Accountable Care Organizations: A Challenging Opportunity for Primary Care to Demonstrate its Value

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Since the passage of the Affordable Care Act in 2010, much attention has focused on the inadequacy of the primary care workforce in meeting the care needs of millions of newly insured Americans. Less attention has been paid to the central role primary care will play in the ACA's signature payment and delivery system reform—Accountable Care Organizations (ACOs).

There are both programmatic and conceptual features of the ACO model that place primary care in a position of potential influence in determining the success of ACOs and, by extension, how providers will be organized and paid in the future. Perhaps most importantly, patients are attributed to ACOs in both Medicare and commercial initiatives based on their receipt of primary care. ACOs are then held accountable for all medical spending for attributed patients. Placing primary care at the epicenter of accountability for the entire spectrum of care could have powerful effects on the structure of provider organizations and markets.

This point merits some explanation. ACO contracts typically include incentives to keep spending under a global budget, but do not yet include prospective global payments that must be allocated by ACOs to all providers involved in the care of attributed patients. Thus, in its current form, the ACO model does not preclude fee-for-service or other (e.g., bundled) payments for specialty and hospital care provided to an ACO's attributed patients. Nevertheless, incentives for primary care providers in ACOs to reduce wasteful spending and steer patients to more efficient providers (e.g., hospitals, specialists, and imaging centers) could substantially alter referral patterns and revenue for competing provider groups. In a competitive market with sufficient participation in ACO contracts, specialty-oriented groups and hospitals will have to be responsive to ACO groups with more primary care providers. Primary care practices may find themselves in high demand by large provider organizations that have traditionally emphasized specialty and inpatient care under fee-for-service incentives. Furthermore, if ACO payment models transition from global budgets to global payments and emerge as a predominant form of provider risk sharing in response to demands for more cost-effective care, control over primary care will become a major determinant of provider revenue and market power.

In addition, there are several reasons why ACOs are likely to focus on constituent primary care practices in their initial efforts to control spending and improve quality of care. Primary care providers exert influence over a wide range of health services, including specialty consultations, laboratory testing, imaging studies, procedures, emergency room visits, elective hospitalizations, and home health care. As hubs of communication and arbiters of recommendations, they are essential to the care coordination and management of complex patients. Finally, because patient care is often fragmented across multiple providers, particularly in Medicare,[1] specialists in an ACO are likely to serve many patients who receive their primary care elsewhere and are therefore not attributed to the ACO. Thus, incentives for many ACOs to improve care efficiency outside of constituent primary care practices are likely to be diminished by the prospect of offsetting reductions in fee-for-service revenue. This misalignment between patients attributed and patients served is likely to be even greater among patients admitted to hospitals that are part of ACOs. Incentives will be much stronger, at least initially, for ACOs to improve care efficiency in primary care practices, where patients are more likely to be covered by ACO contracts.

The opportunity for primary care practitioners and leaders to play a pivotal role in the success of ACOs, however, does not come without its challenges. Incentives to control spending may be quite weak at the organizational level, particularly if the ACO includes many specialists (as many do) or contracts as an ACO with only one payer. The ability of primary care practices within such ACOs to limit

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unnecessary care may therefore be constrained by limited organizational commitment to redesigning systems of care, and by continued organizational emphasis on volume in constituent specialty practices and hospitals. ACOs that would incur losses from systemic cost-reducing changes in care delivery are likely to favor patient-specific care management strategies instead. Case management programs led by nurse coordinators, however, have not consistently generated savings.[2] When integrated into patient care, these programs may yield greater savings,[3] but primary care practices will have to develop successful strategies for clinically integrating care management and coordination activities. Similarly, even if incentives are strong enough to redesign primary care practices within ACOs, the impact of advanced models of primary care on spending is unclear.[4] The patient-centered medical home (PCMH) delivery model has rarely been coupled with high-powered incentives to focus practice capabilities on the task of reducing utilization,[5] but its unproven impact on spending to date suggests that primary care practices in ACOs may have to do more than establish PCMH capabilities for savings to materialize. In addition, ACO payment models generally do not cover the costs of investing in practice capabilities, and do not explicitly direct ACOs to devote more resources to primary care.

Furthermore, transmitting the financial incentives in ACO contracts to individual primary care providers presents a conundrum. Simply devolving risk to the individual physician defeats the purpose of pooling risk at the organizational level—to set a reliable and fair budget. On the other hand, simply splitting up an ACO's savings or losses among its participating physicians presents a free-riding problem. Primary care leaders will have to be creative in developing compensation schemes (e.g., paying directly for value-enhancing activities) and non-financial mechanisms (e.g., use of individual-level profiling, peer pressure, and default systems) that foster cost-effective practices.

Other challenges stem from the brand of primary care that has been cultivated by years of fee-for-services incentives. Low fees for cognitive evaluation and management services, little time with patients, and practice environments with increasing capacity for procedures and tests have likely bred inefficient practices. As primary care providers have been encouraged to substitute behaviors with low marginal time costs (e.g., referring to specialists, ordering tests, and prescribing medications) for time-consuming but potentially value-enhancing activities (e.g., counseling, shared decision making, forming differential diagnoses, and in-office procedures), deficits in key skills may have developed. These deficits and inefficient practices will need to be addressed for ACO payment models to be successful.

More fundamentally, leaders of primary care-based initiatives in ACOs may have to disabuse themselves of the romantic notion that prevention alone will generate sufficient savings. The notion is appealing because preventive care does not require rationing, includes services already reimbursed on a fee-for-service basis, and thus may be enhanced through incremental changes to the status quo. Preventive care coordination and disease management programs, however, have high operating costs and typically must correct underuse among many patients in order to prevent costly complications among a few. Consequently, the net savings may be minimal. Although improving outcomes at minimal additional cost is certainly a worthwhile endeavor, ACOs will likely need to tackle overuse directly to achieve meaningful savings.

ACO initiatives present an opportunity for primary care to assume a responsibility that has largely been shirked by the medical profession—responsibility for devoting society's (and thus patients') resources to health care. For ACOs to slow spending growth and improve outcomes will require innovation and reinvention in primary care. Recognition by primary care leaders of their heightened influence within health care markets and their organizations may help them leverage the resources necessary for practice redesigns. Realistic expectations of savings from various approaches and dissemination of effective strategies will be critical. At a time when health care spending growth threatens the nation's economic future, drastic and potentially harmful cuts in public and private insurance benefits may not be far off. If primary care can demonstrate its value under new payment incentives, there is no better time than now.

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