New ACO Playbook: To Show Standout Performance, ACOs Must Rethink Quality

written by Theresa Hush | May 24, 2021

The health care media are full of articles asserting that ACOs have proven their mettle in delivering health care of highest quality. Citing ACO quality reporting results, CMS and advocates point to the majority of ACOs passing CMS quality standards, and that ACOs are improving their results on quality measures over time. The vast majority of ACOs meet quality measures, with 92 percent passing the qualification for shared savings in 2019.

But is quality performance a distinguishing feature that ACOs can use competitively—and sustain the payment model's long-term prospects? To earn permanency and competitive advantage, ACOs must show that the payment model galvanizes participating providers to perform better than non-ACO groups—specifically, direct contracting entities, Primary Care First groups, and equity-backed practice organizations. While difficult to measure, however, there is some evidence that there is little distinction in quality between regular physician groups and ACOs. We have also questioned whether savings levels have sufficiently advantaged ACOs to be able to argue for continuation of the payment model.

Without a distinction for better outcomes, ACOs miss an excellent opportunity to guarantee survival. With a good public relations strategy of indisputable quality metrics, ACOs could rally patients and physicians alike to their cause. Unfortunately, ACO quality performance, while meeting the standard set for the program, doesn't actually help ACOs stand out as the path to highest quality health care. Why? Both *what* is measured and *for whom* does not go far enough to achieve that goal.

Let's examine current quality performance systems and how ACOs could redesign their own efforts to improve their positioning—while delivering improved results for patients.

How ACO Quality Works, and Where It's Headed

Requirements for ACO quality have changed over time, but have always included patient surveys, CMS-calculated measures, and ACO-reported patient quality measure results. The ACO quality framework was once distinct from other CMS quality programs, but this is changing. The late 2020 introduction of the APM Performance Pathway (APP) applicable to MIPS ACOs (ACOs in the beginning stages of downside Risk adoption, with practitioners subject to MIPS) puts ACO Quality more in line with MIPS, beginning in Performance Year 2021.

The APP has a single score, like MIPS, and includes the same four components: Quality, Promoting Interoperability, Improvement Activities, and Cost. These components can be reported and/or calculated differently for ACOs. As in the past, the Quality component involves surveys of patient health care experience processes performed by a certified CAPHS vendor, CMS-calculated quality measures based on beneficiary claims, and ACO-reported quality measure results.

But the APP is different for one major reason: the quality measurement includes *all* patients in ACO participating practices, not just Medicare or attributed patients. Until the 2021 Performance Year, ACOs used the CMS Web Interface to report quality for a small sample of 248 ACO patients that were loaded by CMS into each ACO's Web Interface app. The ACO staff then worked with ACO participating practices to gather the measure results for those patients. This sample and pre-populating with claims data made it easier to meet quality requirements.

The quality reporting burden on ACOs was reduced by the APP in number of measures, from a high in 2013 of 22 ACO-reported measures, to the 2021 levels of 3 using the new APP reporting method. But it vastly increased the volume of patients for whom quality must be reported under the three measures.

After pressure from ACOs, CMS then allowed continuation of the Web Interface reporting

method as an option for 2021 only, with reporting of the 10 previous measures. The National Association of ACOs (NAACOS), joined by other medical associations and lobbying groups, is continuing to object to the APP rule for 2022, however. If successful, this will hurt the ACOs in the long run. Here's why:

ACO Quality Measurement Harms ACOs by Curtailing Data to Improve Care.

ACOs may feel validated by the good press on ACO quality. But even—and, perhaps, especially—if they succeed in sustaining the prior method of ACO-reported measures through a sample of patients, they will soon find themselves unable to demonstrate their Value compared to medical group models that have pursued a different payment model, or to Medicare Advantage. They simply won't have the data to do it.

The need to have data collection from all practices is the very essence of what ACO advocates are fighting in their quest to change the APP method of reporting. They perceive it as expensive and burdensome to do. And they have acknowledged that they do not collect that data now.

Yet, collecting outcome and transaction data for the practice population is essential to improving patient outcomes and important for Risk payment model success. It allows the ACO to create metrics of quality and outcomes beyond APP measures, which are at best simplistic measures of an ACO practitioner's quality profile. Take this hypothetical scenario, using one of the three APP measures:

> Would you be satisfied to know that your physician met quality requirements for diabetes care based on one HgbA1C value every year? And that your physician group passed quality if more patients had values under control?

One might consider a HgbA1c value to be a minimum bar for assessing the status of diabetic patients. We might also attribute collective lower ranges of levels to indicate quality success. Without more data, however, we actually don't know anything about the quality of care. Does the measure result reflect a lower risk practice, or a more successful practice? And if the measure results in practices with higher values, does that reflect a problem in quality, or a higher-risk patient load? Static quality snapshots tell us little about quality performance, and they can't help to determine a plan to improve outcomes.

The common flaw of CMS measures under both MIPS and ACOs is that they have failed to evolve into outcomes based on better data. But that data is available, and for ACOs it should be put to use in advancing better care.

ACO Quality Measurement That Is Out of Sync Across CMS Programs Puts Physicians at a Disadvantage

Remember the days of pre-pandemic travel, when flight attendants recognized their airline competitors and thanked passengers for choosing them? ACOs would be wise to understand that they are in competition for their physicians, unless those physicians are under salary. Those physician groups are often in competition for patients, and patients are increasingly guided by data. Many physician groups are participating in Risk agreements that require them to improve outcomes to reduce costs.

If the MIPS-reporting physician groups can report quality metrics based on all their patients, yet ACOs do not, over time this will prove a competitive disadvantage. The different payment models and changes in medical group ownership guarantee it.

Separate reporting rules make comparisons between non-ACOs and ACO results even more difficult and cumbersome. They also negate the ability for ACOs to compare themselves with competitors like Medicare Advantage Plans.

Three Ways That ACOs Should Rethink Quality

To make a name in quality, think of how Cleveland Clinic is "doing" heart. They collect all their patient encounter and clinical data and organize specific clinical episodes. Then they evaluate the episodes to identify clinical or administrative triggers that cause outcomes or costs to go the wrong way. They tailor interventions in their processes, and continue to evaluate data in a feedback loop to improvement. And then they develop a content marketing strategy and broadcast their quality—not in Cleveland and in its suburbs, but in other markets like Chicago.

This is what competition looks like, and it is the future. How do ACOs need to rethink their quality programs to meet those challenges? Try some of these basic strategies:

1. Create a vision for quality that is separate from regulatory quality reporting.

Regardless of regulatory requirements, ACOs must chart a path that focuses on where they can excel and how to attract physicians and patients. For ACOs based in primary care, that focus may be on prediabetes and metabolic diseases and their complications. For multi-specialty ACOs, it may also involve other areas of clinical excellence like orthopedics or neurology, high volume services that attract patients. ACOs that develop a quality agenda beyond measure-based reporting can involve physicians in envisioning better outcomes and be aspirational.

Aspiration creates leadership, which, in turn, energizes the ACO to make that vision reality. Anyone who has started a business will tell you that aspiration and energy are keys to growth.

2. Get the data for quality measurement and do much more with it.

Patient data should never be single purpose. Look at your patients not by condition, but by 50 different metrics on how they found you and what they are getting from you (or elsewhere), and what services they received, before they disappeared. Also examine outcomes by individual conditions, by episodes that package all services, by cohorts that examine core conditions with disease progressions, by conditions with various treatment regimens. See which providers are treating patients and look at patients whose treatment regimens aren't improving their outcomes. In these data are the revelations that will define many paths to improvement that will both improve patient outcomes and save money.

3. Involve your physician in data.

Don't start with scoring; it will inevitably spark push back. But give physicians insight into the ACO patients and ACO costs, and how they figure into it. Start small with patient cases, but share feedback on how they compare, and how their costs and outcomes compare with similar specialists. Find mechanisms that are effective for physician discussion and participation, as a learning process. Ask for their contributions to improvements.

If ACOs intend to be known as leaders for quality and efficiency in health care, they have to do more than achieve regulatory compliance. They need to break through the competition. ACOs can demonstrate improved outcomes and better quality services because they can organize and inspire their providers to make it so, while payers cannot. Now is the time to start using their best hand, rather than playing "safe."

Founded 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.

Image: Uriel Soberanes