New ACO Playbook: How ACOs Can Transform Clinical Care for Diabetes

written by Theresa Hush | June 17, 2021



An illuminating article about ACOs, featuring current and former MedPAC chairs' perspectives, argues that savings have been constrained because too much is beyond ACOs' purview to manage. Examples include both external restrictions (the exclusion of prescription drugs and provider fee payments from ACO control) and internal cultural or economic barriers (conflicts of interest that make it difficult to reduce hospitalization revenues).

ACOs Are Caught Between Roles as Provider and Payer

The current ACO model is, indeed, challenging. Blending both provider and payer functions is fraught with conflict. But the provider-directed model was supposed to function closer to the actual delivery of care, and thereby be more capable of generating change. Instead, ACOs have deployed health plan strategies that were implemented decades ago, which failed to

stem rising costs: care coordination, management of referrals, restriction of unnecessary (post-acute) services. Why? For one, many ACOs are separate or subordinate partners to the clinical organization, making it harder to establish change. Or so you might think.

ACO groups are continuing to press Medicare for favorable protections to try and achieve slower savings over time. But if you are an ACO, you are better served by reassessing how to deal with the new competitive environment and how to involve clinicians in efforts to achieve better outcomes and lower costs. How realistic is the idea of a major drop in spending from ACO activities—or an overall improvement in patient health—if the clinical care delivered to patients remains the same?

The idea that an ACO can only perform administrative cost-cutting is weak. During the formation of ACOs, officials lauded provider prototypes like the Mayo Clinic, Kaiser Permanente, and Cleveland Clinic for their exemplary clinical leadership and clinical care. Those organizations are amassing data, artificial intelligence technology, and innovative ventures to tweak clinical processes and improve outcomes. Can your ACO do the same with clinical leadership, even if it takes time? The answer is yes, and here’s why that challenge is worthwhile.

ACO Competition Is Playing by a Different Set of Cost and Care Strategies

As we laid out in our introduction to the New ACO Playbook, ACOs now have a lot of competition. This includes large medical groups that are expanding their territories nationally or regionally, MSO- and equity-backed physician practices

organized to take advantage of value-based contracts, and regional academic or large multi-specialty networks with growth aspirations. These ambitious, consolidated providers with broader regional and national reach are raising expectations for equivalent value from ACOs.

Let’s examine strategies to determine how your ACO can adapt, grow, and realize your vision for your own providers and patients. Chronic illness, particularly metabolic diseases, provide the clearest examples to lay out the possibilities or tweaks needed for ACO models. To illustrate, we’ll take a closer look at clinical interventions for diabetes.

Can Creative Clinical Interventions Improve Lives and Reduce Costs of Diabetes?

The epidemic of diabetes in the U.S. continues to grow. An estimated 8.2 percent of the total population have been diagnosed with diabetes, and at least one-third of Americans are in the queue with pre-diabetes. About one-fifth of people with diabetes are unaware that they have it. The age of diagnosis is younger, and the disease is increasing significantly among children.

Of people with diabetes, 38.6 percent have chronic kidney disease. Diabetes is the leading cause of chronic kidneys disease and also associated with major cardiovascular and ischemic heart disease, stroke, amputations, and diabetic crisis events. Diabetes generates total direct and indirect costs of an estimated $327 billion (2017), which is increasing as health costs rise.

Changing outcomes among people with diabetes would have a

substantial impact. According to one study, lowering the main diabetes marker, Hemoglobin A1c (HgbA1c), by one percentage point or more, lowered total health care costs by an estimated $685 to $950 per year per patient in the improved cohort compared to others. Another study associated a 1 percent increase in A1C with a 7 percent increase in patients' health care costs over the next three years.

ACOs' Current Diabetes Efforts Favor Population Health Triggered by Costs and Events

ACO results in diabetes management vary greatly, with mixed and variable quality results. While one study shows failure to improve medication use and adherence, another shows improvement in the aggregate performance level of the key Hemoglobin A1C (HgbA1c), although this widely varies among ACOs and has no clear causes.

Perhaps your ACO has many clinical interventions aimed at diabetes. In general, however, ACO programs to affect diabetes control or prevention appear sparse, at best, especially given the significant costs associated with the metabolic disease. There are two good reasons:

> Dependence on HgbA1c as the primary diabetic datapoint provides information on glucose levels over the prior two-to-three months, but not the continuous glucose readings necessary for patient feedback, for managing diet and other lifestyle factors, or for ongoing monitoring to prevent adverse events like hypoglycemia. For the greater volume of patients with pre-diabetes, there is similarly no ability to prevent diabetes onset. One encouraging development, Continuous Glucose Monitoring (CGM), is non-invasive

wearable technology that could provide continuous glucose readings for both groups. Yet, insurance and Medicare coverage usually limits CGM coverage to patients already on insulin, and there is slow adoption by physicians, even when CGMs are covered by insurance.

Data is insufficient for clinical management by ACOs, because few ACOs are integrating provider clinical data with claims data, and even those who do, don't have the technology to create a comprehensive view of patient condition episodes, like diabetes. Even HgbA1c levels have only been available to some ACOs, because the previous method of quality measurement only used a small patient sample, so many ACOs are not universally collecting provider data. If you have that problem, you will be hard pressed to meet APP quality reporting requirements in 2022 without immediate action.

ACO Adoption of CGM and Other Wearables Could Be a Game-Changer

Making CGMs available for people with diabetes, as well as for some pre-diabetic patients who are at high risk, could significantly help to slow or halt disease progression, as well as reduce cost overruns. For ACOs, the opportunity to use cheaper, newly available technology to promote clinical integration could have far-reaching effects.

Even on a small scale, ACOs could partner with companies to offer devices to patients either prior to appointments or over a longer time span. CGMs would collect data and provide feedback on diet and lifestyle to patients. This information could be deployed to help implement diabetes education efforts

or nutritional interventions. CGM use could also substantially boost patient self-management through education. Currently less than 5 percent of patients receive their Diabetes Self-Management Education and Support benefits; the CGM would link the patient's own data to knowledge and then improvement.

Engagement in CGM data could also help to advance physician understanding and involvement in patient care improvements, raise awareness of the value of diabetes education for patients, and increase the rate of pre-diabetes screening. Physician involvement is essential, given current low rates of pre-diabetes screening and limited awareness of CDC-sponsored diabetes programs.

Finally, CGM and other wearable technology would enhance ACO efforts to capture clinical data for analysis and development of other interventions.

Use of Continuous Glucose Monitoring and other wearable technologies (soon to include blood pressure) is but one example of how you can simultaneously support clinical interventions to reduce costs, while improving patient outcomes and engagement, along with physician engagement. While financing CGMs could be challenging in the short term, there may be ways to mitigate this through planning, rotating the reusable devices, or seeking partnerships with vendors for benefit of research.

Your ACO has the power today to involve your constituents in real innovation—the best way to meet your goals as well as the competition.

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