Better patient care, at a lower cost? A primary care doctor is testing new models to improve health care

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Christine Meyer, an independent physician in Exton, Pennsylvania, is always looking for ways to provide better care for the patients who come

to her primary care practice each year.

She and her team are spending 20 minutes, on average, with each patient—five minutes longer than they used to. Her office increased the number of clinicians on evening and weekend shifts to be more like an urgent care center; hired four remote front office staffers to make sure patient calls are answered promptly; and added a full-time "coach" to help patients with diabetes keep their condition under control.

What made those personnel investments possible—more than $550,000 last year alone — were bonuses she collected through programs that reward practices for providing high-quality care while also reducing costs.

Meyer's practice is part of a group that ranked fourth in the nation for its performance through an initiative started under the Affordable Care Act. Doctors can earn financial rewards when they more efficiently care for seniors covered by the government's Medicare program, compared to a cost benchmark.

The success affirms Meyer's commitment to doing her part as a primary care physician to solve the stubborn problem of ever-rising health care costs in the United States—which spends more and has worse health outcomes than any other high-income nation.

Other physicians increasingly are working directly for hospital systems, which claim that getting bigger through consolidation is a way to control costs and improve the way health care is delivered. But Meyer believes that independent primary care practices like hers have fewer of the financial conflicts of interest that can compromise efforts to reduce costs.

"It's hard when a hospital system is involved to really look at costs

carefully because by definition the hospital system is taking care of high-cost patients and they do things that cost a lot of money," she said.

An Affordable Care Act creation lives on

The Affordable Care Act expanded health insurance coverage to millions of Americans through Medicaid expansion and subsidies for individual plans. When President Barack Obama's landmark legislation passed in 2010, it also created initiatives to slow the growth of the nation's health-care tab, in part by reducing wasteful spending.

One initiative, the Medicare Shared Savings Program, allows hospital systems and doctors' groups, acting through Accountable Care Organizations (ACOs), to earn bonuses.

Meyer's practice is part of a statewide ACO that ranked fourth-best in the nation in 2022 based on how much less its patients cost Medicare than the benchmark. Her ACO beat the benchmark by 14%, and got to keep $30 million of the savings.

Meyer runs one of the 17 primary care practices involved in her ACO. She sees 1,600 of the ACO's 25,000 patients across Pennsylvania and is trying to keep them as healthy as possible, which reduces expensive hospitalizations. It is easier to understand the concept than say her ACO's clunky name: PA MSSP Legacy + Gateway Enhanced ACO.

The ACO is managed by a national company, Aledade, which helps independent primary care doctors manage their practices. Based in Bethesda, Md., Aledade currently runs 58 ACOs, and nine of them have patients in the Philadelphia area. Last year, it worked with medical practices that managed care for 1.2 million people with Medicare. The privately held company had $675 million in revenue last year, more than double its total in 2021.

An Aledade ACO with patients concentrated in Southeastern Pennsylvania ranked second nationally in savings, even better than the one Meyer participates in. The core of the physician practice in that group subsequently became part of Penn Medicine.

Meyer has seen mixed results from the experiment with ACOs.

She had been part of Delaware Valley Accountable Care Organization (DVACO), which started in 2013 as a joint venture of Thomas Jefferson University Hospitals Inc. and Main Line Health. But during her time with it, from 2016 through 2020, the ACO did not perform well enough overall to earn a bonus for Meyer and other doctors.

In 2022, DVACO earned a bonus for the first time since 2014. Humana Inc., one of the nation's largest private Medicare insurers, partially acquired it the same year for $50 million.

The model depends on health-care providers finding ways to trim costs, largely by avoiding hospitalizations and emergency department visits. Yet when that happens, hospitals lose revenue. The dynamic creates conflicts of interest, said Amol Navathe, an associate professor of health policy and medicine at the University of Pennsylvania.

"Different parts of the organization end up working kind of in tension with each other," Navathe said of hospital-system based ACOs. "On the physician side, it's cleaner."

Aledade's model

A big change Meyer appreciated after switching to Aledade was the company's app, which made it easier for her and other clinicians to get an overview of their patients' needs. For example, she can see when a patient has been in the hospital or is due for routine checkups.

"We could actually make outreach to our patients that needed care, needed attention, needed to be seen. That was a complete game-changer."

For each patient, Meyer also can see diagnoses, which specialists they use, and a score indicating how many health problems the patient has.

Care for a patient with a risk score of 17 will cost Medicare 17 times as much as an average patient with a risk score of 1, according to Aledade's calculations. Meyer sees risk scores well into the teens.

Aledade's practices, however, have come under scrutiny though a 2021 whistle-blower lawsuit unsealed this year. A former employee at the company alleged that Aledade encouraged doctors in its ACOs to make their patients seem sicker than they really are to collect more money from Medicare, KFF Health News reported.

Aledade called the allegations baseless. Meyer, who is not named in the lawsuit, said the claims made her "red hot" with anger.

"In my three-plus years with Aledade, I have never felt pressured, encouraged, or even subtly nudged to 'upcode' patient illnesses," she said.

How the ACO bonuses have changed Meyer's practice

Robert Burford, 67, a retired construction worker from Parkesburg, came to Meyer's practice for a wellness check Feb. 15. From the app, she could see immediately that he was generally healthy, with an extremely low risk score of 0.207.

Burford was nervous when his doctor's office started expanding. But he's happy that her office is now open for more hours, like an urgent care

center.

"They still listen," he said.

All of the 20,000 patients that Meyer and the 19 other clinicians see at her practice have benefited from the enhancements that she has made with the ACO bonus money, not just those like Burford, who have Medicare.

Before Aledade and other similar programs, Meyer and other clinicians in her practice saw an average of 3.7 patients per hour, regardless of their insurance. "We were on a 15-minute schedule, and racing from patient to patient," Meyer said.

Now they see an average for 2.6 patients per hour, which gives them more than 20 minutes per patient—and the practice's overall revenue has grown.

"It feels so good to be able to sit down, look your patient in the eye, not feel like you've got to get to the next person," she said.

During Meyer's first year with Aledade, she hired a diabetes coach. Since then, patients' scores have significantly improved on a test that measures how well the illness is being controlled, Meyer said.

She hopes these improvements will help her practice to keep advancing the quality of its care, enabling it to qualify for more bonuses. When her ACO beats the government's cost benchmark, it gets to keep 75% of the savings. Aledade splits the 75% reward evenly with the practices, based not just on how many patients they see but also on quality of care.

But if the ACO spends more than projected and has to pay money back to Medicare, Aledade takes the downside risk, which could mean paying

75% of the overspending back to Medicare.

"That's critical for a private practice. None of us is sitting on a pile of money that we could pay back to Medicare if we have a bad year," Meyer said.