

Physician-only ACOs lead the way on improving quality and savings

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As physician-only accountable care organizations (ACOs) help move the nation's health system away from fee for service, they are also developing a road map to success for others to follow. But a key challenge remains being able to build the necessary infrastructure with limited resources.

The number of ACOs participating in the various tracks of the Medicare Shared Savings Program (MSSP) increased to 561 in 2018 from 480 in 2017, according to a Centers for Medicare and Medicaid Services' (CMS) fact sheet. Of these, 171 are physician-only entities, up from 134 in 2016. The others include 324 ACOs composed of hospitals, physicians and "other facilities" and 66 Federally Qualified Health Center-operated MSSP ACOs.

Of the 432 MSSP ACOs operating in 2016, 31 percent generated shared savings with 45 percent of physician-only ACOs generating shared-savings, compared to only 23 percent of the 226 hospital-based ACOs.

"Since inception (of the MSSP), physician-owned ACOs have been leaders in quality and in achieving real savings," health care attorney Elias N. Matsakis writes in a new AMA resource on physician-only ACOs. "The opportunity still exists for physicians to form an ACO in their market and take a leadership position in managing patient populations."

Matsakis, leader of the health care and life sciences team at law firm Holland & Knight, adds that CMS launched a new Advanced Alternative Payment Model (APM) for physicians this year: the Medicare ACO Track 1+. This new option limits downside risk for participating practices while also allowing them to collect a lump-sum bonus previously available only to those who assumed more risk.

The new APM is considered friendlier to smaller practices. Smaller MSSP ACOs are outperforming their larger counterparts, but the majority of ACO-served Medicare beneficiaries are seen by integrated health system-operated ACOs, according to CMS.

Market leader defines expectations

“At the core of the ACO concept is a focus on aggressive intervention and proactive and better coordinated care and patient engagement to manage chronic conditions, improve wellness and limit the number of acute events,” Matsakis wrote. “Physician-led ACOs have greater flexibility to contract with those allied providers who will comply with clinical pathways, quality reporting, and care coordination as they are building the ACOs’ network as a new enterprise.”

One of the leading ACOs, the Palm Beach Accountable Care Organization (PBACO) became successful—not by trying to control where its patients seek care—but by “defining expectations and improving coordination with all stakeholders, including specialists, hospitals, home health agencies and skilled nursing facilities.”

The Palm Springs, Florida-based ACO includes 240 primary care physicians and 160 specialists who provide care for more than 51,000 Medicare beneficiaries. Launched in 2012, it was the top financially performing MSSP ACO in 2016, saving Medicare almost \$62.8 million—of which it kept \$30.5 million.

On its website, PBACO explains that its basic strategy is to empower primary care physicians to act as advocates for the Medicare beneficiaries they see by building a relationship of trust, understanding and dependability.

“The physician will identify the unique health care needs of each beneficiary to create a personalized healthcare plan,” the PBACO website states. “The coordinated execution and evolution of this personalized plan will be the basis with which the physician will prove and demonstrate his/her dedication to the beneficiary’s health and well-being and deliver quality outcomes, appropriate utilization and exceptionally improved beneficiary engagement.”

Building a better practice

These savings-generated earnings are needed for a variety of ACO-related investments such as web portals, care managers, timely drug reconciliation, refill monitoring, psychological support, caregiver outreach and dietitians, according to Matsakis.

“The challenge facing physician-only ACOs is the lack of capital to support the infrastructure investment necessary to document and implement MSSP compliance requirements, and meaningfully develop better patient portals, care coordination and clinical pathways,” Matsakis wrote.

He added that some physician-only ACOs have been able to obtain management and information technology software, and to build care coordination and compliance infrastructure from third-party vendors willing to accept a contingency payment based on potential shared savings. Health insurance companies and private equity firms have been active in doing this, according to Matsakis.

Health insurers have programs to help these efforts, but Matsakis warns that, if they collaborate with payers, physicians must maintain governance of the ACO and that they “resist any restrictions on their future contracting.”

“At the outset, the ACO must be permitted to leverage its infrastructure across payers,” Matsakis wrote.

To be successful, physician-only ACOs have to develop “a stable of allied providers” to ensure proper transitions of care and to manage acuity of patients via “proactive population health management,” Matsakis wrote.

“Physician-led and physician-only ACOs have been successful both financially and in improving the quality of their care and patient satisfaction,” he concluded. “Critical to an ACO’s success is a strong primary care physician base, a willingness to invest in the infrastructure necessary to create the patient engagement and care coordination to meaningfully manage at risk populations often with one or more chronic conditions, and a culture of timely and effective communication among patients and their oftentimes multiple treating physicians.”

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