# Unify ACO Quality and Cost Initiatives to Boost Long-term Results

written by Dave Halpert | April 19, 2018

Let’s face it. There’s a pretty low bar to meeting Medicare’s ACO Quality requirements. Most ACOs have achieved acceptable quality performance for Medicare Shared Savings Plans (MSSPs).  They have not, however, achieved the savings needed to be successful.

ACO supporters point to the “Triple Aim” of achieving higher quality, cost savings and good patient experience through an ACO. To fulfill that tripartite goal, we must look past the hype and execute quality-cost initiatives that go well beyond CMS requirements.

# Recognize the Gap Between Quality Reporting Requirements and Quality Care

Demonstrating quality and reducing costs are not mutually exclusive. While there isn't an automatic link between your ACO's success in reporting and its ability to control costs, your biggest savings should be realized by focusing your quality efforts on improving patient health status while designing better care delivery. Note that Quality and quality reporting are distinct.

The link between quality and cost, however, has not been well demonstrated in ACO performance. Quality reporting scores have increased in each of the last three years; in 2017, the average quality score was 94.65 percent. Although quality reporting is successful (both in terms of completion and performance), more than two-thirds of ACOs saw zero shared savings. Only 30 percent of ACOs reaped the benefits of the $700 million distributed by CMS.

To understand how ACO quality reporting can mean so little in terms of savings, let's examine the ACO quality requirements. ACOs are only required to report 15 measures; the remaining measures are calculated from patient surveys and through CMS administrative claims. Those measures are abstract and out of sight.

ACO quality measures also do little to demonstrate patient health outcomes. The 15 measures actively reported consist of 8 preventive care and screening measures, 2 care coordination measures and 5 measures related to chronic conditions. The majority are "process" measures that track whether basic services were provided to patients. In addition, the ACO only reports measure results for a sample of 248 consecutively ranked patients; as a rule, ACOs don't track quality across entire populations nor establish standards based on patient risk. Considering that an ACO has a minimum of 5,000 patients, it is hard to see how quality reporting provides an accurate indication of the ACO's standard of care.

For many, the quality reporting process is simply a matter of hiring and/or reassigning clinical staff to review charts to determine whether an action was performed, or to record the most recent value for a given test. As a result, the "get it reported" mentality removes quality from the equation; the task of reporting becomes an exercise in administration and work-hours. This is perfectly illustrated by the 2018 and 2019 ACO Quality benchmarks. Certain measures are simply graded on a 10-point scale, without consideration of the ACO's past results, the existing population or other ACOs' results.

Predictably, the vast majority of ACOs succeed in reporting, but are not demonstrating their financial value to the level anticipated by the Congressional Budget Office (CBO).

# Making Real Improvements in ACO Quality and Cost Savings Requires a Plan

To achieve cost savings in patient care while promoting better health outcomes, providers will need to unify their view of costs and quality. There are some quality metrics that do tie to cost, but since they're calculated by CMS, they're invisible. ACOs need to be proactive and move these into a unified quality-cost measure set for internal performance measurement.

The usual suspects of excessive costs—readmissions and preventable admissions, emergency department utilization, network outflow—often are ACOs' first targets for measuring cost performance. That's a good step in the right direction, but as a sole cost strategy,  too limited. It's true that post-acute care coordination or similar processes will produce savings from long-standing issues like readmissions. But a more comprehensive approach to redesigning care for groups of patients most likely to generate these issues, such as patients with Chronic Heart Failure, can yield lower costs associated with readmissions as well as preventable admissions and emergency use.  By combining measures associated with patient outcomes, population health processes and coordination of care, along with costs, ACOs can more effectively tackle the quality-cost performance challenge across all dimensions.

# How ACOs Can Establish Integrated Quality and Cost Measurement

Integrating quality and cost performance will involve a holistic review of care delivery and costs. There are starting points within the existing quality measures that you may use to link quality and cost, but don't box yourself in! For example, there are no quality measures related to some of the specialty-specific Advanced Alternate Payment Models, such as Bundled Payments for Quality Improvement (BCPI) or the Oncology Care Model (OCM). If you are able to reduce costs on hip and knee replacements, however, creating joint replacement episodes may still be a viable, measurable quality outcome and will contribute to a larger shared savings pool.

You will maximize your performance by targeting high cost conditions and establishing both quality and cost measures that reflect patient outcomes and cost.  Let's see how this could be accomplished for patients with diabetes and heart failure, specifically focusing on hospital admissions:

# 1. Reduce admissions related to diabetes and heart failure.

ACOs that can shift spending to office and wellness visits are more likely to generate shared savings. CMS is already using its administrative claims to track Ambulatory Sensitive Condition (ASC) admissions for diabetes and heart failure; you can take proactive steps to influence these, rather than just wait for your results. Consider developing your own quality metrics and measure their impact on ASC admissions.  Avoid the measures you're already reporting.

The most recently released results show that ACOs averaged 53 unplanned diabetes-related admissions and 75 heart-failure-related admissions per 100 eligible person-years (how long a patient has been an attributed ACO beneficiary). Person-years adjust annualization to make sure that ACOs aren't rewarded for controlling costs over a year for a patient when that patient was only attributed for a short-time (e.g. a patient became Medicare-eligible halfway through the year). ASC admission rates range widely for these conditions. Unplanned diabetes admissions range from as few as 35 to as many as 160, while unplanned heart failure admissions range from 40 to 187.

ACOs have an opportunity to drastically reduce preventable diabetes and heart failure admissions and their associated costs. Your strategy should focus on potential gaps or stagnant outcomes in your patients' care, and address the reasons for it.

# 2. Review your provider network to ensure that your patients have access to the appropriate specialty mix.

To avoid a gap in specialty care for patients with high-risk conditions, you will need to fix the gaps in your network, either by engaging physicians as full participants or as "other entities." If your ACO does have access to specialty providers, you will need to identify gaps in that access, such as lack of transportation or scheduling availability. Patients who cannot access necessary specialists will go out-of-network for such services, including for emergency and hospital care.

## 3. After establishing that your network has the breadth to handle patients with complex chronic conditions, develop metrics for tracking their care that can blend quality and cost.

For example:

Develop and track a Shared Decision-Making (SDM) Initiative. If primary care providers can engage in a Shared Decision-Making processes with patients, including discussions about barriers to treatment, risks, and relevant research studies, you may build patient engagement along with lower costs of care. The ACO can track results of patient outcomes, costs, and appointments designated to discuss treatment options, as well as patient-selected treatment decisions. SDM must be carefully designed to ensure appropriate time for physician-patient conversations, but with some patient groups, this approach can have a quality and cost pay-off for the ACO.

Encourage and track Annual Wellness Visits (AWVs). In addition to being a critical factor for ongoing patient attribution, these visits are an opportune time to discuss your patients' goals and the strategies to meet them.

Analyze data for the patients who had previous ASC admissions and/or readmissions. For readmissions, determine if is there a common thread (e.g. one post-acute facility vs. another) that will lead you to a coordination-of-care solution or post-acute negotiations.

Measure post-discharge follow up. For patients who have been admitted, look at who was seen within seven days of discharge. In addition to the visit itself, the ACO should track patient feedback from this visit to identify those at-risk for readmissions, such as patients who do not understand discharge instructions, or patients who do not have home care and/or support.

## 4. Engage patients and providers in immunization campaigns.

CMS tracks ASCs related to acute conditions, such as pneumonia, as well as ASCs for chronic conditions. The average cost for a pneumonia-related hospitalization is $9,700. These are not "expected" costs, and an ACO whose patients incur them will see a reduced savings at the end of the year—and a more vulnerable patient population. Therefore, immunizations (a quality reporting measure) and ASCs for the corresponding conditions (CMS cost calculations) should be tracked together.

As more patients receive the immunization, performance rates on the corresponding quality

measures (ACO-14 and ACO-15) will improve. If you decrease preventable hospitalizations at the same time (ACO-43, the Ambulatory Sensitive Condition [ASC] Acute Composite), you will have secured your potential shared savings pool.

It's all too easy to see quality reporting as your sole ACO quality responsibility. But getting caught up in reporting nuts-and-bolts misses your ACOs real opportunity to achieve the Triple Aim. Consider, instead, how you can use your data to design quality and cost performance improvement using integrated metrics. Ambulatory Sensitive Condition Admissions (along with all cause re-admissions, SNF re-admissions, and patient experience) can provide a road map for your ACO, enabling you to identify areas of concern and to address them with long-term solutions, rather than short-term patches.

*Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.*

Image Credit: Chris Charles