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Physician Referral and the Potential for ACOs in Philadelphia

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Disciplines

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ANALYSIS & COMMENTARY

Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s

ABSTRACT **Accountable care organizations are intended to improve the quality and lower the cost of health care through several mechanisms, such as disease management programs, care coordination, and aligning financial incentives for hospitals and physicians. Providers employed several of these mechanisms in forming the integrated delivery networks of the 1990s. The networks failed, however, because of heavy financial losses stemming from hospitals' purchase of physician practices and their inability to align incentives, garner capitated contracts, and develop the infrastructure to manage risk. Although the current mechanisms underlying accountable care organizations continue to evolve, whether and how they will have an impact on quality and costs remains open to question. Care coordination and information technology are proving more complicated and expensive to implement than anticipated, providers may lack the ability to implement these mechanisms, and primary care providers are in short supply. As in the 1990s, success depends on targeting specific populations, such as people with multiple chronic conditions who need and may benefit from coordinated care.**

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Some Problems with ACOs

- Government estimates of ACO startup costs way too low : not $1.5M, maybe $10-15M
- Providers not good at implementing change
- Many components of ACOs (e.g., EMRs, care coordination) not good at controlling costs
- No scope economies

Motivating questions

- Are primary care physicians (PCPs) and other players in the Philly market ready and willing to invest/participate in organizational change?
- In particular, do PCPs make referrals in a way that would support the kind of coordinated, network-based care that ACOs call for?
- What does the current landscape suggest about ACO development?

Physician referrals at the heart of ACOs

- In ACO model, providers likely to be incentivized to manage referrals differently:
  - keep referrals within a pre-defined network;
  - keep referrals down in general to decrease costs;
  - make referrals evidence-based to achieve cost and quality goals.
- (How) will these types of organizational changes work in urban markets dominated by small physician practices and hospital systems?

Research questions: ACOs in the Philadelphia Market?

1. How do referrals currently work in this market?
2. What criteria do PCPs use in selection of specialists?
3. How receptive are physicians to adapting practices? How much of a PCP's reimbursement would need to be contingent on implementing ACO-like practices to induce change?
4. Do key players in Philadelphia share perspectives on ACO implementation? What are their major concerns?

Wharton/Penn Medicine ACO Mixed-Methods Study

- Study commissioned by Penn Medicine
- Penn Medicine identified participants
- In-depth 45-minute telephone interviews:
  - 10 Penn-affiliated PCPs
  - 10 non-Penn-affiliated PCPs in the Philadelphia area
  - 9 specialist physicians in the Philadelphia area (1 Penn-affiliated)
    - Average 28 years in practice, 370 patients/month, practice size/setting varied
  - 5 hospital executives from local community hospitals and a two-hospital system in a neighboring state (160-250 beds, 50% Medicare)
  - 5 major payers in the Philadelphia market
  - 4 specialty network leaders
- Online survey of 29 participating physicians

Interview topics

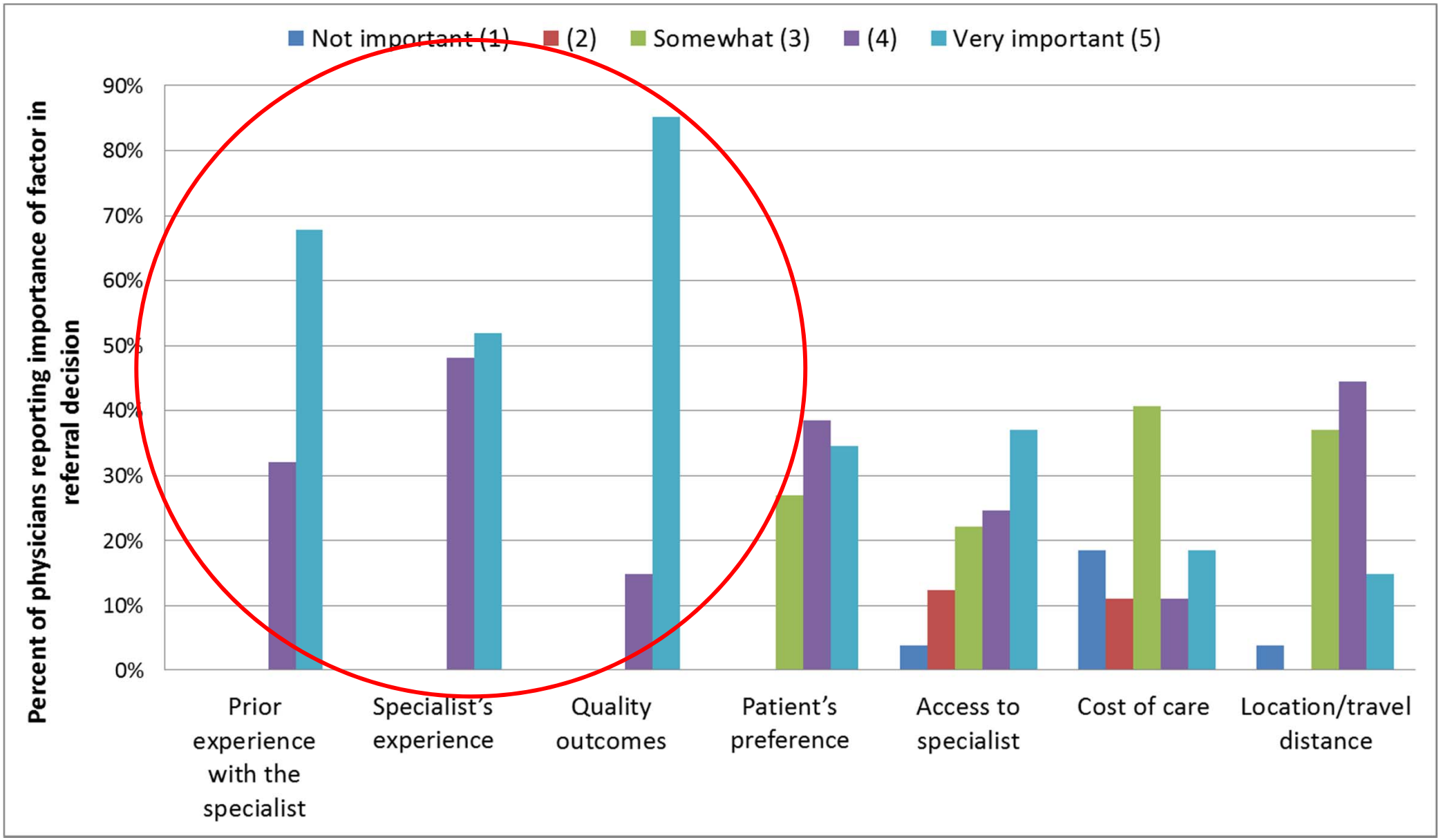
- All
  - Familiarity with/perceptions of health care reform (ACOs)
  - Potential for ACO success in Philadelphia
- Physicians
  - Current referral practices
  - What would it take to change practices?
- Hospital Executives
  - Current hospital structures and implications for ACOs
  - Role of physician-hospital organizational arrangements
- Payers
  - Willingness to invest in, participate in provider ACOs

Average physician profile

Physician characteristics			
	Penn-affiliated PCPs (n=10)	**Non-Penn-affiliated Community PCPs (n=10)**	**Specialists (n=9)**
Years in Practice	28	25	28
Practice Size (# Physicians)	6	3	13
Patients/Month	360	430	320
Knowledge of health care reform (% reporting that they are "very knowledgeable")			
Health care reform	20	11	0
Accountable care organizations	0	22	14
Patient-centered medical homes	20	44	14

How do referrals currently work? What factors drive referral decisions?

- On average, 20% of patients seen are referred
  - 50% for complex care, 50% for routine
- Physicians refer to an average of 24 different physicians in a given month
- Loyalty to an individual (e.g., *Dr. X*) stronger than loyalty to an institution (e.g., *Penn*)
- Factors driving PCP selection of specialists for referrals:
  - Survey question: “When referring a patient, how important are each of the following factors”

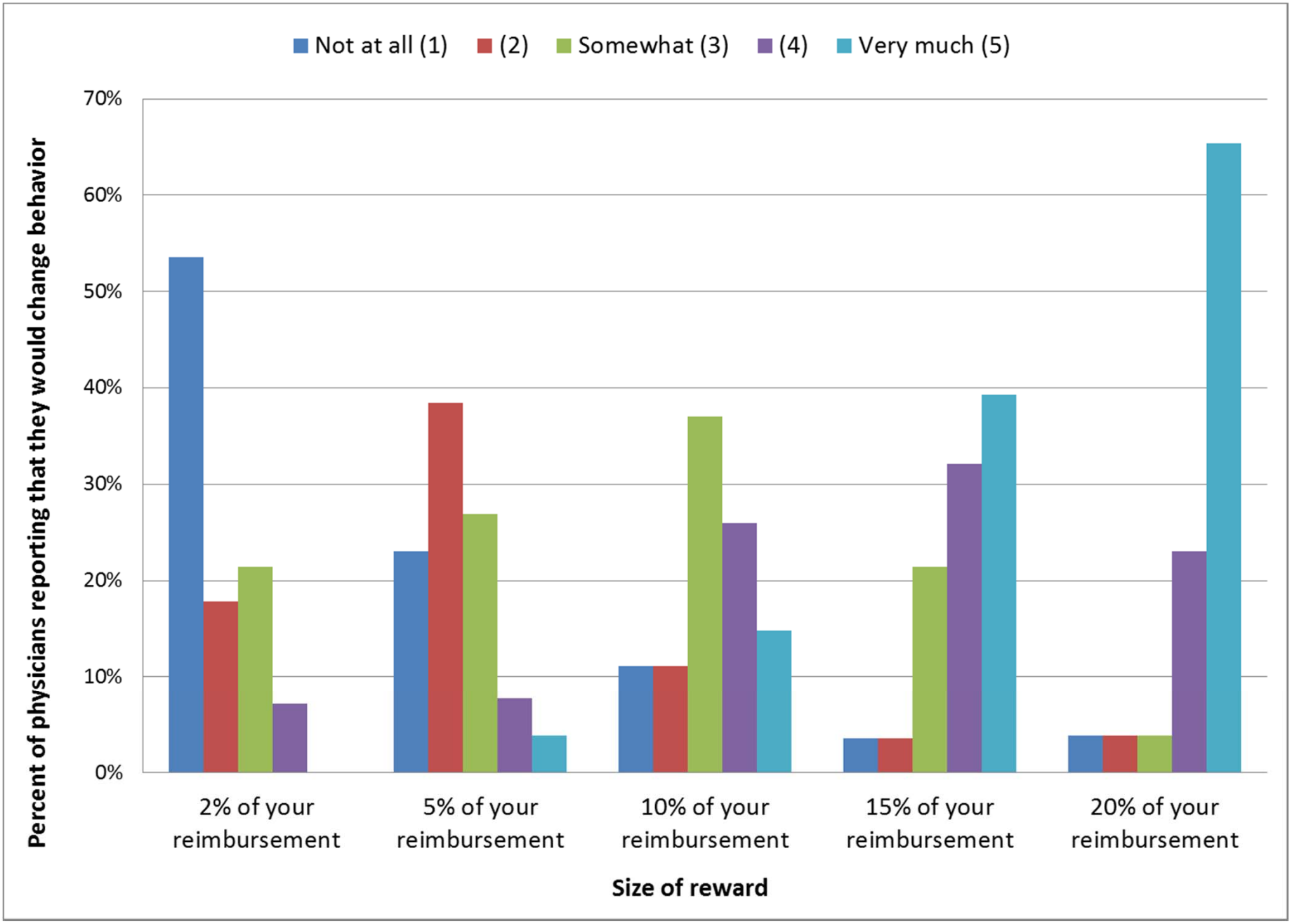


Current referral practices are "sticky" – largely based on personal connections and prior (positive) experience with the specialist

What would it take to change physician practices?

Survey question:

"If you were to participate in a shared savings or "P4P" initiative with an insurer, to what extent would your practice patterns and resource utilization change if the rewards from the payer were each of the following:"



→ Rewards need to be 10-15% of reimbursement for a substantial proportion of physicians to change behavior

Stakeholder views on and concerns about ACO development

1. Optimal size/structure of an ACO in Philly unclear
    - Major concerns: defining networks, managing/paying for out-of-network care, role of comm hosps vs. AMCs
2. Restructuring of relationships given role of PCPs
    - Hospitals concerned about PCP "buy-in," thinking about hosp-physician alignment, PCP employment
    - Physicians concerned about loss of autonomy
3. "Real-time" data is critical
    - Improving/enabling coordination of care
4. Physician reimbursement systems have to change
    - Provider groups at risk, P4P

Conclusions

- Current referral practices not aligned with an ACO-like model and hard to change

  → could impede efforts to implement ACO(s) based on formally-designated networks, evidence-based referral

- Difficult to determine optimal size/scope of ACO in Philadelphia market
  - Major concerns: out-of-network care, "real-time" data and analytics needed to support cross-system patient care
- Need to understand better how care coordination might look in different settings – no "one-size-fits-all" ACO model