Growth and Dispersion of Accountable Care Organizations: June 2012 Update

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EXECUTIVE SUMMARY

The last eight months have seen considerable growth in the number of health care entities commencing accountable care payment arrangements. Despite large variation in models used, this growth is evidence of the increasingly common belief that health care should be more than simply providing and billing for services. Leavitt Partners has utilized both public and private sources to track the activity of 221 accountable care organizations through the end of May 2012. Growth is concentrated in larger population centers though it has expanded to 45 different states. Care coordination and payment models continue to vary depending on the organization leading the initiative, the organizations involved in the ACO and the region or market in which the entity serves. While the various Medicare ACO programs seem to be influencing the direction of accountable care models, the government's role in leading the growth of accountable care is unclear.

Leavitt Partners has tracked the activity of 221 accountable care organizations through the end of May 2012

BACKGROUND

Accountable care organizations represent an evolving idea of how health care should be delivered in America[i] . These entities exemplify the belief that the focus of health care should move beyond merely providing care and billing for services, and should instead focus on influencing the health and wellness of a defined population. By taking on risk for a defined population and being reimbursed, in part, for reaching quality benchmarks, ACOs seek to both improve health outcomes and decrease the growth of health care expenditures.

ACOs exemplify the belief that the focus of health care should move beyond merely providing care and billing for services

To date, multiple variations of accountable care organizations exist. Some entities are involved in the federally-backed Medicare ACO programs with formal legal structures. Others are involved in private ACO programs, either sponsored by providers (such as hospital systems or independent practice associations (IPAs)) or insurance companies seeking to strengthen their involvement in providing population-level care. Additionally, a handful of entities are pursuing the aims of ACOs, but eschew the name ACO and have adopted a different moniker.

By tracking, studying and interviewing entities who are becoming ACOs, we continue to better identify and understand the different approaches that organizations decide to take to advance the ideals of an ACO. As such, we have included ACOs in various stages of development based upon a broad definition of accountable care. Throughout this report, the term ACO should be understood as referencing entities that self-designate as ACOs, have joined Medicare ACO arrangements and/or are embracing the goals of accountable care while using a different designation.

METHODS & DATA

In November 2011, Leavitt Partners published a report detailing ACO growth throughout the country which contained information on ACOs through September 2011[ii]. Due to the considerable flux of entities adopting and engaging in accountable care, the number of organizations involved in ACO programs is constantly changing. The numbers included in this updated report are accurate according to our research through the end of May 2012.

Information on ACOs has been obtained from press reports, news articles, government announcements, news releases, conferences, personal and industry interviews, and other public records. In addition, as part of an effort to gain first-hand insight into ACO activities, we are working on a project to interview all ACOs in America and, to date, have interviewed over 50 ACOs.

As a result of interviewing ACOs and monitoring their growth, we have gained increased insight and have made subsequent changes from our original report. Of major note, we have classified ACOs into four general categories: Insurer ACO, Single-Provider ACO, Multiple-Provider ACO and Insurer-Provider ACO.

In addition to this new categorization, we have updated the number of ACOs by both eliminating and adding entities to the list. Entities have been removed for two reasons: either they were unable to adopt the accountable care model (such as very small physician groups that are better categorized as patient centered medical homes (PCMHs)) or because previously separately identified entities are now known to be working in partnership and in actuality only represent one ACO.

Entities have been added to the report for several reasons. Some have existed for a considerable time but we only recently became aware of their existence (some had purposely not publicly announced their intentions). Others have been newly created since the last report. Finally, there is the special case of the recently-announced Medicare Pioneer ACOs[iii] and Shared-Savings ACOs[iv]; while we were aware of many of these ACOs prior to the official program announcements, a few of these entities are new in this report.

RESULTS

Summary of Results

1) The number and types of ACOs are expanding. 221 ACOs have been identified in 45 states. The number of ACOs continues to grow and multiple, varied models for sharing risk are being tested.

2) Growth is centered in larger population centers. ACOs primarily are found around larger metropolitan regions, often with multiple ACOs competing in the same market.

3) Hospitals systems continue to be the primary backers of ACOs, but physician groups are playing an increasingly larger role. While ACOs sponsored by hospital systems continue to be the majority model, ACOs backed by physician groups have seen the most growth recently.

4) Non-Medicare ACOs are experimenting with more diverse models than Medicare-backed ACOs. Medicare ACOs are relatively restrictive compared to private models which are experimenting with more varied approaches to payment and care coordination. The success of private models will likely direct the future of Medicare ACOs.

5) The success of any particular ACO model is still undetermined. Various organizations are seeking to embrace the goals of improving outcomes while lowering costs. While some organizations have seen some positive preliminary results, no specific model has been shown to accomplish these goals.

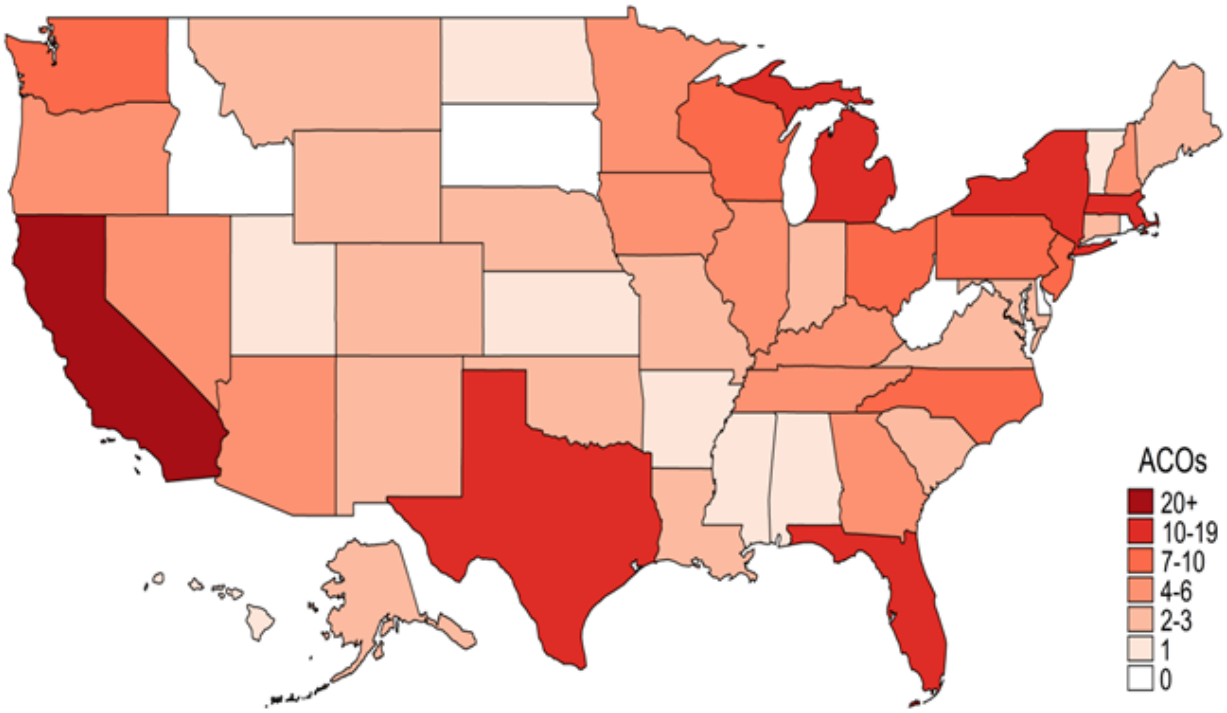
ACOs by State

While health care systems are increasing in size, most cover a limited geographic area, with the majority operating in one state or metropolitan area. This trend is evident when ACO distribution is evaluated at a state level as portrayed in Figure 1.

Leavitt Partners determined the geographic distribution of an ACO by the location of its affiliated hospitals. In some cases, such as with some dispersed ACOs sponsored by insurance companies, we were unable to determine the ACO's geographic boundaries. Of the 198 ACOs we were able to geographically define, 177 (89%) existed in only one state.

As a consistent trend, states with higher populations continue to have multiple ACOs, with California maintaining the largest number. The growth of ACOs throughout the country has continued to increase. Only five states (Delaware, Idaho, Rhode Island, South Dakota and West Virginia) do not have an ACO-affiliated hospital within their boundaries. There are still fewer ACOs in southern states, the Great Plains and the Mountain West regions than their population would predict, while the Midwest has greater ACO activity.

FIGURE 1. ACO DISTRIBUTION BY STATE

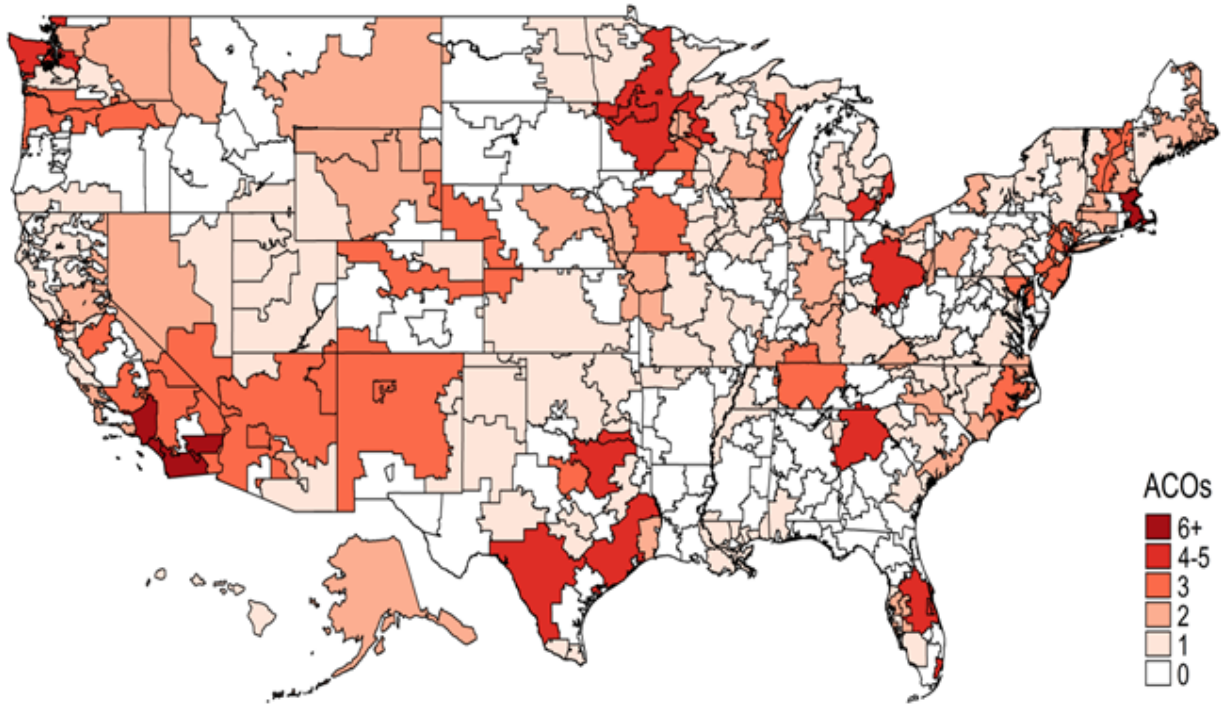


ACO Competition

To assess the competition among ACOs, we chose to evaluate market concentration at a smaller scale than allowed by a state-level analysis. To facilitate the analysis of market-competitiveness, we have mapped ACOs according to their hospital referral region (HRR). HRRs were developed by the Dartmouth Institute for Health Policy as a means of defining where patients are referred for tertiary care[v]. HRRs are indicative of markets where providers compete for patients. Figure 2 includes ACO count by HRR.

ACO growth is continuing in urban centers, with the most intense ACO competition occurring in Southern California and Boston. During the eight months since our last analysis, Florida and Texas in particular have seen the most significant increase in ACO activity. Regions in the Midwest, including Minneapolis, Detroit and Central Ohio, have also seen considerable ACO activity. The Deep South and Appalachia, which are typically ranked as the some of the least healthy regions of the country[vi], continue to see very limited ACO activity.

FIGURE 2. ACO DISTRIBUTION BY HOSPITAL REFERRAL REGION



ACO Sponsoring Entity

In addition to classifying ACOs by their geographical location, we have sought to identify them by their sponsoring entity. While a broad range of models exist to qualify an organization as an ACO, there are a finite number of categories of organizations that lead these efforts. In this analysis we defined the sponsoring entity as the legal organization that primarily directed the creation of the ACO. Each ACO was classified as being sponsored by a hospital system, a physician group (generally an Independent Practice/ Physician Association (IPA)), an insurer or, as a new category, a community-based organization. Community-based organizations represent non-profit, non-medical entities that act as conveners, bringing together other parties to create an ACO.

Figure 3 shows the breakdown of the number of ACOs by their sponsoring entity and Table 1 indicates the headquarters of the sponsoring entity.

In the last 8 months, the number of ACOs sponsored by physician groups has almost doubled

The major change over the past eight months has been an increase in the number of ACOs sponsored by physician groups, which has almost doubled (from 38 to 70). While hospital-sponsored ACOs have continued to grow (from 99 to 118), insurer-sponsored ACOs have remained almost static (growth of 2).

FIGURE 3. ACOs BY SPONSORING ENTITY

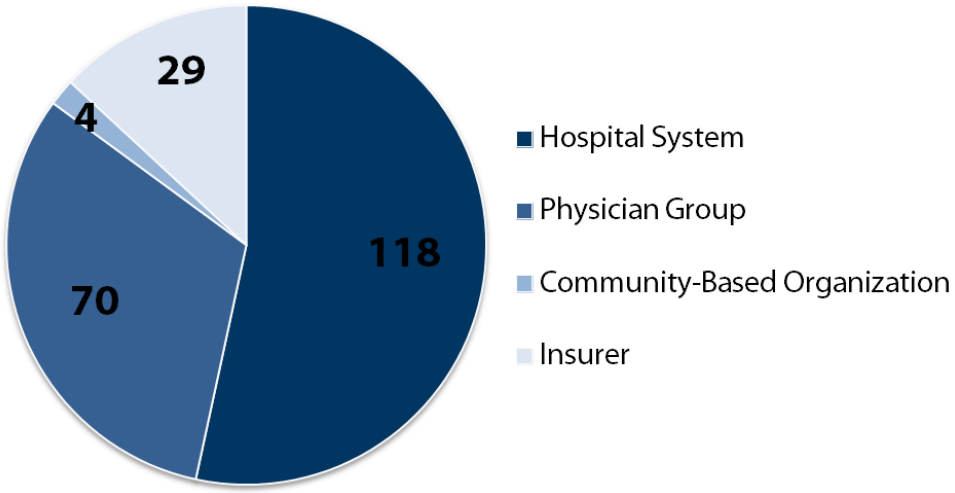


TABLE 1. ACO SPONSORING HEADQUARTERS BY STATE

State	Hospital System	Physician Group	Community-Based Org.	Insurer	Total
Alabama	0	0	0	0	0
Alaska	0	0	1	0	1
Arizona	2	1	0	0	3
Arkansas	0	0	0	1	1
California	12	11	0	2	25
Colorado	0	2	0	1	3
Connecticut	1	0	0	3	4
Delaware	0	0	0	0	0
D.C.	0	0	0	0	0
Florida	2	5	0	2	9
Georgia	1	4	0	1	6
Hawaii	1	0	0	0	1
Idaho	0	0	0	0	0
Illinois	2	1	0	1	4
Indiana	2	0	0	1	3
Iowa	3	0	0	2	5
Kansas	0	0	0	1	1
Kentucky	2	2	0	0	4
Louisiana	1	0	0	0	1
Maine	2	0	0	0	2
Maryland	3	0	0	2	5
Massachusetts	7	5	0	1	13
Michigan	8	3	0	1	12
Minnesota	4	2	0	0	6
Mississippi	0	1	0	0	1
Missouri	3	0	0	1	4

TABLE 1. ACO SPONSORING HEADQUARTERS BY STATE, cont.

State	Hospital System	Physician Group	Community-Based Org.	Insurer	Total
Montana	1	0	0	1	2
Nebraska	2	0	0	0	2
Nevada	0	1	0	0	1
New Hampshire	2	0	1	0	3
New Jersey	6	3	1	1	11
New Mexico	1	1	0	1	3
New York	5	6	0	0	11
North Carolina	3	4	0	1	8
North Dakota	0	0	0	0	0
Ohio	8	0	0	1	9
Oklahoma	1	0	0	0	1
Oregon	1	2	0	0	3
Pennsylvania	5	1	0	2	8
Rhode Island	0	0	0	0	0
South Carolina	1	0	0	0	1
South Dakota	0	0	0	0	0
Tennessee	3	2	0	1	6
Texas	10	6	0	0	16
Utah	1	0	0	0	1
Vermont	0	0	0	0	0
Virginia	0	1	0	0	1
Washington	4	4	1	0	9
West Virginia	0	0	0	0	0
Wisconsin	7	2	0	1	10
Wyoming	1	0	0	0	1
Total	**118**	**70**	**4**	**29**	**221**

Categories of ACOs

Initial research into ACOs has revealed multiple structural variations for implementing accountable care relationships. While it is difficult to categorize some specific ACO structures, with most ACOs it is fairly easy to do based on the parties involved in the relationship. We have categorized ACOs using the following designations:

Insurer ACO: A regional or national insurer who takes the lead in organizing providers in such a way that the insurer bears the burden of assuring accountable care.

Insurer-Provider ACO: The insurer and the provider are equal partners in providing accountable care – both entities provide services that are above and beyond industry expectations.

Single Provider ACO: Usually an integrated delivery system that receives payment for a population and takes on the responsibility of providing accountable care. The payer's involvement is generally limited to the provision of a risk-based payment.

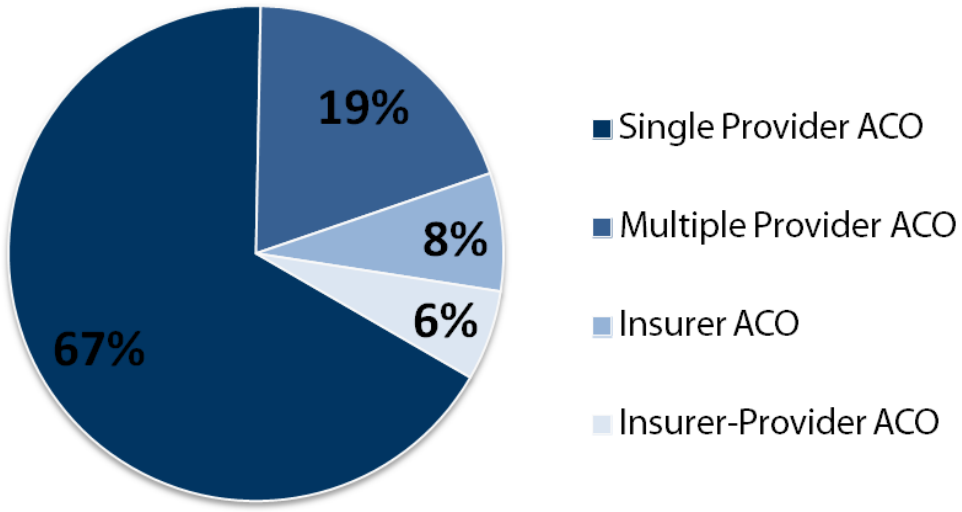
Multiple-Provider ACO: Two or more providers (usually a hospital and a physician-organization) have partnered (i.e. do not own each other) to provide accountable care for a population. The insurer involvement, like the single provider ACO, is limited to the provision of a risk-based payment.

Table 2 and Figure 4 include information on the number of ACOs within each category. The dominant model for ACOs is currently based around single provider groups. However, there is an increased number of ACOs forming from various provider groups that join to share risk. Insurers, particularly larger insurer organizations, are playing an instrumental role in developing ACOs, including (1) investing in competencies that enable care coordination, and (2) promoting and sponsoring risk-based arrangements with small and large provider organizations (ACOs as well as less involved arrangements like PCMHs).

TABLE 2. NUMBER OF ACCOUNTABLE CARE ORGANIZATIONS, BY CATEGORY

Organization Type	Number of ACOs
Single Provider ACO	148
Multiple Provider ACO	43
Insurer ACO	17
Insurer-Provider ACO	13

FIGURE 4. ACOs BY SPONSORING ENTITY



DISCUSSION

The solution to high quality health care and sustainable cost growth has eluded American health care for the past five decades. Insufficient data exist to conclude that the accountable care movement, as we know it today, will prove to be the answer. In fact, current experimental models will likely evolve substantially over time, with private sector models capable of faster evolution than government models. It is clear that leading organizations across the provider and payer sectors are increasingly committing to experimentation and iteration of risk-based payment models.

In spite of the growing strength of this movement, the location and distribution of ACOs still elicits many questions regarding the forces driving this movement. Preliminary interviews have indicated that many ACOs are formed by entities that believe accountable care is "the right" approach to care for patients, while others have adopted the model as an escape hatch from the threat of declining traditional reimbursements taking a "lesser of two evils" approach.

Despite the proliferation of ACO activity, no dominant model has emerged. Backers of ACOs range from private insurers to hospital systems to IPAs participating in the Medicare ACO program. In addition to the varied approaches to accountable care, continual changes are being implemented during the ACO creation process as participants seek to learn what it means to practice accountable care.

The role of the Medicare ACO program in shaping this movement is also unclear. While 59 organizations have already become Medicare ACOs, it is still the minority model of participation. While some entities have actively endorsed the shared savings concept, preliminary interviews indicate that the Medicare shared savings model is likely a temporary step toward something different.

The success or failure of private models will influence the direction the Medicare accountable care program takes

Medicare ACOs may have provided the impetus for the ACO movement, but it appears that they may not be the driving force behind accountable care's continuing development. Medicare ACOs are dissimilar from private ACO endeavors in many ways. Of particular importance, private ACOs appear to be more flexible and are experimenting with more varied payment and risk-bearing models. It is likely that the success or failure of private models will influence the direction that the Medicare accountable care program takes.

LIMITATIONS

The major, continuing challenge for tracking ACO development is the indefinite nature of ACOs. Without a firm definition of what encompasses "accountable care", it is difficult to pinpoint every organization that is an ACO. Other than the legal structures that have agreed to participate in the Medicare ACO programs, no bright line defines whether any entity is, indeed, an ACO. Ongoing challenges include (1) separating the entities that are ACOs in name only from those that are pursuing the goals of accountable care and (2) identifying the organizations that are explicitly seeking the same goals of ACOs while ignoring the accountable care nomenclature. As we interview entities identified as ACOs, we are better able to address the former challenge while difficulty remains with the latter.

A second limitation involves categorizing the types of entities that sponsor ACOs and the types of ACOs that exist. Due to the variability between ACOs it is difficult to create definitive standards as to which entities fall into these few categories. While interviewing these entities our preliminary categorizations are often confirmed, though changes are made. More challengingly, interviewing these entities occasionally reveals that they do not fall clearly into any one category.

A final challenge involves correctly mapping the geographic distribution of ACOs. Throughout this report we have relied on the location of hospitals affiliated with ACOs to determine their coverage area, but ACO coverage is not limited to hospital capture areas. Also, simply because an ACO has an affiliated hospital does not mean that it is necessarily practicing accountable care with a patient population near any specific hospital. All maps, then, must be viewed with an understanding of this limitation.

FUTURE WORK

As ACOs become firmly established, it is increasingly important to measure the results of different models

Understanding the path that accountable care will take requires constantly monitoring ACO activity. As part of this monitoring process, Leavitt Partners is developing a definition, born from interviews with ACOs, to delineate accountable care. In addition to interviewing existing ACOs, there needs to be an understanding of why some entities are not embracing the accountable care model and why some markets have yet to see meaningful ACO activity. Most significantly, as ACOs become firmly established, it is increasingly important to measure the results of different models. Only by identifying the models that lead to the goals of higher quality and lower cost growth can the ACO movement be effectively integrated into the health care system as a whole.

REFERENCES

[i] See Mark McClellan et al., "A National Strategy To Put Accountable Care Into Practice," *Health Affairs* 29, no. 5 (May 1, 2010): 982 –990.

[ii] David Muhlestein et al., *Growth and Dispersion of Accountable Care Organizations*, White Paper (Leavitt Partners, November 2011), http://leavittpartners.com/wp-content/uploads/2012/03/ACO-Whitepaper.pdf.

[iii] Center for Medicare & Medicaid Innovation, "Pioneer ACO Model", n.d., http://innovations.cms.gov/initiatives/aco/pioneer/.

[iv] Centers for Medicare & Medicaid Services, "Shared Savings Program", May 29, 2012, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/.

[v] See Dartmouth Institute for Health Policy and Clinical Practice, "Dartmouth Atlas of Health Care", n.d., http://www.dartmouthatlas.org/.

[vi] See United Health Foundation, "America's Health Rankings", n.d., http://www.americashealthrankings.org/.

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Leavitt Partners is a health care intelligence business providing clients with the best available window to the future of health care. By conferring with an authoritative group of health care thought leaders known as FuturePanel™ and applying a qualitative predictive model called FutureFrame™, Leavitt Partners helps clients see the future of health care.

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

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