total	State	Hospital System	IPA	Insurer	Total
Alabama	0	0	0	0	Montana	1	0	2	3
Alaska	0	0	0	0	Nebraska	1	0	0	1
Arizona	2	1	0	3	Nevada	0	0	0	0
Arkansas	0	0	1	1	New Hampshire	2	0	0	2
California	8	7	2	17	New Jersey	5	3	1	9
Colorado	1	0	1	2	New Mexico	1	1	1	3
Connecticut	1	0	1	2	New York	4	3	1	8
Delaware	0	0	0	0	North Carolina	2	2	1	5
D.C.	0	0	0	0	North Dakota	0	0	0	0
Florida	2	1	0	3	Ohio	7	0	0	7
Georgia	1	2	0	3	Oklahoma	1	0	0	1
Hawaii	1	0	0	1	Oregon	2	1	0	3
Idaho	0	0	0	0	Pennsylvania	4	0	2	6
Illinois	3	1	1	5	Rhode Island	0	0	0	0
Indiana	1	0	1	2	South Carolina	1	0	0	1
Iowa	1	0	0	1	South Dakota	0	0	0	0
Kansas	0	0	0	0	Tennessee	2	1	2	5
Kentucky	2	1	0	3	Texas	8	4	0	12
Louisiana	1	0	0	1	Utah	1	0	0	1
Maine	1	0	1	2	Vermont	0	0	0	0
Maryland	2	0	2	4	Virginia	1	0	0	1
Massachusetts	5	2	2	9	Washington	3	3	0	6
Michigan	8	3	1	12	West Virginia	0	0	0	0
Minnesota	2	2	3	7	Wisconsin	7	0	1	8
Mississippi	0	0	0	0	Wyoming	1	0	0	1
Missouri	3	0	0	3	**Total**	**99**	**38**	**27**	**164**

DISCUSSION

With the Medicare Shared Savings Program still to be implemented, the substantial growth of Accountable Care Organizations indicates a trend within the health care industry towards the accountable care model, partially independent of government incentives. With significant regional variation, it is unclear, though, what is driving market-level ACO growth. In some large markets, such as Boston, ACOs are proliferating, while in other large markets, such as Washington DC, they are not. Market specific clustering is a prevalent feature—if there is one ACO, it is more likely that another is nearby. Further tracking of ACO growth and dispersion will provide a more sound conclusion as to whether ACO adoption is primarily a response to competitors, indicated by future ACO growth remaining concentrated around existing ACOs, or indicative of the success and effectiveness of the model, thereby dispersing throughout all markets.

As a consensus regarding the definition of an ACO continues to develops, evidence exists that the basic tenets of accountable care have existed in many organizations for years, and only the title of ACO is new. Preliminary review of the organizations we have identified indicates a trend toward proclaiming oneself as an ACO with only modest changes to the care process, rather than radically redesigning the organization to become something fundamentally different in the future. It appears, for now, that defining oneself as an ACO represents an acceptance of the direction the industry has been headed rather than an adoption of a truly new form of care delivery.

Further tracking of ACO growth and dispersion will provide a more sound conclusion as to whether ACO adoption is primarily a response to competitors.

The range of entities that have sponsored ACOs, from small IPAs to national insurance companies indicates the wide range of business models that will ultimately provide accountable care. Under the Shared Savings Program, entities must be care providers to qualify[16], but non-provider insurance companies are a major backer of ACO growth, indicating a much broader definition of what type of entity can provide accountable care. Important insights will be drawn by observing which models succeed in reaching the overriding goal of increasing value through improving quality, lowering costs or both.

LIMITATIONS

With neither a set definition nor a national method for identifying ACOs, it is difficult to precisely identify and study such organizations. It is possible that some of the organizations which should be considered ACOs are missing from our study and some, such as organizations that self-identify as ACOs but will never ultimately adopt any type of care coordination or bear any risk for a population, may not belong. Accurate representation of all ACOs will happen with further analysis of the current organizations on our list and future identification of other ACO entities.

There are also limitations with mapping where the ACO is located. The geographic area covered by an ACO is not always clear, leading to possibly inaccurate depictions of the geographic dispersion of ACOs. For example, some sponsoring organizations have a population they presently serve, but the ACO they have announced may only exist in part of the region that the sponsoring organization, as a whole, covers. Additionally, some ACOs are organized by regional or national entities that may cover ill-defined patient populations in many states, making completely accurate determination of the geographic region that the ACO covers unknowable.

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CENTER FOR ACO INTELLIGENCE

Leavitt Partners Center for ACO Intelligence tracks regional and national trends related to ACOs and other emerging care delivery systems.

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