Can Provider-Led ACOs and AAPMs Deliver Health Care Transformation?

written by Theresa Hush | March 15, 2018

“In times of rapid change, experience could be your worst enemy,” said J. Paul Getty. He might have been giving us advice on how to transform health care.

We have reached the tipping point for broader adoption of ACOs and other Advanced Alternative Payment Models (AAPMs) to organize health care and payment under both Medicare and commercial insurance. But our recent experience cannot tell us whether these approaches will work.

This, despite the fact that an estimated 10 percent of insured individuals—32 million people—were already covered by private and public ACO services in mid-2017. And we reached that point even before Medicare approved 124 new ACOs for 2018, for a total of 10.5 million Medicare beneficiaries. Note that the private sector covers more ACO patients than Medicare, although the model originated as a Medicare solution.

CMS is pushing Medicare away from the current payment program into AAPMs, including ACOs.

The agency is clearly supportive of MedPAC recommendations to overhaul MIPS, the alternative Medicare Value-Based Reimbursement program, and escalating AAPM participation.

So, now that we're here, can ACOs and other AAPMs actually deliver on the goals of cost control and quality? As the AAPM model of ACOs moves toward greater risk, effective actions to control costs will be essential—and disruptive to their providers, their array of services and, potentially, to their patients. Here are some critical questions:

> How can providers steward a system that depends on voluntary patient loyalty to keep services within the ACO?
> How can ACOs—especially facility- and technology-heavy ACOs—sustain controlled costs below a benchmark with annual reductions?
> Will providers be willing to trim specialists and technology to keep within budget?
> Can providers really deliver on better outcomes for patients, including those with high risk and difficult social needs, and still lower costs?

This is where ACO economics and patient needs come into conflict. ACO analytics will identify which patients have higher risk and which patients have problematic utilization. The expenditure thresholds, lowering each year, create risk for providers as they begin to launch programs to address solutions for these patients, such as better service coordination and necessary interventions.

ACO Success Is Erratic, but Belief Runs High (Not Always Among Physicians)

Success among ACOs has been spotty, at best, and difficult to achieve for most organizations. The difficulties arise across all types of ACO structures: physician-led, hospital-led, jointly led, and so on, although at least one analysis confirms much better results from ACOs led by independent physicians. Additionally, while first year activities can yield easier savings with lower readmissions, sustained effort is difficult and uncertain. Indeed, ACOs can go from success one year to missed targets the next, making it hard to keep providers when financial risk is imposed.

The fact is, no one has discovered the tried-and-true recipe for ACO success, despite the various success criteria optimistically listed by ACO vendors. And, to be sure, specific systems have achieved big payback. Belief in the model runs high within the industry. Many provider organizations maintain an opportunistic belief in the ability to capture market share and grow. Health plans and other financial watchdogs hold the current Fee-for-Service system in such disdain that they view a more organized alternative with better intentions as a good step.

Health plans have found a way of partnering with providers, ensuring ongoing business services and contracts that keep the bottom line healthy.

For private physicians, ACOs appear to offer a chance to acquire infrastructure that might otherwise be unaffordable and, possibly, a path to maintain independence. However, physicians who actually participate in ACOs are not uniformly convinced that the model can be successful, and many do not even understand the particulars of their own ACOs. In addition, many physicians do not believe that the ACO actually contributes to savings and do not feel benefited.

Continued ACO Savings Require More Than the Basics

Anecdotes from the ACO frontlines show that many tend to pursue the same initiatives. Among them:

- Efforts to reduce re-admissions, such as post-discharge contact or arrangements for aftercare;
- Population health initiatives to fill gaps in care (such as those defined by quality measures);
- Analytics to identify high risk individuals or those with high emergency room use and steer them into various interventions, if possible, such as case management;
- Annual Wellness Visits, which may be combined with other efforts to elicit patient-reported outcomes, gather quality data, establish risk levels, or segue into Chronic Care Management, as well as other reimbursed continuity of care programs;
- Physician data sharing and goal setting, including embedded compensation plan incentives to meet targets;
- Patient outreach where the patient is attributed to specialists but appears to have no primary care provider;
- Various disease-based management programs, often beginning with diabetes;
- Identifying variations in care.

Nothing is wrong with these initiatives. They are solid ways to take responsibility for a panel of patients and move away from episodic, acute care. They are also not easy to orchestrate, because they demand additional workload from practices, changes in workflow, data gathering and physician engagement.

Even if these programs are perfectly implemented and successful—most organizations only have bandwidth for a few—they won't be enough to produce ongoing savings. Why? In addition to the fact that the expenditures benchmark demands more savings every year, these

initiatives do not address the key areas where high costs may reside.

To achieve substantial savings, ACOs will need to target lower utilization of services beyond just hospitalization and emergency room use. They must look to the drivers of such costs and facilitate resolution of patient needs.

Four Ways ACOs Can Achieve Breakthroughs in Quality and Cost

The cost drain of an aging population, coupled with obesity and chronic disease, must push providers to adopt mechanisms that are well beyond the scope of most current health care providers. ACOs will need to create bridges to community organizations as well as connect directly to the patient, going well beyond traditional roles and services. It's a tall order for organizations that are transitioning from simply providing services to embracing accountability for patient health. However, there is no surer way for ACOs to achieve required savings than to address the rising prevalence of risk, disease progression and inequity of care.

1. Reduce health disparity among patients.

The ACO agenda usually tends to focus on "reducing variation" in care as a cost problem. If patient populations were truly homogenous, this would make sense. But not all groups of people have received the same type of care in the past, due to inequities tied to race, ethnicity or gender.

Reducing variation is a process-oriented task to fill gaps in care; improving outcomes requires that services be individualized to patient needs. ACOs have had a difficult time addressing costs and quality effectively for groups such as minorities and women, as revealed by their performance.

Why does health equity matter to the ACO goal? Because minority groups and women represent, in the aggregate, a substantial number of patients who generally have a higher incidence and severity of chronic conditions that will have a large effect on the ACO's results, but who also have legitimate concerns or trust issues with providers who have stereotyped them or failed to communicate effectively. Addressing disparity will affect two key factors in ACO savings: patient loyalty and focused interventions, both of which will impact total costs.

Reducing health disparity can have a profound effect on outcomes and affordability of care for patients, according to a Road Map suggested by the National Quality Foundation. This should also help distinguish provider-led ACOs from payer initiatives, like HMOs of the past. The

provider-led ACO should have a mission to deliver compassionate and respectful care with the intent of improving patient health; it will take more diligent efforts to test and implement health care interventions, along with improved communication.

2. Implement Shared Decision-Making.

As we've discussed in a series of articles on medical decision-making, one key to achieving better results—both clinically and financially—is to clarify the benefits, potential harms and costs of treatments for patients. Shared Decision-Making provides a path for patients to rationally choose services, facilitated by their physicians' information and guidance .

Shared Decision-Making requires time for conversations between physician and patient, which in the past have been marked by interruptions and failure to recognize the patient as a rational decision-maker.

To achieve positive results on savings, the ACO must work to re-calibrate physician attitudes, encouraging a better understanding and appreciation of the patient as decision-maker. Only through true physician-patient partnerships will patients maintain loyalty and follow through on plans made with their providers.

3. Partner with community organizations or seek support to provide necessary social services to patients.

Many patients face hardship in managing both health care and health care expenses because of unmet social needs. Some AAPM models have recognized this by incorporating social support, such as CPC Plus. ACOs, however, have no stipulated requirement to facilitate social services to patients.

As more providers recognize patients' need for social support, community models are emerging to develop investor-owned social impact bonds, medical-legal partnerships and other social support vehicles. ACOs that are targeting long-term outcome improvement should consider social support interventions among their tools to meet this goal, as well as to garner patient loyalty.

4. Develop measures and payment structures for specialists, especially episodic payment contracts.

One downside of most ACO models is the ambivalent relationship between the ACO and its participating specialists. Under Fee-for-Service, specialty costs are an expensive, often uncontrollable item for the ACO. There is consternation about the participation—or not—of specialists, with some ACOs choosing a "contractual" model for referral physicians.

A better approach is to organize payment episodes for participating specialists, coupled with measured Shared Decision-Making. Under this model, specialty physicians can guide patients through a process of making treatment decisions, and any resulting decision to undergo procedures or treatment could be part of an episodic care agreement. That would cap payments to the specialty, while ensuring that Fee-for-Service incentives to perform treatments and procedures are absent or reduced.

Can Providers Lead the Transformation of the Industry?

So far, ACO savings are lukewarm. While some argue that performance to date recognizes that neither provider nor patient is compelled to join an ACO, this is not the sole factor. The existing ACO program has simply not demanded participation. The requirements will change substantially going forward, stimulating ACOs to be more innovative and demanding.

But can they lead the transformation? That remains to be seen. If ACOs are able to reengineer a path that promotes patient loyalty, better medical decisions and patient-centric programs, they can legitimately claim such leadership. That will require more attention to and discrimination among patient groups, less "bucketing" of patients into populations based on broad criteria that is primarily clinical, and replacing patient "management" or engagement with solutions to identify and meet their needs.

ACOs can choose an alternate path, selecting healthy populations and attempting to redline their services for only affluent or well people. Or, they can try to maintain peace by avoiding change and focusing on easy savings. Neither of these two routes is likely to succeed in the long run. Redlining sick individuals will backfire as patients are unable to find providers and must resort to flooding emergency rooms. Low hanging fruit is quickly harvested, leaving ACOs no alternative but to make changes to stay below expenditure thresholds or, under financial risk, pay money back to the government.

Experience may, indeed, be the drag on rapid change in health care. But commitment and innovation to improve patient health can be the gas that propels us there.

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