Virtual First Care Coalition by DiMe Digital Medicine Society

Quickstart Guide to Partnerships between V1C Providers & ACOs

Are you a virtual-first care (V1C) provider seeking to build relationships with accountable care organizations (ACOs)? If so, this quickstart guide will support your efforts to establish successful relationships with ACOs.

ACOs | What are They?

- Groups of doctors, hospitals, and other healthcare providers come together voluntarily to provide coordinated, high-quality patient care.
    - Although initially conceived by the Centers for Medicare and Medicaid Services (CMS) to improve cost and quality for Medicare patients, ACOs have become an increasingly popular model in the commercial, payer-sponsored insurance market.
- ACOs types*
    - Hospital-based (owned): hospitals and health systems sponsored the majority of new ACOs from 2010 to 2015, 25% in 2018.
    - Independent: Physician-group-led ACOs are the dominant ACO model now, making up 45% (the remainder are jointly sponsored).
    - Physician-led ACOs tend to be smaller (e.g., 20,000 lives) and need more sophisticated health information technology and data analytics capabilities. Despite less capital, infrastructure, and experience managing risk, they have consistently achieved better savings and quality outcomes, lacking conflicting incentives to drive patients to hospital beds and procedures.
- Primary care is often the foundation of an ACO, but some have specialists and may include hospitals, nursing homes, and other healthcare facilities hospital-based ACOs.
- **Medicare Advantage** members are not eligible to join ACOs.
- **Payment model:** ACOs are the tip of the spear for the movement away from fee-for-service, volume-driven payment. ACOs share risk by agreeing to meet cost and quality targets, receiving a share of any savings it produces for meeting the targets (“upside risk”) but must repay Medicare for falling short (“downside risk”).

Penetration & Outlook Motivations

- The number totaled 483 in 2022; more than 11 million Medicare beneficiaries were in Medicare Shared Savings Program (MSSP) ACOs in 2021.
- Growth in Medicare ACO contracts has plateaued, and they are now outpaced by commercial and Medicaid ACO contracts (76%).

*Source

- It is more concentrated in urban areas, where over 20% of covered lives are in ACOs, but it is increasing in the Deep South and Northern Great Plains.
- Other value-based contracting models are emerging, including direct contracting and advanced primary care models, which promise to reduce administrative complexity, increase the potential for risk-sharing, and deliver up-front payments in conjunction with greater accountability for total spending and hospitalization rates.

Partnering Motivations

ACOs tend to focus on identifying and closing gaps in care for two reasons:

- ACOs have a strong diagnostics game and a desire to reduce wait times for patients needing specialty care.
- They want to discern their members' health challenges and create an efficacious care plan to treat them directly or refer them to a specialist if needed.

V1C providers can be effective partners to ACOs because their value-based, risk-sharing payment models align well with the efficient, goal-directed, outcomes-focused care that is the V1C trademark. A successful ACO carefully monitors and manages quality and cost: two areas where V1C can deliver value.

Practices within an ACO have more flexibility than traditional fee-for-service arrangements to provide non-traditional services that yield more responsive, high-quality, and cost-effective care. However, administrative complexity may impede contracting.

- **Identify and close gaps in care:**
    - Seek partnerships to close gaps in care, including investing in virtual services, public health competencies that address social determinants of health (SDOH), and care coordination to improve health economic outcomes.
    - Prioritize secondary preventive care, especially where it can reduce deterioration, unplanned urgent and emergency services, and hospitalization/re-hospitalization.
- **Improve risk adjustment:**
    - Payment to ACOs is tied to risk adjustment at the patient and population levels.
    - ACOs invest heavily in diagnostics and data analytics to stratify populations and enable accurate risk factor adjustment (RAF) scoring based on patient comorbidities and severity.

- **Augment primary care:**
    - Primary care takes a central role in the coordination of services across the care continuum.
    - Focus on meeting quality performance goals while minimizing duplication of services and optimizing the use of high-cost specialist care and services and procedures, especially services delivered by out-of-network providers.
    - ACOs typically want to keep the low and low-moderate end of specialist acuity in-house, so they invest in partnerships supporting primary care practices in managing these patients.

V1C Partnering Considerations

- **Close gaps in care and reduce unnecessary interventions:**
    - **Extend and support primary care:** Offer faster access to specialty care consultations to assist in containing out-of-network costs, collaborating to select patients most appropriate for ongoing care.
    - **Provide timely access:** Offer high-touch, high-cadence interactions for complex and at-risk patients to promote engagement, patient self-management, and care plan adherence.
    - **Improve risk stratification:** Specialty care V1C practices are uniquely suited to improve timely and accurate diagnosis and patient triage and facilitate member risk scoring for ACOs.
    - **Leverage digital medicine and non-traditional care teams:** Leverage care navigators, along with remoting monitoring supported by AI and clinicians, to monitor and intercept high-cost decompensation and escalation events.
    - **Close the communication loop:** Establish workflows and triggers for escalating care, clear communication, and data-sharing channels; be aware that you may need to document within the ACO electronic medical record (EMR).
- **Partnership & payment agreements vary:**
    - It may include services agreements and/or a Business Associate Agreement (BAA).
    - V1C may receive a membership fee, bill ACO directly for some services, and submit claims to insurance for others.
    - Consider innovative and differentiating clinical programs or agreements that include time-bounded outcomes targets for intensive care programs and transfer of care back to primary care.

Case Studies and Additional Resources

See how others are using these recommendations in practice:

biofourmis CareHive™ Heartbeat™ wellinks

Visit the **V1C Care Transitions Toolkit** to view additional helpful resources.