

Can Physician Networks Affect ACOs' Effectiveness?

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Among healthcare practitioners and policymakers, accountable care organizations (ACOs) have gained attention for promising to formalize networked care delivery. ACOs could be key to a future of integrated and patient-centered care. Their aim is to formally establish care networks across patients' physician teams, offering a fiscal reward for networks that lower costs and increase positive outcomes.

Enter Russell Funk, a professor of strategic management and entrepreneurship in the Carlson School of Management whose education is rooted in organizational sociology, who worked with fellow department member Aks Zaheer and graduate student Dennie Kim to identify a relevant case study and a team of coauthors from the University of Michigan Medical School. Kim, who is the lead author on their resulting study, "Informal Clinical Integration in Medicare Accountable Care Organizations and Mortality Following Coronary Artery Bypass Graft Surgery," says of their impetus, "We already know that many of society's big problems, like healthcare, but also education, sustainability, and poverty, need the combined efforts of multiple stakeholders. However, we still don't know enough about the recipes that lead to more effective partnerships, both among multiple organizations and between organizations and their communities."

The authors chose coronary artery bypass graft surgery (CABG) because it is both relatively expensive and relatively common among Medicare recipients, and they examined costs and patient outcomes between organizations that had and did not have ACO agreements in place. Put simply, Kim tells us, "participation in a Medicare ACO, alone, is not associated with a statistically significant change in mortality following heart bypass surgery at the health system level." He hastens to caution, however, that this isn't the

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whole story: "For health systems with lower levels of multidisciplinary work—meaning that physicians were more likely to share work with others within the same specialty—ACO participation did not significantly change patient outcomes. However, in health systems that already exhibited high levels of multidisciplinary work, ACO participation was associated with significantly *better* patient outcomes." That is, for highly integrated health systems, ACO participation seemed to unlock the benefits of integration, with better results for patients and for the systems' bottom lines.

Further, scholars increasingly believe that ACOs "learn" over time, such that early low-performers may exhibit better and better outcomes over time. Thus, when Centers for Medicare and Medicaid Services' administrator Seema Verma recently announced a move to make ACOs adopt "downside risk" models in which failure to lower costs and improve outcomes against benchmarks would mandate a financial penalty, it gave researchers like Funk and Kim pause. "ACOs need time to 'learn' how to become integrated and change the way they deliver healthcare," Kim explains. "Therefore, increasing the amount of risk they take on may discourage participation in a program that may, eventually, stimulate positive health system change." In a world in which policy aims and practical implementation rarely converge perfectly, it would seem ACOs need time to both prove and improve upon their promises. ■

Informal Care Coordination in Medicare ACOs

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One of the biggest challenges we face in improving health care is knowing how to scale-up innovation. New care and payment models—advanced ACOs, bundled payments, narrow networks—abound in Medicare, Medicaid and the commercial space. But understanding *what* works and *why* is at the crux of making the system work better for all. This study is important because it helps us understand both.

Dennie Kim, Russell Funk, Aks Zaheer, and their team write that the key lies in care coordination, not merely contracts.

As they note, ACOs have been a big part of Medicare's portfolio of value-based initiatives, designed to improve beneficiary care and reduce costs. In 2018, 12 million Medicare beneficiaries (30% of the fee-for-service population) received care from ACOs. But the success of Medicare ACOs has been tepid. Savings have been small and may not cover program costs. Patient outcomes have nudged higher, but not uniformly. Variance swamps trend.

So much so that, in December 2018, Centers for Medicare & Medicaid Services (CMS) announced a restructuring of Medicare ACOs under the new "Pathways to Success" program. Most Medicare ACOs currently do not face financial consequences when costs increase. Pathways to Success changes this, requiring ACOs take on risk, while at the same time encouraging new programs that engage beneficiaries in their care. Data show that over time when ACOs are at risk for

costs, they perform better. Moving forward, CMS is emphasizing accountability for costs as a requirement for advanced value-based payment models.

The authors suggest another, complimentary, path to success: ensuring that providers have the "informal" networks in place to provide meaningful care coordination. This is appealing from research, clinical, and policy perspectives. When ACOs have saved money, they have often done so by improving care coordination across the continuum. Patients receive better preventive care, keeping them out of the emergency room and preventing hospitalizations, especially for exacerbations of chronic illnesses. Rehabilitation and post-acute care is coordinated at discharge and emphasizes care at home rather than in nursing homes, where appropriate.

Medicare faces unique challenges in making sure elders are treated in tightly knit, effective networks of care. While commercial payers can incentivize patients to seek care inside a preferred network, under law, FFS Medicare cannot restrict choice of providers. Patient "leakage" is one of the biggest challenges facing ACOs. In Medicare, the emphasis is on the carrot—engagement—rather than the stick. A terrific extension of the paper might drill down on utilization and referral data to help us understand the provider and patient linkages that matter, and see if they save money as well as lives. ■