KODA HEALTH

A GUIDE FOR ACO LEADERS

The ACO leader's guide to advance care planning

How a leading ACO reduced total cost of care in the last year of life by combining a digital advance care planning platform with longitudinal clinical support.

$8,520
Median per patient reduction in total cost of care

42%
Reduction in total cost of care versus matched controls

79%
Reduction in terminal hospital admissions

51%
Increase in hospice utilization

EXECUTIVE SUMMARY

A proven lever in the period that drives the most spend

SITUATION

MSSP ACOs delivered strong results in the most recent performance year. The program returned record net savings to Medicare and paid significant shared savings to participating ACOs. As the program matures and benchmarks tighten, each strong year raises the bar for the next, and the LEAD model that begins in January 2027 will extend total cost of care accountability further. ACOs are looking for new levers, and with a quarter of Medicare spending concentrated in the last year of life, advance care planning is a natural place to look.

COMPLICATION

The care model levers that drove the program's early savings, including transitions of care, chronic disease management, and preventive screening, are now part of the cohort's baseline. Marginal gains are harder to find. The last year of life remains one of the largest remaining cost wedges, and one that few ACOs have systematically addressed.

RESOLUTION

Houston Methodist Coordinated Care, one of the largest ACOs in Houston, deployed Koda's advance care planning platform across a cohort of seriously ill Medicare beneficiaries. An independently actuarial reviewed matched control study documented a 42% reduction in total cost of care and median per patient savings of $8,520, with stronger savings in the decedent subgroup. This guide walks through the deployment, the methodology, and how to estimate the impact on your own attributed panel.

80%
of patients want to discuss advance care planning

7%
are engaged by providers nationally

25%
of Medicare dollars are spent in the last year of life

AT A GLANCE

Results from the Houston Methodist cohort

One year after deployment, cost, utilization, and end of life quality all moved together, and engagement held across every subgroup.

$8,520

Median savings per patient, a 42% reduction in total cost of care relative to matched controls.

$11,237

Median savings per patient in the decedent subgroup, the population where end of life spending concentrates.

79%

Reduction in terminal hospital admissions, the clearest signal that care matched stated preferences.

51%

Increase in hospice utilization, with 25% longer hospice stays.

Equitable

Engagement was equitable across race, gender, and socioeconomic status, with all content written at a sixth grade reading level.

THE CHALLENGE

The bar is rising across the MSSP cohort. The next dollar of savings is harder to find.

Performance Year 2024 was a strong year for the program. The Medicare Shared Savings Program returned record net savings to Medicare, and a substantial majority of ACOs earned shared savings payments. That outcome, however, sets the new benchmark every ACO is measured against going forward. Mature ACOs face rebasing pressure on their next agreement period, even after the 2024 Prior Savings Adjustment partially mitigated the ratchet effect.

The care model interventions that drove early savings, including transitions of care, chronic disease management, and preventive screening, are now part of the cohort's baseline performance. They still matter, but they are less likely to produce the next incremental dollar. The last year of life, by contrast, remains a disproportionate share of total Medicare spending and one of the largest cost wedges few ACOs have addressed. It is also the period in which the gap between patient preferences and delivered care is widest.

Benchmark trend pressure is rising

A strong cohort year raises the bar for the next cycle. Mature ACOs carry rebasing pressure into every new agreement period.

LEAD raises total cost accountability

The LEAD model replaces ACO REACH in January 2027, extending total cost of care accountability and adjusting upside and downside risk.

End of life concentrates spend

Estimates vary by methodology, but the last year of life consistently emerges as one of the most concentrated cost centers in Medicare.

ACP engagement is lowest where it matters

Few Medicare patients have a structured, documented plan. The gap is widest among seriously ill members, who are also the highest cost.

Generic ACP programs fail in ACO settings for predictable reasons

START HERE

The savings come from the conversation and the family alignment it creates, not from the legal document.

In the Houston Methodist cohort, members who went through a high quality planning process saw savings whether or not their directive was ultimately signed. Savings were in fact higher in the unsigned group. Any program designed to produce paperwork rather than alignment is optimizing the wrong outcome.

01

Verbal ACP in the annual wellness visit

Physician led conversations are constrained by visit length. Completion rates are low, documentation is not portable across providers, and most clinicians have never been trained to lead these conversations, so quality cannot be assured across a population.

02

Document storage registries

Registries answer where a document lives. They do not address whether the conversation happens, whether the plan is completed, or whether the care team sees it at the moment of decision.

03

Mailed packets and internal staffing

ACOs managing thousands of attributed beneficiaries cannot staff enough social workers or chaplains to reach them, and mailed packets go unused.

KODA'S MODEL

Stratify the population, engage the patient, write preferences back to the chart

Koda runs the process end to end so your care teams do not absorb it.

01
Identify

Koda stratifies the attributed population by mortality risk, so outreach begins with the members whose care decisions carry the most clinical and financial weight.

02
Invite

Patients complete the plan at their own pace through a digital experience, with family alongside them. State compliant legal documents are auto drafted, signed, and notarized, then written back to Epic and other major electronic health record systems as discrete data.

03
KodaCares

The highest risk patients receive longitudinal one to one telephonic palliative support from registered nurses and licensed clinical social workers. Support scales without the ACO adding a single full time equivalent.

85%
Completion rate among engaged members

+87
Net Promoter Score across the Koda platform

0
New FTEs required from the ACO

HOW IT WORKED AT HOUSTON METHODIST

52.7% of referred members completed their plan

Houston Methodist Coordinated Care, one of the top performing ACOs in the country, identified a population of seriously ill Medicare beneficiaries and referred them to Koda for enrollment. A previously published analysis documented that 52.7% of those members completed their advance care plan, with engagement equitable across race, gender, and socioeconomic status. This guide assesses the impact of that engagement on utilization and total cost of care.

ORGANIZATION

One of Houston's largest ACOs, serving over 50,000 Medicare beneficiaries.

COHORT

145 Koda users matched one to one against 145 controls.

FOLLOW UP

Risk adjusted outcomes over 12 months of Medicare fee for service claims.

"Koda has been so impactful to our value based care initiatives because **it takes the burden of advance care planning off the provider** and allows patients to do it in the comfort of their own home, at an accessible reading level, in a culturally sensitive way."

Julia Andrieni, MD
Senior Vice President, Population Health and Primary Care. President and Chief Executive Officer, Houston Methodist Coordinated Care ACO

MATCHING METHODOLOGY

A third party analytics team matched each participant using a high resolution digital twinning approach accounting for demographics, clinical risk, predicted mortality, and social determinants of health.

QUANTIFIED OUTCOMES

Cost, utilization, hospice, and patient experience

COST

$8,520

Median per patient reduction in total cost of care, a 42% decrease relative to matched controls

$11,237

Median per patient savings in the decedent subgroup

UTILIZATION

24%

Decrease in inpatient length of stay, 1.62 days ($p = 0.005$)

33%

Decrease in ICU utilization ($p < 0.001$)

79%

Decrease in terminal hospital admissions

HOSPICE

51%

Increase in hospice utilization

25%

Longer hospice stays

PATIENT EXPERIENCE

+83

Patient Net Promoter Score

ICU length of stay also fell by 0.92 days ($p < 0.0001$). All figures are risk adjusted over a 12 month follow up period and reviewed by an independent third party actuarial team.

NEXT STEPS

Estimate the impact on your own attributed panel

START HERE

Book a free 30 minute ACO savings benchmarking call

We benchmark your attributed panel against the Houston Methodist cohort and walk through the implementation pathway, including EHR integration and the referral workflow.

Book the benchmarking call

Jen Tagliaferro, jen@kodahealthcare.com

Try the MSSP savings calculator

Enter attributed panel size, decedent rate, current end of life spend, and your shared savings rate. The calculator returns a projected savings range, payback period, and estimated MSSP benchmark impact.

Read the peer reviewed study

For the clinical evidence reader on the buying committee: the published Houston Methodist engagement analysis and the full matched control methodology.

Peer reviewed manuscript under review at the American Journal of Managed Care.

Independent third party actuarial review of all cost and utilization findings.

Koda Health. Updated May 2026. Authors: Tatiana Fofanova, PhD and Desh Mohan, MD.