Opportunities and Challenges for Physician-Led ACOs—A Recap of the ACO Learning Network Workshop

By Julian Whitekus

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Early high-performance networks have been available in a few locations, but the new version of accountable care organizations (ACOs) has greatly expanded in recent years. ACOs were popularized by the Brookings Institution and the Dartmouth Medical School efforts between 2006 and 2009, which led to the formation of the first non-Medicare ACO in 2010. Subsequently, the Affordable Care Act established a new voluntary program called the Medicare Shared Savings Program (MSSP) that allowed for the establishment of ACO contracts with Medicare. ACOs are groups of providers that are responsible for the care of a designated population of patients. As of first quarter 2014, the Brookings Institution estimated that there were 610 Medicare and non-Medicare ACOs serving over 20 million members. Of these, 360 are MSSP ACOs serving almost 5 million Medicare beneficiaries in 47 states, and the remaining 250 are non-Medicare ACOs serving nearly 15 million beneficiaries. Based on the first national survey of ACOs, the results of which were published in the June 2014 edition of *Health Affairs*, physicians appear to be taking an active leadership role in forming ACOs and now outnumber hospital-based ACOs. The survey found that 51 percent of ACOs are physician-led, while an additional 33 percent of ACOs reported that they were jointly led by physicians and hospitals. Only 3 percent of ACOs reported that they were led by hospitals alone.

Physician-led ACOs face a number of challenges, which were discussed recently at the ACO Learning Network Workshop in Washington, D.C. on April 25. Topics included securing capital to invest in infrastructure, transitional care management, patient engagement and population management. A brief summary of the discussion is provided below. This focuses primarily on the physician-led ACOs that are a part of the federal Medicare program. Physician-led, high-performance networks for Medicare Advantage and commercial populations face somewhat different challenges.

The cost to establish and maintain a federal ACO creates an impediment for many smaller organizations, most of which are physician-led. They lack the financial resources to support necessary operations, which in turn limits the organization's ability to grow its membership and, therefore, the level of its participation in the shared savings program. It threatens to undermine the success of ACOs that under-invest in infrastructure (e.g., health information technology, electronic medical records, hiring additional physicians' assistants and care managers, etc.), which is necessary to employ best practices and maintain the highest standards of care management and coordination for its members. For non-federal programs, this cost is sometimes shared by the insurer.

Physician-led ACOs are less apt to include hospitals and other types of providers. As a result, physician-led ACOs may face greater challenges than other ACOs in managing transitions between settings of care and managing hospital-based care. Event notification (i.e., Admissions, Discharge and Transfer (ADT) messaging) can and is being used to improve transitional care management. Many ACOs have developed procedures whereby network hospitals send text messages to primary care physicians (PCPs) to notify them when their patients are in emergency rooms, admitted to hospitals, and ultimately discharged. Waiting for claim data to implement a treatment protocol is too long. Real-time notification offers ACOs the opportunity to improve care, reduce cost and receive higher payments from the Centers for Medicare & Medicaid Services (CMS) by meeting the time frames required under transitional care management guidelines (e.g., direct contact by telephone or electronic communication with the patient within two business days of discharge, face-to-face visit within 14 calendar days of discharge, etc.).

Innovative IT applications can be very helpful in improving patient engagement and getting patients to take actions that are consistent with their doctors' advice. Some plans are achieving a 95 percent engagement success rate using IT portals. Examples of IT portals' capabilities include:

- PCPs can send an article on controlling blood pressure (BP) to all their hypertensive patients.
- Patient vitals such as BP readings can be graphically represented and compared to a normal range and included in an email.
- Appointment notifications can be sent via email and accepted by clicking a link within the email.
- Secure messaging can be initiated by patients who have questions for their providers about care.

Beyond the improved performance, these IT features help improve the patient branding experience with the ACO, maintain patient loyalty and improve the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey scores.

In addition to population management tools available, at-risk patients (i.e., those patients with either high-risk medical conditions or rising risk) can be identified by the ACO using patient-reported outcomes and consultation with their physicians. Studies have shown that greater savings are achieved over a two- to three-year horizon by focusing efforts on improving care for "rising risk" patients. In managing at-risk patients, it is important to know which patients are already engaged so that each care manager can prioritize his or her workload more effectively. This will create additional savings since care managers are an expensive cost component for an ACO.

While PCPs can improve and impact the overall cost of care, the majority of the payments go outside of the PCP (e.g., in-patient care, PAC, imaging, drugs, etc.) so who a physician-led ACO chooses as a partner can be very influential to its bottom line. Creating high-value referral networks with efficient specialist groups represents one important component in this partnership. In forming relationships, it is recommended that both the PCPs and specialists have an agreement in advance to clarify roles, expectations and pre-consultation communication prior to a referral. Failure of the PCP and specialist to communicate with one another can result in additional costs and duplication of services (e.g., who is responsible for checking vitals? If both practitioners perform the tests it is expensive). Likewise, in prospective payment models, the reimbursements need to be negotiated upfront, and in the case of episodic and global risk models, how these payments are allocated needs to be agreed upon.

Again, the speakers were mostly focused on the federal Medicare ACOs. Commercial programs and Medicare Advantage programs face similar challenges, but the non-hospital component is often managed by the carrier.

Also, although not discussed at the conference, the other major new concept (patient-centered medical homes) has many similarities with the physician-based ACOs.

The increase in number of physician-led ACOs will certainly have important implications in shaping how care is delivered in the United States. However, they are likely to face greater challenges in integrating and transitioning care among several providers and may lack the financial resources to invest adequately in their infrastructure. On the other hand, they have far less fixed costs and inertia. By working with reinsurers, insurers or issuing stock or debt, physician-led ACOs may have greater access to capital. And, by learning from other integrated delivery systems, they can improve their care delivery model. Finally, there is a significant potential to improve patient engagement that some ACOs have achieved using population health tools with IT applications, which should improve member compliance with their doctors' instructions and ultimately provide better care at a lower cost.