Accountable Care Organization Initiatives to Improve the Cost and Outcomes of Specialty Care

Robert E. Mechanic, MBA; Louise Secordel, MBA; Sam Sobul, MPA; and Jennifer Perloff, PhD

ABSTRACT

OBJECTIVES: To assess initiatives to manage the cost and outcomes of specialty care in organizations that participate in Medicare accountable care organizations (ACOs).

STUDY DESIGN: Cross-sectional analysis of 2023 ACO survey data.

METHODS: Analysis of responses to a 12-question web-based survey from 101 respondents representing 174 ACOs participating in the Medicare Shared Savings Program or the Realizing Equity, Access, and Community Health ACO model in 2023.

RESULTS: Improving specialist alignment was a high priority for 62% of the 101 respondents and a medium priority for 34%. Only 11% reported that employed specialists were highly aligned and 7% reported that contracted specialists were highly aligned. A subset of ACOs reported major efforts to engage specialists in quality improvement projects (38%) and to convene specialists to develop evidence-based care pathways (30%). They also reported supporting primary care physicians through providing specialist directories (44%), specialist e-consults (23%), and sharing specialist cost data (20%). The most common challenges reported were the influence of fee-for-service payment on specialist behavior (58%), lack of data to evaluate specialist performance (53%), and insufficient bandwidth or ACO resources to address specialist alignment (49%).

CONCLUSIONS: Engaging specialists in accountable care is an emerging area for ACOs but one with numerous challenges. Making better data on specialist costs and outcomes available to Medicare ACOs is essential for accelerating progress.

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Accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP) have made significant investments in primary care, practice-based care management infrastructure,[1] enhanced care transitions, and post–acute care management.[2] However, relatively few have undertaken comprehensive initiatives to improve the cost and quality of specialty care. For example, one early study of ACOs found little attention devoted to surgeons or surgical care.[3]

As ACOs mature, they are paying more attention to managing specialist services. Specialists account for approximately 70% of spending for outpatient office visits in the US,[4] and they frequently prescribe expensive diagnostic services, procedures, and drug regimens. Specialty care utilization has grown rapidly, with physician referral rates doubling between 1999 and 2009[5] and the mean number of specialist visits in Medicare growing 28% from 2009 to 2019.[6]

Outcomes for complex patients can be improved when primary care physicians (PCPs) and specialists collaborate. For example, several studies have shown that comanagement of Medicare surgical patients with multidisciplinary teams that include internists or geriatricians reduced length of stay and mortality.[7,8] However, comanagement is not the norm in many organizations, and the levels of communication and coordination between PCPs and specialists when patients are referred are frequently inadequate.[9-11]

ACOs should theoretically be able to improve coordination between PCPs and specialist physicians. However, 2024 MSSP ACOs have a mean of 33 participating physician groups,[12] often with different information systems and diverse professional cultures. Results of a recent survey found that three-fourths of ACOs have 6 or more electronic health record (EHR) systems.[13] On average, ACOs have twice as many specialists as PCPs. Despite this, most specialty care that ACO beneficiaries receive is provided by clinicians who are not part of their ACO.[14]

In November 2022, the Center for Medicare and Medicaid Innovation (CMMI) announced a strategy for value-based specialty care that includes sharing specialty care performance data with ACOs, expanding bundled payment models, and developing new

models with incentives to improve coordination between PCPs and specialists at the point of referral.[15] Both ACOs and policy makers want better integration of specialty care in ACO models. However, there is little published literature describing ACO specialist alignment strategies. This article provides a snapshot of current ACO activities to influence specialty care from a 2023 survey.

TAKEAWAY POINTS

Policy makers and accountable care organizations (ACOs) want better integration of specialty care in ACOs. Little is known about ACO activities to improve specialty care costs and outcomes. We surveyed Medicare ACOs to better understand current activities to improve specialty alignment.

- Although improving specialist alignment is a priority for many respondents, few currently report high levels of alignment.
- ACOs are trying multiple strategies to engage specialty physicians and improve referrals from primary care.
- Challenges to specialist alignment include the fee-for-service orientation of most specialist physicians, lack of good data to evaluate specialist performance, and insufficient organizational bandwidth.
- Transparency of specialty costs and outcomes is essential to addressing these challenges.

METHODS

We conducted a survey of Medicare ACO executives to assess the current state of their initiatives to manage specialty care spending and improve outcomes. The survey targeted ACOs participating in the MSSP or the Realizing Equity, Access, and Community Health (REACH) Model as of January 1, 2023 (N = 588). A 12-question web-based survey was sent to ACO executives in March 2023. Periodic email reminders were sent to nonrespondents over the next 2 months. Survey results were merged with publicly available information on Medicare ACOs to compare the characteristics of respondent and nonrespondent ACOs.

Survey questions were developed by the Institute for Accountable Care in consultation with industry experts to establish face validity. We pilot-tested the survey with 5 ACO executives responsible for their organization's specialty care strategy and asked for feedback on the clarity and relevance of questions as well as missing concepts that should be added to the survey. The survey questions were primarily multiple choice or statements that respondents were asked to rate on a 4-point Likert scale. There were no open-ended questions except when respondents selected and completed "other" categories that were offered as a choice. The survey defined "ACO contracts" as those where an organization is rewarded on performance based on a total cost of care (TCOC) budget target. "Specialist alignment" was defined as having specialist physicians who collaborate with the organization's initiatives to control total spending and improve clinical outcomes in TCOC contracts.

A subset of respondents represented multiple ACOs, including convenor organizations that offer management services to multiple provider groups in different ACOs.

RESULTS

We received 101 completed surveys from respondents representing 174 ACOs, which accounts for 30% of Medicare ACOs in 2023. Respondent ACOs were larger and more likely to participate in 2-sided risk contracts than nonrespondents (**eAppendix Table 1** [eAppendix available at **ajmc.com**]). Survey results are reported based on the number of individual respondents.

Improving specialist alignment was a high priority for 62% of the 101 respondents and a medium priority for 34%. ACOs were most interested in improving alignment with cardiologists (83%), orthopedists (57%), and oncologists (34%). Overall, respondents reported limited specialist alignment, with only 11% indicating that employed specialists were highly aligned and 7% indicating that contracted specialists were highly aligned (**Figure**).

Approximately half of respondents reported offering financial incentives for specialist performance or behavior. Thirty-six percent reported incentives for clinical outcomes, 29% for cost outcomes, and 21% for patient satisfaction (data not shown). Data on the amount of the incentives paid were not collected.

We asked ACOs to report on their current initiatives to improve specialist alignment and whether they considered it a major or minor activity (**Table**). The most common activities that respondents indicated as major were engaging specialists in quality improvement projects (38%) and convening specialists to develop evidence-based care pathways (30%). Few reported sharing performance reports (11%) or entering bundled payment contracts (14%).

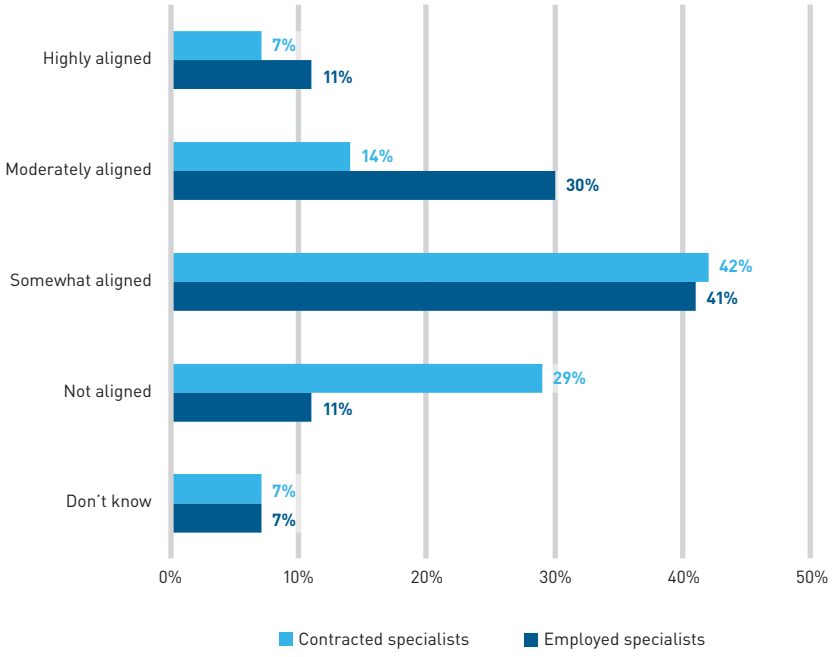
ACOs are also trying to help PCPs make appropriate, cost-effective specialist referrals. Nearly half reported providing PCPs with a directory of specialists, but few (15%) reported providing PCPs with a preferred list of specialists for most major specialties (Table). Other activities to support PCP referrals were offering specialist e-consults (23% reported this was a major activity), establishing workflows that encourage referral to high-performing specialists (22%), and sharing specialist cost data (20%).

We asked ACOs to identify their top 3 challenges to improving specialty alignment (**eAppendix Table 2**) by choosing from a prespecified list with a write-in option. The top challenges were the influence of fee-for-service payment on specialist behavior (58%), lack of data to evaluate specialist performance (53%), and insufficient bandwidth or resources to address specialist alignment (49%). Other challenges included lack of specialist interest in collaborating with the ACO and lack of a local competitive market for specialist services.

DISCUSSION

ACOs that have successfully slowed spending need to find additional efficiencies to continue generating savings, and specialty care is a

FIGURE. ACO Rating of Current Degree of Specialty Alignment With ACO Cost and Quality Objectives



ACO, accountable care organization; VBC, value-based care.

Source: Self-reported data from 101 ACO executives representing 174 Medicare Shared Savings Program or Realizing Equity, Access, and Community Health ACOs in 2023. Likert scale in response to the question: "How well are the specialist physicians in your ACO/VBC contracts aligned with your efforts to manage costs and improve outcomes?"

TABLE. ACO Activities to Improve Specialty Care Outcomes and Spending[a]

Initiatives to improve specialty physician alignment	Major activity	Minor activity	No activity
Engage specialist physicians in quality improvement projects	38%	52%	10%
Convene specialist physicians to develop evidence-based care pathways	30%	48%	22%
Enter bundled payment contracts for specialist services	14%	30%	56%
Provide "unblinded" performance reports to specialist physicians	11%	40%	49%
Initiatives to help PCPs make better specialist referrals	**Major activity**	**Minor activity**	**No activity**
Create a directory of specialists for PCPs	44%	26%	29%
Offer specialist e-consult to PCPs	23%	36%	41%
Establish primary care workflows that encourage referral to high-performing specialists	22%	30%	49%
Share specialist cost data with PCPs	20%	38%	43%
Provide a preferred list of high-performing specialists for referrals	15%	22%	63%
Share specialist clinical outcome data with PCPs	13%	32%	55%
Internal review/authorization of selected specialist referrals	10%	26%	64%
Ask PCPs to qualitatively rate specialists	9%	18%	72%

ACO, accountable care organization; PCP, primary care physician.

[a]Percentages may not total 100 due to rounding.

Source: Self-reported data from 101 ACO executives representing 174 Medicare Shared Savings Program or Realizing Equity, Access, and Community Health ACOs in 2023. Likert scale in response to the listed activities.

logical place to look. However, it is challenging to find efficiencies in a fragmented delivery system where specialists are well compensated by fee-for-service payment. Results of this survey of organizations participating in Medicare ACOs indicate that although improving specialty care is a high priority, most respondents currently believe their ACOs have not achieved necessary alignment with specialists. Furthermore, it shows that ACOs are experimenting with many different strategies to improve specialty care but that no particular approach has been broadly adopted.

CMMI would like to encourage better collaboration between PCPs and specialists. One approach is making it easier through electronic consultations. Nearly 25% of respondents reported that offering specialist e-consults to their PCPs was a major activity. Some organizations have successfully used e-consult and e-referral systems to reduce unnecessary specialty referrals, support virtual comanagement of certain conditions, and reduce patient wait times.[16,17] Medicare recently began paying between $18 and $75 for interprofessional consults depending on the time spent. CMMI's new Making Care Primary model also includes a $40 e-consult code for primary care providers and a new $50 ambulatory care comanagement code for specialists. How these new payments will affect PCP-specialist collaboration is yet to be determined.

Twenty-nine percent of the 101 ACO respondents in our survey reported financial incentives for specialists' contributions to cost efficiency. However, some ACO executives expressed concern that adding specialist incentive payments could dilute future shared savings distributions for PCPs. They also questioned whether they could offer high enough incentive payments to change behavior, given specialists' current fee-for-service incomes. Results from a prior study of 160 ACOs found that 26% offered specialist incentives tied to cost savings, but there were no differences in ACO savings per beneficiary between those with and without cost-related incentives.[18]

Some ACOs are creating workflows that encourage PCPs to refer to efficient specialists. In contrast to Medicare Advantage, in which beneficiaries are often financially obligated to use in-network providers, ACO beneficiaries

still have the freedom to see any certified Medicare provider without a referral. In CMMI's ACO REACH model, ACOs can contract with preferred specialists for discounted rates and reallocate a portion of those discounts to reward high performance. Developing preferred lists based on objective performance measures typically requires the assistance of vendors because many ACOs simply do not have enough patient volume to reliably evaluate the performance of medical specialists. However, the costs can be prohibitive for all except large ACOs. Therefore, the quality and comprehensiveness of specialist performance data that CMMI shares with ACOs is important.

Limitations

This study has several limitations. The survey response from 101 individuals representing about 30% of Medicare ACOs is limited and likely skewed toward organizations already engaged in this work. Respondents' organizations were larger and more likely to participate in 2-sided risk contracts than ACOs generally. Therefore, the study results are probably not generalizable to all ACOs. Instead, they should be viewed as a snapshot of activities undertaken by a large group of leading ACOs that have begun developing approaches to address the cost and outcomes of specialty care. Finally, we designed this survey for brevity and convenience, which limited the amount of detail we collected. Further research is needed to develop more precise indicators of ACO specialty alignment efforts, including the size, intensity, and impact of engagement efforts.

CONCLUSIONS

Engaging specialists in accountable care is an emerging area of focus for ACOs but one with numerous challenges. Making better data on specialist costs and outcomes available to Medicare ACOs is essential for accelerating progress. ■

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Author Affiliations: Brandeis University (REM, JP), Waltham, MA; Institute for Accountable Care (REM, LS, SS, JP), Washington, DC.

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Address Correspondence to: Robert E. Mechanic, MBA, Brandeis University, 415 South St, MS 035, Waltham, MA 02453. Email: mechanic@brandeis.edu.

REFERENCES

1. 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
2. Huckfeldt PJ, Weissblum L, Escarce JJ, Karaca-Mandic P, Sood N. Do skilled nursing facilities selected to participate in preferred provider networks have higher quality and lower costs? *Health Serv Res*. 2018;53(6):4886-4905. doi:10.1111/1475-6773.13027
3. Dupree JM, Patel K, Singer SJ, et al. Attention to surgeons and surgical care is largely missing from early Medicare accountable care organizations. *Health Aff (Millwood)*. 2014;33(6):972-979. doi:10.1377/hlthaff.2013.1300
4. Davis KE, Carper K. Use and expenses for office-based physician visits by specialty, 2009: estimates for the U.S. civilian noninstitutionalized population. Statistical brief 381. Agency for Healthcare Research and Quality. August 2012. Accessed June 20, 2023. https://meps.ahrq.gov/data_files/publications/st381/stat381.pdf
5. Barnett ML, Song Z, Landon BE. Trends in physician referrals in the United States, 1999-2009. *Arch Intern Med*. 2012;172(2):163-170. doi:10.1001/archinternmed.2011.722
6. 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
7. Shahrokni A, Tin AL, Sarraf S, et al. Association of geriatric comanagement and 90-day postoperative mortality among patients aged 75 years and older with cancer. *JAMA Netw Open*. 2020;3(8):e209265. doi:10.1001/jamanetworkopen.2020.9265
8. Shaw M, Pelecanos AM, Mudge AM. Evaluation of internal medicine physician or multidisciplinary team comanagement of surgical patients and clinical outcomes: a systematic review and meta-analysis. *JAMA Netw Open*. 2020;3(5):e204088. doi:10.1001/jamanetworkopen.2020.4088
9. Forrest CB, Glade GB, Baker AE, Bocian A, von Schrader S, Starfield B. Coordination of specialty referrals and physician satisfaction with referral care. *Arch Pediatr Adolesc Med*. 2000;154(5):499-506. doi:10.1001/archpedi.154.5.499
10. Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *J Gen Intern Med*. 2000;15(9):626-631. doi:10.1046/j.1525-1497.2000.91119.x
11. Timmins L, Kern LM, O'Malley AS, Urato C, Ghosh A, Rich E. Communication gaps persist between primary care and specialist physicians. *Ann Fam Med*. 2022;20(4):343-347. doi:10.1370/afm.2781
12. Medicare Shared Savings Program: accountable care organization participants. CMS. Accessed January 28, 2024. https://data.cms.gov/medicare-shared-savings-program/accountable-care-organization-participants
13. Perloff JN, Sobul S. Use of electronic health record systems in accountable care organizations. *Am J Manag Care*. 2022;28(1):e31-e34. doi:10.37765/ajmc.2022.88818
14. Barnett ML, McWilliams JM. Changes in specialty care use and leakage in Medicare accountable care organizations. *Am J Manag Care*. 2018;24(5):e141-e149.
15. 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. CMS blog. November 7, 2022. Accessed June 1, 2023. https://www.cms.gov/blog/cms-innovation-centers-strategy-support-person-centered-value-based-specialty-care
16. Chen AH, Murphy EJ, Yee HF Jr. eReferral—a new model for integrated care. *N Engl J Med*. 2013;368(26):2450-2453. doi:10.1056/NEJMp1215594
17. Vimalananda VG, Orlander JD, Afable MK, et al. Electronic consultations (e-consults) and their outcomes: a systematic review. *J Am Med Inform Assoc*. 2020;27(3):471-479. doi:10.1093/jamia/ocz185
18. Ganguli I, Lupo C, Mainor AJ, et al. Association between specialist compensation and accountable care organization performance. *Health Serv Res*. 2020;55(5):722-728. doi:10.1111/1475-6773.13323

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