Title

Accountable Care Organizations and Specialists: Opportunities for Neurologists.

Journal

Neurology: Clinical Practice, 14(1)

ISSN

2163-0402

Authors

Mechanic, Robert

Shortell, Stephen

Publication Date

2024-02-01

DOI

10.1212/CPJ.0000000000200251

Peer reviewed

COMMENTARY

Accountable Care Organizations and Specialists

Opportunities for Neurologists

Robert E. Mechanic, MBA, and Stephen Shortell, PhD, MPH, MBA

Neurology: Clinical Practice 2024;14:e200251. doi:10.1212/CPJ.0000000000200251

Correspondence
Mr. Mechanic
mechanic@brandeis.edu

Abstract

More than 700,000 physicians and advanced practice clinicians participate in Medicare ACOs, which is responsible for the cost and quality of care for more than 13 million beneficiaries. Nearly 40 percent of neurologists who treat Medicare patients are already in an ACO. The Centers for Medicare and Medicaid services is now implementing a strategy for value-based specialty care that promotes active ACO management of specialty services while some ACOs are starting to direct referrals to preferred specialist networks. Neurologists can benefit from engaging with ACOs through enhanced patient data, an emphasis on team-based care, care coordination support for their patients, and financial rewards for performance. Neurologists can help ACOs as the population ages, including by helping ensure appropriate use of expensive new therapies for neurologic conditions.

The Medicare Shared Savings Program (MSSP) is the nation's largest alternative payment model (APM), which in 2023 comprised 453 accountable care organizations (ACOs), 573,000 participating physicians and advanced practice clinicians (APCs), and nearly 11 million assigned beneficiaries.[1] An additional 132 ACOs are in the new Realizing Equity and Community Health (REACH) ACO model with 132,000 clinicians and 2.1 million beneficiaries.[2] In the past year, the Centers for Medicare and Medicaid Services (CMS) announced a goal of having all Medicare beneficiaries in an accountable care relationship by 2030, and it has made major changes in the MSSP to attract new participants beginning in 2024.[3]

ACOs in the MSSP and REACH are responsible for the cost and quality of care delivered to Medicare beneficiaries who are assigned to the ACO when they receive the plurality of their primary care from an ACO physician. Each ACO is subject to a spending benchmark that is based on a blend of its historical per member, per year (PMPY) spending and regional average PMPY. The regional blending can increase the benchmark of a regionally efficient ACO by up to 5 percent, and it previously could reduce the benchmark for regionally inefficient ACOs by the same percentage. However, CMS eliminated the negative regional adjustment for contracts beginning in 2024.

ACOs with performance year spending below their benchmark may be eligible to earn shared savings if they achieve acceptable quality scores on measures that include preventive care screening, blood pressure control, hemoglobin A1c control for persons with diabetes, and patient experience. There are multiple risk tracks in the MSSP, and some ACOs are required to pay back shared losses if their spending exceeds the benchmark. Evaluations of Medicare ACO models have generally found savings of 1 percent to 2 percent annually.[4] Physician-led ACOs have generally outperformed health system–based ACOs, at least in the initial years of the MSSP.[5]

ACOs have invested in developing high-performing primary care teams and practice-based care management capabilities,[6] improving care transitions, and managing postacute care.[7] Few, however, have developed comprehensive initiatives to improve the cost and quality of specialty

Heller School for Social Policy and Management (REM), Brandeis University, Waltham, MA; Institute for Accountable Care (REM), Washington, DC; and School of Public Health (SS), University of California Berkeley.

Funding information and disclosures are provided at the end of the article. Full disclosure form information provided by the authors is available with the full text of this article at Neurology.org/cp.

care. However, this is beginning to change. Specialists account for 70 percent of US spending for outpatient office visits, which often give rise to expensive diagnostic services, procedures, and drug therapies.[8] Between 2009 and 2019, the average number of specialist visits in Medicare grew by 28%.[9] As ACOs mature, more are examining specialist services as an important area for future savings.

ACO management of specialist services is being encouraged by the CMS. Last year it announced a new strategy for value-based specialty care where it proposed giving ACOs enhanced data on specialist performance, expanding bundled payment models, developing new models that encourage coordination between primary care physicians and specialists at the point of referral, and establishing financial incentives for ACOs to actively manage specialty care.[10]

What does this mean for neurologists? In 2021, 7,600 neurologists already participated in 334 MSSP ACOs representing nearly 40 percent of neurologists treating Medicare patients in that year. Slightly more than half of ACO neurologists were concentrated in 50 ACOs sponsored primarily by large academic and tertiary health care systems. Some or perhaps many of these neurologists are unaware they are in an ACO. However, that will change as ACOs invest in programs to address specialty care cost and outcomes.

ACOs are extremely diverse, and the resources and tactics they devote to managing specialty care will vary. The Medicare ACO landscape has evolved from mostly provider-sponsored organizations to a growing contingent of entrepreneurial "convener groups" that manage multiple ACOs and that now account for 30–40 percent of the Medicare ACO program. These organizations, such as Aledade, VillageMD, and Privia Health, and large corporations, such as CVS Health, Optum, and Humana, recruit physician groups and provide management services for value-based contracting. They typically do not employ specialists or own hospitals, and many are building selective networks of specialists to serve as preferred referral partners. This trend will continue as more eligible patients choose Medicare Advantage overseen by private sector health plans.

By contrast, many large health system–affiliated ACOs with employed specialists still rely heavily on fee-for-service income and have conflicting incentives when it comes to reducing unnecessary spending. Although these organizations may be slower to engage medical specialists in value, they may eventually feel pressure to align services in a value framework to reduce Medicare spending either in response to competition from the types of convener entities mentioned above or through growth in all-payer cost control efforts like Maryland's total cost of care model.

ACOs will initially focus on specialties where they spend the most money like cardiology, orthopaedics, and oncology. Some ACOs will use episodes of care to analyze specialist performance and identify efficient providers. Medicare's main episode initiative—Bundled Payment for Care Improvement Advanced (BPCI-A)—has 34 90-day episodes that are primarily triggered by inpatient hospitalizations. BPCI-A has only 2 neurology-related episodes: stroke and seizures, but these represent only one aspect of work performed by neurologists. These episodes are not ideal for evaluating neurologist efficiency because they are usually emergent and depend on the performance of multiple parties including ambulances, hospitals, and other clinicians. Neurologists cannot control all of the episode costs, but they can influence them working as part of a well-functioning care team.

Much of the variation in the cost of Medicare 90-day stroke and seizure episodes is due to postacute care utilization in rehabilitation hospitals and skilled nursing facilities. These are areas in which ACOs have successfully reduced spending.[11] Neurologists can play an important role by contributing to the design of improved care pathways that appropriately match postacute services to the needs of individual patients.

There are many potential benefits for neurologists as members of an ACO. One is more comprehensive information about their patients including data broken out by race and ethnicity to address potential inequities in care. CMS gives ACOs historical claims data for attributed beneficiaries that can be used to develop a full picture of their health care utilization. Second is feedback on the quality metrics that can be used for continuous performance improvement to provide better care.[12] Third is an emphasis on team-based care, which can improve communication, coordination, and patient outcomes. Fourth is availability of care managers who can support patients between clinic visits with education and coaching. Fifth is an opportunity to earn shared savings bonuses and "advanced alternative payment model (AAPM)" bonuses of up to 5 percent under the Medicare Access and CHIP Reauthorization Act (MACRA)—though funding for future AAPM bonuses will require congressional action. Finally, as ACOs begin to adopt more aggressive specialty care strategies, aligned neurologists will receive more referrals from ACO physicians.

Not all neurologists will view ACOs positively. There is wide variation in the way health care organizations treat their physicians, and ACOs are no different. ACOs may create new administrative tasks like convening meetings to discuss care pathways or review performance measures. Physicians who are cost or quality outliers will be asked to explain why their practice patterns differ from the norm. There is no academic literature exploring whether ACO physicians are more or less likely to experience burnout. However, the principal factors driving burnout including electronic health records, excess administrative requirements, and the futility of adequately serving complex patients in 15-minute office visits were not created by ACOs. Moreover, the best ACOs are physician centric, support team–based care, and try to reduce administrative burdens so physicians can spend more time with their patients.

Neurologists who are passionate about improving value will find receptive ACO leaders. As the US population ages and expensive new therapies are introduced for dementia, Parkinson disease, multiple sclerosis, and other neurologic conditions, ACOs will need guidance on the appropriate use of these therapies. US health care will face continuing pressure to manage spending while improving quality, advancing patient safety, and addressing inequities in care. Over time this will lead to closer scrutiny of neurologists. However, ACOs will need neurologists and will potentially provide new resources to those willing to collaborate with them.

Conclusion

Value-based care is here to stay. Organizations participating in Medicare ACO programs are expanding into value-based arrangements with commercial and Medicare Advantage health plans. National retailers like Amazon, CVS Health, Walgreens, and Walmart have made large investments in primary care specifically to compete in value-based care. These organizations will eventually set their sights on improving the quality and value of specialty care. Still unknown is how quickly specialist strategies will be deployed and whether the strategies will be effective. Our practical advice to neurologists is to make sure you know about the value-based initiatives in your community and be proactive about establishing a dialog with ACO leadership. Doing so will help you make informed decisions about how to best position your practice in response to an evolving marketplace.

Study Funding

Arnold Ventures Grant #22-06921.

Disclosure

The authors report no relevant disclosures. Full disclosure form information provided by the authors is available with the full text of this article at Neurology.org/cp.

Publication History

Received by *Neurology: Clinical Practice* August 2, 2023. Accepted in final form December 5, 2023. Submitted and externally peer reviewed. The handling editor was Editor Luca Bartolini, MD, FAAN.

Appendix Authors

Name	Location	Contribution
Robert E. Mechanic, MBA	Heller School for Social Policy and Management, Brandeis University; Institute for Accountable Care	Drafting/revision of the manuscript for content, including medical writing for content
Stephen Shortell, PhD, MPH, MBA	School of Public Health, University of California Berkeley	Drafting/revision of the manuscript for content, including medical writing for content

References

1. Center for Medicare and Medicaid Services. *Shared Savings Program Fast Facts – as of January 1, 2023*. Accessed July 19, 2023. cms.gov/files/document/2023-shared-savings-program-fast-facts.pdf.
2. Center for Medicare and Medicaid Innovation. *ACO REACH Model Fast Facts*. Accessed July 19, 2023. innovation.cms.gov/media/document/aco-reach-model-fast-facts.
3. Rawal P, Jacobs D, Fowler E, Seshamani M. Building on CMS's accountable care vision to improve care for Medicare beneficiaries., *Health Affairs Forefront*. Accessed July 31, 2023. https://www.healthaffairs.org/content/forefront/building-cms-s-accountable-care-vision-improve-care-medicare-beneficiaries
4. Medicare Payment Assessment Commission. 2019. Report to the Congress: *Medicare and the health care delivery system*. Washington, DC: MedPAC.
5. McWilliams JM, Hatfield LA, Landon BE. Hamed P, Chernew ME. Medicare spending after 3 years of the medicare shared savings program. *N Engl J Med*. 2018; 379(12):1139-1149. doi:10.1056/NEJMsa1803388
6. Lewis V, Schoenherr K, Fraze T, Cunningham A. Clinical coordination in accountable care organizations: a qualitative study. *Health Care Manage Rev*. 2019;44(2):127-136. doi:10.1097/HMR.0000000000000141
7. Huckfeldt PJ, Weissblum L, Escarce JJ, et al. Do skilled nursing facilities selected to participate in preferred provider networks have higher quality and lower costs? *Health Services Res*. 2018;53:4886-4905.
8. Davis KE, Carper K. *Use and Expenses for Office-Based Physician Visits by Specialty, 2009: estImates for the US Civilian Noninstitutionalized Population*. Agency for Healthcare Research and Quality. 2012. Accessed June 20, 2023. meps.ahrq.gov/data_files/publications/st381/stat381.pdf.
9. Barnett ML, Bitton A, Souza J, Landon BE. Trends in outpatient care for medicare beneficiaries and implications for primary care, 2000 to 2019. *Ann Intern Med*. 2021; 174(12):1658-1665. doi:10.7326/M21-1523
10. Fowler L, Rawal P, Fogler S, Waldersen B, O'Connell M, Quinton J. *The CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care*. 2022. Accessed July 23, 2023. cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care.
11. McWilliams JM, Gilstrap LG, Stevenson DG, Chernew ME, Huskamp HA, Grabowski DC. Changes in post-acute care in the medicare shared savings program. *JAMA Intern Med*. 2017;177(4):518-526. doi:10.1001/jamainternmed.2016.9115
12. Shortell SM, Toussaint JT, Halvorson GC, et al. The better care plan: a blueprint for improving America's Healthcare System. *Health Aff Scholar*. 2023;1(1):1-6.

How to cite this article: Mechanic RE, Shortell S. Accountable care organizations and specialists: opportunities for neurologists. *Neurol Clin Pract*. 2024;14(1):e200251. doi: 10.1212/CPJ.0000000000200251.