Reluctant Providers Can Benefit from Fresh Approach to ACOs

written by Theresa Hush | March 29, 2018

It's no secret that CMS wants to move providers away from MIPS and the Fee-for-Service payment system, toward an Alternative Payment Model (APM) like an Accountable Care Organization (ACO). This past January's announcement of an additional 124 new ACOs implies that we have reached a tipping point, with ACOs becoming more prevalent than standard Fee-for-Service payments.

But that optimism overstates the status of ACOs, both in terms of numbers and success. Despite a steady increase of new ACO approvals and ACO provider participation—including an attractive 5 percent bonus for providers who participate in an Advanced APM (AAPM) with financial risk—the pace of growth is moderate. Only 2 million more Medicare patients were attached by CMS to ACOs from 2017 to 2018. Just over half of ACOs have successfully come in under expenditure and savings targets, with a much smaller share receiving bonuses.

In addition, in the six years since the first ACOs were approved, only around a third of Medicare beneficiaries in the regular Medicare program have been attributed to an ACO for services

overall. That's significantly below the 50 percent target set by CMS for 2018, and a long stretch to reach Advanced APM status, or ACOs with financial risk. For providers under the risk-based Next Generation ACO model, several ACOs actually terminated their programs in the end of 2017 because they feared failure under risk.

Majority of Providers Are Still Unprepared for the ACO Model

Clearly, the majority of providers have not been ready to make the change to an ACO. Why? Only a small number of the 562 ACOs have succeeded in achieving any savings at all, and some now risk repayments to Medicare. The majority lack the confidence that they can organize efforts that will pay off in savings, loyal and satisfied patients, and contented physicians.

Non-ACO providers have legitimate organizational and market issues that raise barriers for ACO participation or development. One is a network cost structure based on hospital or large group ownership of facilities, technology and high-end specialty services. Once cash cows, these investments are now costly to an ACO organization.

Some current ACOs are in concentrated urban areas and have more mature networks, market penetration or dominance, and experience in value-based commercial insurance participation. But for providers who have yet to develop or participate in ACOs, there are legitimate reasons to be reluctant, including current higher costs coupled with lack of physician network cohesion or engagement.

Physicians Are the Front Line of ACOs, But Not Always in the Inner Circle

Technically, the ACO model is physician-focused, because patients are assigned to physicians who are delivering the majority of their primary care services. Based on that attribution, all other costs are assigned to the ACO—regardless of whether the attributed physician ordered the care.

Most physicians are now employed by hospitals and health systems or large multi-specialty groups. Even in geographic areas with the largest percentages of independent practices, a minority of physicians are on their own. Of those primary care physicians making up the core of ACO attributed patients, even more are employed by hospitals.

Nonetheless, physicians remain both skeptical and uninformed about health care reform, with a

declining number believing that ACOs are likely to increase quality or decrease cost. Physicians also strongly mourn the loss of their clinical autonomy and time for patients—who strongly agree that time with their physicians is too limited.

For an ACO to successfully provide cohesive, coordinated and cost effective care, the front line physicians must believe that they have the assistance of their ACO organizations to provide this kind of care. They will need information and support, but they also must be part of the enterprise's design and thought leadership.

ACOs Should Embrace Health Care Consumerism To Win Loyalty

When an ACO is formed, parent organization and provider attitudes toward and treatment of patients often die hard. ACO application and review of attributed patients are geared to viewing them as assets, rather than as individuals. Techniques on how to "manage" patients and avoid network "bleeding" are frequently discussed. This prevailing view of patients as a monolithic group, distinguished mainly by risk level, is—to say the least—troublesome.

Patient concerns about providers are well-documented, and all these issues will be carried over to an ACO unless leadership reengineers attitudes, processes and patient communication. Why bother? Because informed consumers are critical to the ACO's success. Unless patients are guided with facts and cost information about their options, they will not trust ACO providers.

A recent patient survey revealed some noteworthy data for providers forming ACOs:

> Patients not only agree with physicians that visit time is inadequate; even more patients than physicians believe this to be true.
> 90 percent of patients believe that their providers should look beyond results and evaluate obstacles to improvement in their health.
> Most patients are very concerned about their ability to pay for medical care.
> Most believe that the system is too complicated and don't understand reforms.

Business has understood for a long time that consumer loyalty derives from addressing consumers' expressed needs, not by telling them what they should do. For an ACO to achieve a more successful care model, patient trust is essential. That trust must be earned by a concerted effort to achieve what Fee-for-Service health care could not—providing reliable, accessible information for health care consumer decisions.

Would-Be ACOs Increase Chances of Success with Innovative Development

The challenge for ACOs rests on their ability to achieve cost savings, for two reasons: First, most ACOs score similarly on quality reporting, regardless of size or organizational structure. Second, saving money is the hard part and the highest concern for organizations at financial risk.

Several factors seem to predict ACO cost savings. On the quality front, ACOs that have been in the program longer tend to do better. Predictably, more physician-led ACOs achieve shared savings than hospital-led ACOs. And surprisingly, smaller ACOs seem to do better than larger organizations.

Note that ACO success appears to dovetail with physician appreciation and prompt attention to patient concerns. This suggests that size may not be as much a determinant of success; rather, ACOs should work toward better physician communication and stronger leadership. Furthermore, hospital-based ACOs should rethink how they are constructing their ACOs to be more successful, a significant challenge to the model.

Lay a Solid Foundation with a Creative ACO Development Agenda

Many organizations naturally assume that they can achieve success based on historical prowess of market share and size in the Fee-for-Service world. But it appears that successful ACOs are trending toward leaner, more physician- and patient-focused organizations as a model that can work, if—a Big If—there is enough cash for the initial and ongoing investment.

Providers envisioning how to construct a successful ACO should consider this development agenda:

> Create an ACO primary care nucleus. A nucleus of primary care physicians is the core of an ACO. Cost information is available from Medicare, with permission by the practice, that can be used to evaluate the group based on past quality reporting and cost history, in order to identify potentially successful groups.
> Develop an ACO plan around 5,000-10,000 patients of those primary physician practices targeted as likely successful and willing. A multi-specialty group may need to consider separating business units of participating primary care physicians and other professional staff, to align their economics with the ACO.
> Create degrees of separation from existing organizations, if needed. Regardless of

whether a hospital organization or physician group is leading the charge on ACO development, physicians are so central to the services that they should be leaders of the organization. Referral patterns built on stoking volume to specialists and technology-driven services will require reevaluation of specialty services (and fees) by the ACO. Politically challenging to accomplish in one organization, this effort could benefit by creating a separate entity, at least on a pilot basis. This would help remove those participants from the organization who do not believe in the ACO or are averse to financial risk.

Appoint a patient advisory board that participates in development and ongoing initiatives. To address the health care consumer issues identified previously, the ACO's leadership must be in dialogue with patients, including patients who will not be attributed to the ACO.

Choose technology for population health, analytics, quality reporting and guidance of the ACO. Begin assessment of the proposed practices and patient population to establish the key initial areas of focus.

Establish patient communication preferences and mechanisms. ACO approval is too late to begin the process of securing communication channels, which should be drafted in concert with the patient advisory board and modified as needed later. If there are external vendors who will play a role in patient communications, they can be pre-selected during this phase.

Establish materials for patients on cost and key initiatives that will help them understand what the ACO is, how they may benefit, and how to provide input as patients and participants.

All of the above are pre-application activities that can be done by groups currently involved in the MIPS program. In fact, using the four components of MIPS can help organizations do the spadework: reviewing comparative costs, establishing population health and performance improvement, and creating quality registries for Medicare-specific populations along with all MIPS-eligible patients.

The success of ACOs may lie in the ability of the principals to side-step current culture and obstacles to create a new design for care, powered by physicians and patients. For organizations still holding out on development, the promising track is to start small and grow, using current data and infrastructure under MIPS as an ACO start-up.

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