ACO Economics 101: Optimize the Physician Network For Patient Choice

written by Dave Halpert | April 5, 2018

The inaugural MIPS 2017 submission period closed in a fog of uncertainty. The demise of MIPS looms on the horizon, with little discussion of opportunities for improvement. Heath and Human Services Secretary Azar has advocated for removing the quality reporting component of MIPS, while the Medicare Payment Advisory Committee (MedPAC) recommended scrapping MIPS altogether and pushed for a transition to Alternate Payment Models .

Note that neither of these recommendations advocate a return to a simple Fee for Service model—it is not sustainable financially. Value-Based Health Care is here to stay, but Advanced Alternate Payment Models (AAPMs) with financial risk are the favored path, rather than a transitional program like MIPS. The Quality Payment Program already incentivizes providers participating in Alternative Payment Models, with ACOs being the most popular option. Since the first approvals in 2012, the number of ACOs has increased each year; there are now 561 Medicare Shared Savings Programs and Next Generation ACOs, with 10.5 million attributed beneficiaries.

The big question for providers: How to increase confidence in Return on Investment for ACO development? With millions of dollars in potential losses at stake, creating an ACO with two-sided risk requires understanding the details of Medicare's economic model. Drawing on the experience of ACOs with the best performance track records, providers are most likely to succeed by focusing on five key areas that will influence outcomes:

Optimize ACO physician network for patient choice;
Improve cost performance through specialty referrals and post-acute care;
Manage participating providers' risk and reward;
Reengineer processes for chronic conditions;
Facilitate patient Medical Decision-Making.

Although there are other opportunities for achieving health care savings, concentrating on these five areas will reap the most gains. Let's take a closer look at how to optimize two fluid components of the ACO to build a solid economic foundation: the physician network and the patient population.

How Medicare Attributes Patients Can Affect ACO Savings

Medicare attributes patients to an ACO through a formula based on which provider most recently provided services to that patient—either a primary care physician or a specialist. If the patient is assigned to the ACO based on a primary care relationship, odds are the patient will stay within the ACO network and its referral arrangements to receive care. However, if the assignment is to a specialty physician because the patient only received care during prior years for a particular condition or procedure, patient care is less likely to be coordinated successfully.

A Strong Primary Care Network Better Positions ACOs for Success

Since all patients have free choice to see any Medicare provider, the first job of the ACO is to optimize the possibility that the patient will stay within the ACO network and referral arrangements to receive care. This is the keystone to managing costs. Developing a strong primary care ACO network lays the foundation.

To avoid being tied to patients who are not truly managed by an ACO primary care provider, ACOs should be wary of certain pitfalls in the attribution methodology. For example, patients may be attributed based on an encounter with a Nurse Practitioner or Physician Assistant, regardless of setting. So, a patient who sees a Nurse Practitioner in a specialist setting may tip

that patient's attribution to the specialist, particularly if there are multiple visits with that NP. In cases where the NP is in a high cost setting (e.g. an oncology center), an ACO will be challenged to manage these patients' healthcare expenditures.

Attribution Formula Can Result in More ACO Specialists and Higher Cost Patients

How the ACO incorporates primary care and specialists in the physician network is essential to maximize patient connection and decrease cost. There is a particular risk, especially common in health systems with many employed physicians, of including large multi-specialty and single-specialty groups. In large systems, a network dominated by specialists participating under a single legal practice entity is a reality. Since Medicare defines participating practices by the ACO's designated Tax Identification Number, an ACO with specialty volume risks the higher likelihood of patients being attributed to those specialists for receiving specialty, but not primary, care.

Specialist-dominated patient attribution results will skew the ACO patient population toward higher costs. Even when risk-adjusted, the ACO has less likelihood of reducing higher costs, especially in the short term. Because the medical home of the patient is not well established, there is less opportunity to avoid emergency room visits, services of other specialists outside the system for different conditions, and coordination of care, in general. A handful of larger systems or multi-specialty groups with a strong primary care core may have the resources and experience to overcome specialist attribution issues. But for most, it will take years to recognize and correct the issue.

Three Ways ACOs Can Better Align Attribution of Patients

ACOs can adjust attribution with three key strategies:

1. Incorporate a Strong Primary Care Core, Strengthened by Physician Leadership.

An ACO sponsor must have a core network of primary care physicians that accounts for the vast majority of patient attributions to its ACO. If this network does not exist, or if the population attributed to primary physicians is less than the minimum population of the ACO, it may be wise to consider delay until this goal is achieved.

Attribution is one of the strongest predictors of ACO success. The ideal attribution is based on primary care attachment—*not* because this will eliminate patients who may already be challenged with high-cost conditions but, rather, because it will be harder to coordinate best care for the patient *without* the primary care team. Conversely, the ACO's goal is also *not* to target only patients who are in control of their complex conditions. The ACO must develop its foundation on a medical home and neighborhood model to respond to patients' conditions, risks and barriers to care in a coordinated way that deals with the whole patient. There are many reasons why patients are appropriately seeing specialists and not primaries for their care—but they may also not be the best initial patient population for the ACO to begin its work. Success will require staging of ACO development, and the network will change over time.

Information about existing ACOs is compelling enough to proffer a "smaller and lighter" option with a carve-out of physicians from a larger health system into a dedicated ACO network. As hospitals, physician practices and extended services have consolidated, large enterprises have formed—often with demonstrably higher costs. Those consolidations were intended to gain market share and patients under Value-Based Health Care. But larger size does not guarantee savings. Also, bureaucracy and politics of large organizations can impede innovation. Businesses seeking market disruption often develop new subsidiaries that are more nimble and unencumbered to create change. An ACO may be well served to consider a similar approach.

2. Use Appropriate Selection Criteria for ACO Providers

How ACOs select providers requires a different approach than under Fee-for-Service. Basic ACO economics penalize, rather than reward volume. Thus, the traditional physician selection criteria— number of physician admissions, volume of services, and high-end services—hurt and do not help ACO efforts. Instead, ACOs should consider their providers' previous cost profiles, requesting copies of Medicare QRURs. These cost reports, in addition to expense profiles, will also flag attribution issues for specialty physicians who are providing the plurality of primary care services.

Other data on providers will also be of value. These include patient surveys, quality rankings from health plans, referral arrangements and preferences, and review of financial and quality data. Physicians participating in an at-risk ACO are, in essence, going into business together and tying their future revenues to the success of the enterprise. These physicians should be willing to share data to strengthen that enterprise.

3. Use Mechanisms That Encourage Primary Care Attribution

Some mechanisms exist to facilitate primary care attribution. The idea is to create a stronger bond between the patient and the primary care provider and avoid un-referred care.

Primary care providers can use Annual Wellness Visits (AWVs) to ensure that patients are seen and evaluated. Patients attributed to specialists can be offered AWVs to begin the process of engaging the patient with a primary care physician. While these visits require extra time (and are not pro bono) they provide a forum for preventive care, screening and chronic disease management—as well as a proactive mechanism to calculate real patient risk for population health initiatives. The primary care connection and preventive care are among entry requirements that some administrators and physicians with ACO experience consider important.

Annual Wellness Visits can also benefit the ACO by adjusting attribution. An AWV each year will ensure that the patients being cared for (and kept healthy) continue to be attributed to that ACO. Since spending targets are based on patients seen during the prior performance period, ACOs should also ensure that those who had an AWV the previous year return during the current year.

Primary care providers can also help to curb the myth that a visit to a specialist (along with another round of diagnostics) means better care. A Shared Decision-Making process that promotes patient activism will help patients to weigh benefits and harms of services and make better medical decisions. For example, home based palliative care at the end of life for patients within an ACO led to cost savings, as hospice utilization increased, while hospitalizations decreased. In short, patient choice can effectively align with the ACO's strategic objectives if both the physician and patient are provided the time and support to set goals and make decisions.

Lessons on Economics from Past Financial Risk Models

An ACO differs from an HMO—the predominant model of financial risk in past decades—by two main features. First, the ACO is a provider entity and drives the organization of its physician network. Second, the patient is free to choose providers from the entire Medicare physician panel, without penalty.

These two aspects must be in balance for the ACO to achieve efficiencies as well as improved patient outcomes. Patients must be satisfied to stay in the network. Their satisfaction stems

from a more trusted relationship with their main physicians, a greater sense of involvement and control, and more information, in keeping with their goals.

Let's not sugarcoat it—having a lot of primaries in the network and patients attributed to primaries isn't enough for an ACO to make it. There is much more required for success. Good communication methods, enough time to ask questions and make choices, and cost transparency will all affect patient loyalty and action. But without sound selection of an ACO network or physicians who are willing to lead and innovate, an ACO can't even get off the ground.

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