Cost Savings Aren’t the Only Objective for ACOs: Growth Matters, Too

written by Theresa Hush | August 24, 2021



Keeping within expenditure limits is a top priority for most

ACOs for Medicare. That makes sense. Savings are the main distinguishing feature of an ACO arrangement, as opposed to straight Fee-for-Service reimbursement. ACOs that accept downside risk can't afford to exceed the expenditure target. It's in their best interest to create initiatives to cut costs and control expenses—especially for services outside the ACO, such as post-acute care.

But a cost strategy only focused on trimming expenses will likely fail the ACO in the long run. Why? Medicare ACOs face an annually decreasing expenditure limit that mandates them to lower costs with actions that are more aggressive each year. Not only are aggressive measures harder to achieve, but also they will not be enough, alone, to fulfill what the ACO needs.

ACO's Future Depends on a Continual Influx of Younger, Healthy Patients

Most providers developed ACOs because they saw a time-limited opportunity to ensure patient market share and to practice Value-Based Health Care while it was relatively painless. But to accomplish a goal of market share, the ACO strategy must optimize the fundamental stratum for ACO success: a steady stream of healthy, loyal patients that will balance the costs of very sick patients and allow the ACO to be solvent. That's also the actuarial formula of health plans—the sphere in which ACOs now operate.

The Medicare Shared Savings Program (MSSP) attributes a patient population to providers based on the recent experience of those patients and asks that providers manage services for those patients within a budgeted limit. Even if those patients are healthy, the cohort will age and develop significant illnesses

over time. If the group is higher risk, older or poorer already, the ACO has a financial challenge from Day One.

Even with the best first-year savings and a stellar array of cost initiatives, the ACO must attract additional and healthy patients into the organization for the future of the enterprise, while also improving the costs of current patients. A general rule of business solvency is to keep current customers while attracting new ones. Up until now, health care providers did not worry much about appealing to consumers, by virtue of insurance-directed coverage. But the management of financial risk, coupled with patients' free choice of provider, compels re-thinking.

Allowing patients to choose their providers affects the growth and sustainability of an ACO in an elemental way. If patients go elsewhere for services, the physicians will also leave to practice where they can maintain professional growth and personal economics. The ACO—even more than its participating groups and institutions—must be accountable for patient growth by understanding and responding to consumer health care issues. Here are three action steps to help ensure a sound growth strategy for ACOs:

Step One: Make Loyalty and Retention for Current ACO Patients a Top Priority

If your current patients are already getting services outside the system, your first action plan must be to determine the weaknesses in your existing network and patient operations. You won't be able to attract new patients if your ship is leaking. If you haven't been conducting regular queries of patients using the providers that give you more detail than CAPHS, now

is a good time to start.

The examination should include an analysis of your data for patterns in network use, in order to identify gaps in services or quality issues—perceived or real—that cause patients to seek services elsewhere. In addition, review cases where patients incur services and claims outside your network after seeing your primary care physicians or specialists; this is a key indicator of obstacles in your operations that could be turning customers away because of scheduling problems, communication issues or lack of confidence.

If you are a health-system-based ACO with participating specialty providers, examine your attribution of ACO patients to ensure that every patient has a primary care home in your ACO, as well. Adverse cost for your ACO comes from patients who are attributed to your ACO for expensive specialty services and who then attach to other ACOs' primary care physicians, once they are well. You will likely lose such patients permanently, regardless of the specialty care, because of other ACO referral practices.

Your clinical efforts to improve existing patients' health status will drive the costs of that cohort now and in years to come, if they remain with your ACO. To enable healthy, loyal patients, your cost strategy must, of course, include efforts aimed at reducing the costs of patients with high risk or intensive conditions. Your data and technology to reduce costs will require more than the claims data you get from CMS, so your actions must entail creating data sufficiency by integrating provider data with clinical detail to support cost interventions.

Step Two: Understand Characteristics of Your Existing Population and What's Next

In your Medicare population, the patients using most services are probably older and require more intensive care. Don't make the mistake of attributing the needs and preferences of these patients to those on your growth agenda. Generational differences are stark not only between large, decades-determined cohorts, such as Baby Boomers and the Silent Generation but also between the generations that comprise each cohort. For example, research on the younger Boomers shows they are less willing to accept authority, more technology-savvy, and consumer-oriented. These preferences should steer ACO growth strategies.

That means your retention and growth plans must be two-pronged:

- Make loyalists of current patients by meeting their clinical needs and improving their health outcomes (which will also reduce costs), and
- Appeal to the preferences of younger consumers by understanding that they may still be working or caring for their own parents and need responsiveness to time constraints, on top of clinical excellence.

Historically, providers have focused on bricks-and-mortar and clinical excellence programs to appeal to patients. Why isn't this the most fruitful direction under risk? First of all, bricks and mortar are expensive and stationary, while patients are looking for convenience and access. That's why they are going to pharmacy-based services in greater numbers, and demanding Telehealth to avoid the inconvenience and time of visits.

Second, while clinical excellence is, of course, extremely important, constructing an ACO marketing plan on high-cost services may attract patients needing them, but not necessarily the others who seek a good medical home with convenience, good access, communication and better control over their medical decisions.

In other words, if you want to be a specialty player, perhaps you should not be an ACO; rather, concentrate your efforts on episodic bundles that can be marketed to an ACO. But if your path is to an ACO, then appeal to patients who are well, as well as sick.

Step 3: Promote ACO Growth through Voluntary Commitments by Patients/Consumers

In the past decade, health care providers have consolidated into large, vertical administrative conglomerates, in the name of efficiency. Nonetheless, there is significant evidence of higher costs and reduced competition in health care. What enabled this consolidation strategy? The belief by providers that market share could help them negotiate better rates with health plans, improve their ability to develop ACOs, and fend off competitors.

ACOs formed by consolidated health care providers claim their market share by annexation, designating patients into the ACO through Medicare's attribution policy. While smaller and non-consolidated ACOs also claim a patient population in the same way, the basis of those arrangements tends to be on physician relationships, rather than corporate use. Even so, it's unlikely that patients consider this ACO assignment an actual choice, and they demonstrate that fact by using non-ACO

services. To be sure, however, most patients are not even aware that they have been attributed to a provider organization, in the first place.

The point is that ACOs must develop voluntary commitments from consumers to replace or secure their partnerships with patients, despite the lack of an official ACO or provider lock-in arrangement by Medicare. These voluntary commitments must come from both existing patients and new ones.

How can ACOs engineer such voluntary commitments from consumers? They can build responsiveness and touch into their operations, appealing to the next generations who will use their services to help design those very services. That will require that ACOs adopt more consumer-oriented technology for appointment scheduling and dialogue with providers, along with ease of navigating services and cost transparency.

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