New ACO Playbook: How to Supercharge Your ACO

written by Theresa Hush | October 21, 2021

Throughout the last decade of ACO development, many have struggled to identify what actually makes ACOs successful. Analyses have been fraught with conflicting conclusions. Studies have tagged type of ownership (hospital-based vs. physician-led), geographic region or urban-rural factors, primary-care-only versus specialty participation, ACO payment model type, patient volume, and operations strategies as links to success or failure.

While such studies are often insightful and worth considering, they won't pass scientific muster. That's because ACO success does not depend solely on an ACO's organizational attributes.

Success in Your ACO Business Is Driven by Vision and Execution

Like every business trying to achieve goals and make money, your ACO is driven to success by *internal energy and vision*, combined with *good execution of strategies*. Without both of those, you can't reach any of these touchstones for success:

Higher savings

More patient volume
Better health care outcomes and health care experience for patients

To Really Succeed Against Competition, You Must Reach a Higher Benchmark

To attract physicians, recruit patients to your providers and facilities, and sustain CMS continuation of the ACO MSSP model in the face of competing alternatives to achieve federal goals, you must achieve these targets *to the maximum degree*. Otherwise, you are vulnerable.

You can't just moderately succeed by producing savings compared to your ACO algorithm for savings. You will need to lower the total cost per patient compared to benchmarks related to others, such as competitive groups, regions, risk levels, and prior experience. Why? You will always be compared to competitive models, and your comparative value must be clear.

Supercharge Your ACO with Tools for Success

Throughout this series we have presented many specific strategies that may either help you to make your ACO achieve higher value, or, because of your particular ACO environment, may not be appropriate. ACOs will need tools that are plug-and-play with their specific systems, physician network, and competitive environment. But there are common ingredients for every ACO, and these are the essentials:

1. Let vision develop your ACO, not regulatory reactivity. Create your ACO as a forward-thinking leadership venture in medicine, not an administrative back office.

Positive energy and inspiration create culture and "brand" that your clinicians can associate with clinical excellence and patient service. Whether you're a large or small organization, if your objectives focus on coordinating care rather than advancing patient care, your ACO will not weather the competition. Ask these questions to evaluate actions you might take to strengthen your ACO's backbone:

Is clinical leadership included in the governance of your ACO?
Does your ACO communicate with physicians routinely on ACO initiatives and recruit physicians to participate in crafting improvements?
Are you working with practice ownership and management to provide physician

incentives and time to participate in data review, clinician review of patients queued up for possible intervention, and participation with improvement programs?
Are your improvement activities only focused on administrative activities, or do you have specific outcome improvement activities that involve clinicians?

2. Technical infrastructure is a necessity to ACO business. Data provides the pathway to all of your initiatives, and patient data requires a safe place.

Whether you build or buy your technical infrastructure (or use a hybrid of build and buy) is a question of your size (money) and expertise. You can purchase secure technology infrastructure services reasonably on an annual basis, even if you are small. You should not store and use data on your own systems—including claims data and population health—when that data has any personal protected information, unless you have technical architecture that is continually tested and has layers of security. If you are purchasing services through a vendor, your serious review of their data architecture and security is a must. HIPAA-compliant is a baseline requirement for systems—but HIPAA is not a data architecture, it is an overarching rule. The devils in security are truly in the thousands of detailed settings of storage and access to data, continual testing and review, and more eyes on security.

The minimal technical infrastructure for ACOs is a database (see 3, below) with applications for using its data, including analytics, patient episodes or another cost engine, quality measurement and population health. You or your providers will also need tools for communicating and sharing information with patients, including transparent pricing. In addition, you will need to facilitate access to patient records from your providers for your patients, and from provider-to-provider.

3. Build data sufficiency as the generator for ACO initiatives.

Your ACO should be collecting patient-identified clinical data, social determinants, and prescribed drug data from provider systems. Integrated with claims data, this provides you with both comprehensive and detailed data for macro-analytics on costs, and microanalyses of patient episodes based on procedures and conditions. Ask these questions to determine if you have enough information to create significant population health interventions:

Can you identify patients that have persistently poor control of their chronic conditions, based on risk indicators and outcomes over time?

Are you able to track any episodes of care, either chronic conditions or procedures?

4. Use patient episodes of care to prioritize cost and outcome improvement programs for patients of highest risk.

You can create patient episodes by organizing services by common chronic conditions and by including all services that are related to those diagnoses within a defined period of time. Time-based patient episodes give you information about which factors drove higher-cost episodes. Across all practices, you will be able to identify patients for clinician review, changes in treatment plans, medications or monitoring through devices and wearables. Ask these questions to evaluate whether your strategies are taking advantage of good data:

Are your clinicians able to view comparable costs of surgical procedures for their referral specialists?
Can you identify patient cases where earlier intervention may have avoided suboptimal outcomes or progression of disease?
Are you able to include patients with risk factors like diabetes in your population health program?

5. Physician-focused collaborations and improvements are a must for supercharging your ACO's receptivity to physicians.

Avoid passive communication with physicians in favor of collaborative investigation of cost drivers, data sharing, coaching, and development of improvements. Ask these questions to see if your physicians are receiving better information from your competition:

Are your physicians seeing "cost data" through benchmarks or scores? If they are, you are missing the opportunity to receive feedback on cost drivers. Scores are not data; they are judgements.
Are your physicians involved in clinical intervention developments as a result of episode-revealing analytics?
Do your physicians have routine access to ACO analytics?

6. Universally applied quality and evidence-based measures (like ACO Performance Pathways “APP” along with customized evidence-based measures derived from condition episodes) will help your ACO bridge quality and cost, and boost savings.

How? Measuring your providers’ patient population on an ongoing basis enables you to identify patients with needs during the course of the year. These patients can be queued up for clinician review or for visits based on measure results, so that you are both improving quality and preventing deterioration of the patient’s condition. End-of-year quality reporting deprives you of initiative. Progression of disease, continuation of low-value treatments, and disabling risk factors affect your total patient care cost. Ask these questions to examine whether you are prioritizing quality efforts for your ACO:

> Are you using patient sample data (web interface) to complete your ACO quality reporting, or is data insufficiency disabling your view of services and costs for all patients?
> Have you set clinical or other measures that are consistent with ACO aspirations of patient care?
> Is your population health triggered only based on post-emergency and post-admission data, so you cannot prevent occurrences?

7. Create a multi-dimensional improvement program that prioritizes at-risk patients in various populations, identified by patient risk factors, conditions, and outcomes.

Some ACO improvements programs have been lopsided in favor of administrative outreach based on data paucity. Tackling the largest issues impacting costs—behavioral health is a big one—requires ACO intention to arrange external and community resources or involve clinicians in integrated primary care/behavioral health initiatives, fueled by sufficient data to identify patients at risk. So, too, will analytics certainly identify patients with high risk on outmoded pharmaceutical regimens, sometimes due to financial issues, that require clinician review in a systematic improvement effort with pre-identified patient populations.

Supporting physicians in meeting ACO benchmarks means facilitating practices with the ability to easily review and schedule patients who need services, aided by data-driven patient

populations built on episodes that identify patients with risk. Ask these questions to evaluate your opportunity for engaging your ACO clinicians and staff:

> Are your improvement efforts focused exclusively on post-event outreach to patients, to avoid the next instance of costs?
> Do you have formal referral arrangements for services that your ACO providers don't offer, including specialty and behavioral health services? Do these arrangements include shared data agreements with cost and quality evaluation, and your clinicians' feedback?
> Is your population health program capable of identifying interventions based on patient risk factors and clinical treatment?
> Do you provide or arrange patient programs for education and risk prevention or management?
> Besides required patient surveys, do you collect any patient-reported outcomes?

You *Can* Supercharge your ACO!

CMS and other payers are frustrated that Fee-for-Service incentives still drive health care cost escalation. The Medicare Trust Fund is predicted to run out of money by 2026. The bleeding must stop. There will be payment models like capitation and other risk models—not just for ACOs, but for most providers. The fact that physicians are exiting private practice and are attracted to organizations that can provide data and support is an indication both that physicians, for their part, understand the future, and that they will need support to participate in risk models.

Consolidated entities like equity-funded practice organizations, MSO-equity-funded partnerships or owned practice organizations, and health-system-funded practices are surging because they see an opportunity to drive their destiny through Value-Based Care. All these organizations are making investments in the tools for success.

You can be a small, physician-driven ACO and, with vision and clinical leadership, make small but annual investments to put your ACO in the Supercharged mode.

You can be a community-based hospital-run ACO and, with vision and clinical leadership, reinvent your future with reasonable investments to put your ACO in the Supercharged mode.

You can be a heavyweight system that is still counting Fee-for-Service revenues, and turn the ship toward Value-Based Care, either through an ACO or one of the competitive models, in Supercharged mode.

What you can't do is simply ride out the trend toward improving health care for your patients while holding costs down, without deteriorating your physician network and patients. Your size may give you more time or less for that ride, but your ACO will crash. It doesn't really matter whether your opportunity is the ACO shared savings plan. What matters most for your future—and will transcend any value-based payment model—is that you are Supercharged.

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Image: Yale Cohen