New ACO Playbook: Can Coordination of Care Save Enough Money to Save ACOs?

written by Theresa Hush | April 30, 2021

Central to the controversy about ACOs' potential for Value-Based Care is whether they actually save enough money and reduce costs fast enough. Researchers and advocates have produced various independent studies of ACO savings, the most generous estimating $1.8 billion in cumulative savings over the first three years of the program, almost double CMS estimates. Many others, however, dismiss the small proportion of savings—at a few percentage points—relative to total Medicare spending.

The previous CMS administration was clearly dubious about the shared savings model. It favored payment models that put providers at financial risk to increase cost reduction incentives, even though that resulted in declining ACO numbers. ACOs are now on a "glide path" that leads to increasing levels of risk over time, changing the "win-win" approach that was the hallmark of initial ACO development. CMS also introduced payment models like Primary Care First (PCF) and Direct Contracting (DC) to fix payment levels for Medicare through capitation, which competed with ACOs for patients and providers.

Provider Actions to Control Costs Are at Center of Dispute

For policymakers, coordination of care has been a hallmark concept associated with ACO benefits. Here's how the current CMS Innovation Center website expresses the values of the original ACO concept: providers voluntarily come together "to give coordinated high quality care . . . [that] helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors." Well-coordinated, high-quality care produces savings, according to CMS.

But can ACOs can really control traffic between every chronically ill patient and the ACO health network, helping them to get appropriate care and improving clinical decision-making in the process? There are a number of reasons why many ACOs find this problematic:

> The ACO is often separate from the chain of command in practices and health systems, thus not always in a position to command resources, staffing, and even cooperation from practices;
> Financial incentives still favor volume over efficiency in patient care;
> ACOs with independent practice participation don't usually have interoperabile systems between those practices, and many also don't collect timely provider data, making it difficult to identify patients' current status or services;
> Technology investment has been historically very low among ACOs, leading to lack of information to coordinate care for many patients.

Current ACO Coordination of Care Efforts Are Basic and Inconsistent

Most ACOs would agree that they have not yet achieved the future in well-connected care. According to one study, the first years after ACO formation are consumed by primary care transformation, implementation of care management, and reduction of emergency room use. Few ACOs address specialty services costs and specialty network development, clinical standards of care, and acute care during that time.

As to high risk or high cost patients, where we might expect ACOs to have been able to make real progress, one recent evaluation of ACOs' programs for seriously ill patients reveals that while most can identify seriously ill patients, only 8-21 percent of ACOs had major initiatives to affect their care. Notably, the small number of ACOs that successfully carried out these initiatives did achieve substantial reductions in per-beneficiary costs, emergency department use, hospital admissions, and other indicators.

Many ACOs have developed successful coordination of care efforts that are specifically targeted to patient populations and health care problems. Most ACOs perform some patient outreach and population health activity to reach out to patients. But to characterize these coordination of care activities as “well-connected care” per CMS is an overreach, especially for ACOs that are strapped for resources and lack data.

The status of care coordination raises questions about how ACOs can meet goals and be successful Value-Based Care models, and how to prioritize their strategies:

> How can ACOs speed up the process of enabling more connected, informed health care among their providers and patients, or “advanced” coordination of care?
> What tools are necessary for ACOs to generate effective coordination of care activities?

Three Strategies for Faster, More Significant Coordination of Care Activities

Savings is the metric that policymakers associate with ACO success. The political process is rarely sensitive to the need for time to effect cultural change, or the difficulty of overcoming obstacles; rather, the pressure is always on finding the next thing that might work. In that environment, the rise of competitive payment models suggests that ACOs may have a shorter time frame to gain ground.

Here are three very targeted but comprehensive strategies to make coordination of care more effective:

1. Organize data to identify the most significant and high cost patient risks, especially chronic metabolic and systemic disorders, and behavioral health.

Coordination of care should include clinical planning and organization of care, not just administrative patient outreach. Creating episodes of care for patients with diabetes, heart disease, and related metabolic disorders is the starting point for analyzing associated risk factors and outcomes, and then creating smaller patient cohorts for specific interventions.

Patients with diabetes or other conditions comprise too large a group to be considered for interventions; the variable needs between patients is too big, and patients have outcomes across the spectrum. To effectively target patients for coordination, start with outcomes and disease progressions, because these are the strongest indicators of present and future costs. It

is also essential to evaluate various points of patient crises in connection with these episodes, such as emergencies or admissions, and create further subsets of patients needing treatment review, community services, and changes in care teams.

What tools are necessary to perform these tasks? Claims data is essential, of course, to identify historical patient issues. But provider data is richer in clinical information and can provide more current data about outcomes and most recent patient crises. Integration of these two data sources is essential for true coordination of care. Creation of episodes is beyond the capability of most ACOs and even health systems; use of outside analytics and technology companies will be required.

2. Build specialty arrangements to allow data sharing and collaboration on care plans between primaries and specialists.

Sharing of episode data is essential for bonding primary care and specialty physicians in coordinated and patient-focused care in cases involving multiple outcomes and complex treatments. ACOs building specialty referral arrangements in urban markets may have an advantage because of the competition for these patients among specialty groups. But even in rural environments, specialists would appreciate and gain from data sharing.

As financial payment models progress, ACOs should look for opportunities to negotiate mutually beneficial arrangements with specialty groups that will benefit both parties and the patient.

Where specialists are difficult to find—like behavioral health, for example—using episodes to analyze patient success will clarify the areas where it is necessary for ACOs to reach out to community resources.

3. Create care plans and care teams in concert with patient cohorts that reflect common issues, including social determinants, historical utilization, and outcomes.

This technique can be used to effectively standardize care plans on a spectrum of patient status/risks. This promotes treatment regimens and care teams, which have been shown to be more effective in improving outcomes care in diabetes and heart disease.
To be comprehensive, episodes must be able to identify all the professionals providing relevant

care to the patient with the episode condition(s). Again, use of a vendor to create episodes that are clinically and financially cohesive is an essential tool for this intervention.

For ACOs limited to coordination activities that are administratively focused on patient outreach and appointments, using these clinically-focused strategies sounds daunting. But capture of provider data will be necessary for ACOs to even complete quality reporting beginning in 2022, so these ACOs and their providers should already be thinking of ways of to overcome this historical obstacle. Here's the plain truth: without taking more assertive action on patient costs, typical ACO efforts have significant limitations. ACOs will need to arm themselves with the tools of larger systems, competitive equity-backed practices, and Medicare Advantage plans, all of which are building data to perform more advanced coordination of care.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Randy Fath