Create Value for Consumers by Leveraging ACO Provider Choice

written by Theresa Hush | July 12, 2018



Medicare and commercial insurers are adamant about moving providers from Fee-for-Service to financial risk for services, and CMS is losing patience over providers' reluctance to

embrace downside-risk ACOs. Why are providers so worried about accepting risk? Because, they say, provider choice will ruin their potential for savings.

With an estimated 25 percent of patients seeking services outside the ACO—for 60 percent of attributed total costs—providers argue that they can't control total expenses, yet are on the hook for savings. They blame lack of coordinated care, duplicate tests and differences in the standard of care.

Coordinated Patient Care Inside the Organization: Myth and Reality

Let's examine the facts about patient care coordination. It would be a surprise to most patients to learn that their care is "coordinated." That's because if any coordination is occurring, it is between providers and not with the patient. With the possible exception of post-discharge follow-up to avoid readmissions, "coordination of care" has focused on provider communication and information sharing, without necessarily including the patient.

Provider-to-provider communication about the patient creates a mythical coordination of medical care. If patients are not part of the loop, how can they take an active role in executing a plan of care? The operative scenario assumes that providers are in control and directive, while patients are managed and comply with orders.

The reality of care coordination is this: Typically it's the patient or a family member/support person who must iron out inconsistencies or gaps of a particular care plan, link communication among providers and prepare for the next step. As

organizations have gotten bigger and more bureaucratic, frustrated consumers are increasingly challenged to "work the system"—to get answers from providers, to arrange for services and, certainly, to challenge any objectionable administrative or clinical policy.

Finally, even the degree of provider coordination is overstated. Beyond medical record sharing with central diagnostics tracking, the frequency of collaboration between physicians is questionable in ACOs, even when patients have overlapping chronic conditions. Patients and families are either left to coordinate their own services between providers or respond to multiple coordinators all acting on behalf of different providers.

It is any wonder that consumers want to choose their own providers?

The Appeal of Outside Specialists and Providers to Consumers

Almost all ACOs across the country have met Medicare's ACO quality measures. These consist of 16 measures reported on a sample of several hundred patients, most of which are basic service messages, such as a blood pressure reading taken once per year at a patient visit. Similar MIPS quality measures are criticized by MedPac because the data cannot help consumers compare the quality of physicians. Nonetheless, CMS, MedPac and providers have deemed ACOs successful in delivering high quality care.

Consumers who seek care outside an ACO do so for either positive or negative reasons. Positive reasons include a

recommendation from someone they trust about a particular specialist or more familiarity with a group that is well known in the region. Adverse experience of any kind in the ACO, but particularly poor history in the specialty targeted by the patient for care, will negatively affect patient choice and favor care outside the ACO. Lack of communication, difficulty getting services, and extensive time spent working the system are all adverse experiences. Combine that with lack of good comparative data on providers and the lack of transparency in referral policies, and it's clear that consumers are making a completely rational choice to seek providers elsewhere.

Is Outside Care Less Efficient or Poorer Quality?

ACOs argue that when patients get care outside their network, coordination breaks down and care may not reflect ACO providers' agreed-upon quality standards. Here's an important question: how do they prove their case?

Data now emerging on physician behavior indicates that physicians perform the same regardless of ACO participation, even with differing protocol directives.

Health care systems are novices when it comes to measuring cost performance. Without pricing and episodic claims data, not only can they not accurately claim that other providers are less efficient, but also they can barely evaluate their own data.

Better Strategies for Responding to Consumer Choice in ACOs

ACOs are responding to provider choice provisions not as

financial risk-bearing entities, but as Fee-for-Service providers. Provider statements and articles that decry “patient leakage” as an issue of revenue loss are essentially admitting that their concern is not what patients are getting when they go outside the system, but what providers are losing.

As a result, some ACOs are deploying strategies to counteract patient leakage and keep specialty services inside, and doing so without revealing their referral system to patients. This dangerous practice, which choked the HMO gatekeeper movement to death, is also unlikely to gain either savings or loyal patients. To have even a chance of succeeding, ACOs would have to know cost performance of competing providers, which few have programs to do.

But there are two alternative strategies that ACOs should embrace to benefit their patients and their organizations. In tandem, these strategies can help improve performance for specialists as well as add value for patients making decisions within the system.

1. Specialty Provider Strategy

>>Develop and deploy a specialty performance measurement system to use in referral policies. Often, ACOs either refer to their own employed physicians or reinforce historical referral patterns, rather than develop a value-based performance system. Both internal and external participants in the ACO should be included in measurement of key medical and quality indicators corresponding to ACO patients. If available, data should include larger populations or public reporting.

Ideally, ACOs should develop episodes of care, when feasible, for incorporation of outcomes, quality, cost and patient feedback. There will be providers who are unwilling to participate, but the lack of data should be reflected because it is an important indicator for consumers.

>>In referring patients to specialists, ensure transparency of the methodology for recommending physicians. It is important that patients are not directed, but advised, using as objective a process as possible. The ethics of ACO referral practices is already coming under scrutiny and can backfire if not handled appropriately.

2. Consumer Strategy

>>Develop value-based initiatives aimed at the real customers: consumers. Health care is now emerging into a market where purchasing is based on value. Roji Health Intelligence has written extensively on how providers can be more consumer-focused; we've compiled some of our best articles here.

Unlike previous eras, consumers are shouldering a heavier proportion of health care costs and will be the primary decision-makers about their health care spending in the future. It's time to model efforts after retail and other businesses—accepting that consumers make rational choices because of benefits, cost and fit with lifestyle and preferences—and to encourage those choices.

These approaches, not handcuffs, create the way to keep consumers in the system. First, we must build the best provider network using a reliable and objective measurement process.

Then, we market and sell those services to consumers using predictable, transparent prices.

Founded as ICLOPS 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. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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