With Competing Payment Models on Hold, What's the Future for ACOs?

written by Theresa Hush | March 19, 2021

When CMS first announced new primary care payment models in

April 2019, ACOs understood that their future might be threatened by competition for both physicians and patients. If medical groups could independently contract with Medicare under these models, they would have the advantage of greater control over their physician network, referral arrangements, and clinical decisions.

The Value-Based primary care models of Direct Contracting (DC) and Primary Care First (PCF) were presented as a strategy to fortify primary care and independent practitioners. By combining prospective payment, quality monitoring, and incentive pools for lowering admissions and total costs, providers could potentially reap the benefits of risk without the go-between health plan or an ACO. But these models also served a key goal for CMS to move providers away from Fee-for-Service reimbursements.

Now CMS is walking back some of the previous administration's decisions and reviewing these payment models—as we predicted. While this is a "normal" reset to evaluate prior programs within a larger programmatic context, there's good reason to expect that the Geographic DC Model will not see the light of day. It's unlikely that the PCF model for highest risk individuals will come to fruition, either. What that means for the ACO MSSP (Medical Shared Savings Program) model—given a recent delay in the applications schedule—is sparking new speculation. Here's what's at stake:

With New Health Care Imperatives, What Models Make Sense for the Future?

The fragmentation and fragility of our health care system has never been clearer than this past year, along with our system's

strengths. The difficulty of implementing a public health response through private health care systems and entities, and the uneven capabilities of different communities, evidence the urgent need to reassess goals to achieve real Value for the health care system. Those goals are at least partly engineered through federal policies. And with a stated intent of creating a public option for health care coverage, they will certainly get a diligent review.

The stream of changes and new models announced under the prior administration had a common theme: move toward risk-based reimbursement for providers. These shifts were also often disruptive. Rather than building on prior initiatives and revising them, the new models demonstrated a change in course. This was especially true not only of changing reimbursement models, but also of whole systems of care.

ACOs, along with Direct Contracting, Primary Care First, and Specialty Care Models—plus Medicare Advantage—now all overlap in a complicated and sometimes competitive approach to providing and financing health care. To see how this works (or, rather, doesn't) let's examine the announcements to bench Geographic DC and the PCF High Risk models while review is underway.

Who Leads Health Care in Communities?

Some CMS primary care models challenged the structure of health care leadership in communities, as well as who can take responsibility for the most vulnerable patients. That was definitely on display with Geographic DC as well as PCF High Risk.

In most large and mid-sized urban areas of the country, local competition between providers is strong, even fierce. Physician and patient loyalties matter, and both large and small systems have become more vertical with hospital-owned physician practices. The opposite is true of rural health care, where there may be only one hospital and few physicians, and patients must travel far to access either.

The Geographic DC model depends on carving up territories for Medicare patients. Urban health systems have struggled for decades to breach the boundaries of these territories, in order to create larger referral networks for patients. They set up outposts for primary or specialty care in communities already occupied by competitive systems. But rural networks are largely so cash poor that it would be next to impossible for them to take a shot at this program.

Even if we assume that the Geographic DC model could work in urban areas, who could lead a successful system for patient care that involves competitors? Providers have invested in their own physical plants, networks, and technology arsenals. They conduct competitive research and other functions. Gaining a voluntary cache of patients under risk-based payment is not enough of an incentive for them to exert effort over a larger territory. They already have all the patients they can handle, in many cases. Risk upsets their current incentive and revenue structure for just one segment of their patient population. Why bother?

Those most likely to try and organize geographic contracting regions are health plans and equity-backed groups with the capital and entrepreneurship to do so. Health plans have the

history of behind-the-scenes partnerships with ACOs, and some primary care-based equity groups have growth plans tied to population risk payment. But neither arrangement may be compatible with the current agenda focused on repairing health care fragmentation and health inequities. Without that compatibility, the prospect of spending political capital on Geographic Direct Contracting seems unlikely.

What Role Should the Public Health Care System Play in Value-Based Care?

The PCF High Needs, Seriously Ill model goes straight to the community system of public hospitals, clinics, federally qualified health centers, and private providers. These often overlap geographically. The model creates potential opportunities for collaboration among entities, and some individual organizations might be interested.

Even if providers see an opportunity, however, there are two reasons why a commitment to a large-scale program for a PCF population with special needs is unlikely. First, the payment model is capitated Risk, with success hard to achieve. For politically rooted public systems, it is doubly hard. Second, there will be political concerns about whether the model promotes a separate and unequal system of care.

Both obstacles will winnow the field of providers willing to participate to a small number. It may be small enough that the truly interested providers—and CMS—might decide to accomplish such a program through a single demonstration program and waiver, rather than a formal process as outlined. This would make it less expensive and less problematic, but not less complicated in an integrated Value-Based Care effort. In the

end, a small-scale experiment that cannot be replicated may not be worth the effort. Instead, there may well be a desire to create models that can foster the best solution for people with high needs, wherever they live and access health care.

How Do ACOs Fit into the Future Landscape?

One of the more obvious lessons of ACOs in recent years is that the category is not homogenous. Large and small, new and experienced, successful and not, risk-averse or pro-risk, independent providers or cohesive network, hospital or physician-based—it's hard to characterize a model so individually configured. In addition, ACO results are driven by non-generic factors, activities they have pursued, the connection with ACO participating physicians, and the particular patient population. In short, the future of ACOs is unlikely to be defined by simple criteria, and certainly not only by total cost savings.

The last few years have focused on ACO savings and payment models, with a movement toward standardizing quality requirements across all providers while reducing the number of quality measures. But there has been little activity in pushing the agenda of outcomes improvement, of illness risk reduction, and activities that will generate large long-term cost reduction. The Diabetes Prevention effort, which stands apart, has no place in any of the new payment models. As the new administration focuses on health disparities, risk factors and activities to improve results will probably emerge as more important.

These activities depend on data and clinical improvement strategies. ACOs consisting of independent or disparate

provider groups may have a much harder time leveraging these tools. Many lack the infrastructure and provider source system data to examine costs and clinical outcomes on a detailed basis. While there will still be easily achieved savings from care coordination and reducing costs of specialty and post-acute services, the pot of gold is found by engaging providers and patients in care and clinical decision-making.

The future for ACOs will hinge on how fast they can mature from invisible administrative entities into systems with the most improved outcomes and costs. If they can provide the central hub for data and tools to help participating physicians and patients improve, ACOs will grow into permanent, essential care models. Their alternative is to remain payment models with a future that awaits all payment models: eventual replacement with a newer design.

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Image: Dan DeAlmeida

Why Health Equity Will Be Measured in Value-Based Health Care

written by Theresa Hush | March 19, 2021

After the first wave of COVID-19 case numbers and deaths in

Spring 2020, it was Mayor Lori Lightfoot of Chicago who broke the story of how the virus was distinctly ravaging Black and brown communities with higher hospitalizations and deaths. In Chicago, alone, Black residents were dying from COVID-19 at six times the rate of other Chicagoans. While the virus has been unsparing across the board, there is a tragic trifecta—people who are older, or of color, with serious underlying conditions, are dying in greater numbers, with a disproportionate percentage of deaths afflicting underrepresented groups.

COVID-19 is not unique in exposing the inequitable consequences of worse risks and insufficient health care among people of color. From rates of maternal death to outcomes in metastatic breast cancer and cardiovascular disease, people of color and women fare badly. But the COVID-19 tragedy has raised consciousness politically of health inequities and is now an articulated priority in the new president's agenda.

Women, especially Black women, have faced an uphill battle on achieving good health care. Distrust in their reports of symptoms, prejudices about motives and even scientific realities, shortage of research focused on women and women of color, and poor treatment are but a few of the obstacles. One of the most heartbreaking stories recently involves Dr. Susan Moore, a Black doctor who contracted and then died of COVID-19. Despite her medical credentials, her reports of pain were not taken seriously, and she was denied adequate pain medication (a common issue for Black patients, suspected of seeking drugs). When she complained and exerted her medical knowledge, she was ignored on the grounds that she was "intimidating" (a frequent issue for women in positions of strength or knowledge).

Almost two years ago, Roji Health Intelligence published a series of articles based on research on health inequities, which we compiled as an e-book in June 2019. In 2021. We expect to see proposed solutions for addressing these issues coming from the new Biden administration. Value-Based Health Care concepts will expand to incorporate fairness and access in health care, as well as how to measure level of effort. But not everyone sees or feels how differential health care works. To refocus attention on these serious, substantive inequities, we are re-releasing our e-book , “Not Second Best: Inject Value in Women’s Health Care,” to provide essential context for one of the next big directions for health care. Please click here.

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Image: Eye for Ebony

7 New Value-Based Health Care Directions You'll See in 2021

written by Theresa Hush | March 19, 2021

Everyone who's reeling from 2020 is hoping for light in 2021.

Health care, especially—systems, hospitals, clinical practices and their providers—wants the pain to stop. What might lie ahead for health care next year? Here's what we're thinking about the near future, and what you should watch for in 2021.

1. Health care providers will be fortified.

If one thing is clear from the election results, it's that relief is coming to help providers on the pandemic's front line. Money won't be free-flowing, but it will be targeted to areas of financial distress. We should expect initiatives to centralize purchasing and distribution of personal protective equipment stockpiles, ending the competition between hospital systems and between states—and probable actions against price gouging. Likewise, efforts to monitor staffing resources and create mechanisms to send medical staffing to hotspots should emerge, as well as information exchanges to share best practices, treatments, and experiences in health care settings. Reporting related to vaccine distribution and administration will also be more centralized and transparent, with time.

Beyond the pandemic, health care providers will be supported for adopting targeted telehealth, perhaps tied to clinical depth and population health. For example, patient telehealth with video and capture of clinical values from wearable devices may trigger incentives for providers (and sometimes patients). The potential for measurement of these visits and their applicability in patient engagement efforts will heighten telehealth's value.

2. Value-Based Health Care will shift from a focus that is mostly on cost of care to include health equity and access.

Biden campaigned on an agenda of universal access and reduction in health care inequities, along with recovery from the pandemic. The current administration has favored free market health care decisions, such as allowing lower cost coverages for employers based on restricted benefits and provider networks. Incremental privatization of Medicare, by favoring enrollment in private Medicare Advantage plans, was viewed as a positive development—and potentially a transition to fixed fees for coverage. The emphasis in Value-Based payment models was creating accountability for providers through financial risk for providers and shared costs for patients, while creating transparency to enable better consumer medical choices.

You should expect the idea of "Value" to continue, but be redefined to include health equity and access, and tied into efforts to strengthen the Affordable Care Act. CMS will begin to measure health outcomes by population groups and to foster initiatives to eliminate inequities. The CMS definition of Value will be broadened to include long-term outcome improvement, as opposed to just quality processes, in addition to health equity. Quality reporting under the Merit-Based Incentive Payment System (MIPS) will continue, but there will be changes in measures and performance requirements that reflect the standard of care as well as the accountability of providers, and that ensure patients' voices will be heard.

3. There will be more support for ACOs and other APMs that continue to develop infrastructure and power for better health care—demonstrated by data.

CMS took aim at ACOs during recent years. The new administration is more likely to want to shift away from Medicare Advantage, after evaluating whether it is really helping patients and not just selectively enrolling healthy patients.

While ACOs have been an important Value-Based Health Care strategy, they have had mixed success and have lost much support. The number of ACOs has also remained stagnant, because of CMS efforts to induce risk.

The new CMS is likely to offer and possibly support ACOs with strong network capacity and resources for expansion, while evaluating changes that need to be made. There will be pressure on ACOs to achieve health equity and long-term health outcomes, have community presence and support, and foster more transparency and outreach to consumers and patients. But ACOs also have the opportunity to grow, and CMS will offer more tools to ACOs to help them achieve a greater presence in their own organizations.

The new administration will want to organize its Value-based efforts on organized delivery systems, such as ACOs and/or health systems, with existing infrastructures to coordinate and improve care. Like previous administrations having a “systems” focus on health care equity, access, and achieving quality and cost performance, the Biden administration will certainly

invest in making health care work better. But it will do so by working to improve what providers are delivering, rather than primarily using payment models.

Backing off provider risk in ACOs is unlikely, because there will be an urgency for the program to show savings. Capitation programs within ACOs and use of other negotiated payment mechanisms may also be present or expanded, such as Direct Contracting within ACOs, so that ACOs actually have more leverage in their environments. Experimentation with payment models for ACOs, or ACOs given latitude to develop broader, coordinated networks under negotiated rates, is a distinct possibility as long as equity can be ensured. The primary goal for CMS is to motivate providers to progress along the track of cost and outcome accountability, while helping them develop the tools to do so.

We should see a reconsideration of ACO success factors, organizational models, and other factors that inhibit development or growth, and more evaluation of the progress of various models. There may be a merging of various models, and more teeth—yes, not less—to ensure that the models produce both savings and better long-term costs.

4. Some Value-based models will be discontinued.

All Value-based payment models will be vetted, and federal support for some payment models will disappear based on results, provider support, and how well they fit into a general health care agenda for Value.

For example, Geographic Direct Contracting, just announced, is

an unlikely initiative without strong community support. With the model focused on super-coordination across multiple health care entities and specifically targeted to organizations already capable of managing risk, the geographic Risk model could be payer-organized in most regions. Keen competition between providers—and a lack of centralized provider or public health infrastructure to support geographic operations and data—could prohibit provider direction of the model. A payer-fostered Geographic Direct Contracting program would inevitably be labeled as a Medicare privatization program.

Likewise, Direct Contracting outside of ACOs and other payment models like Primary Care First may be seen as a distraction and better accomplished within a redesigned ACO program. Specialty care models, however, may endure with modifications and support from providers and patients.

5. MIPS will continue, with reinforcement of central values.

MIPS came about shortly before the end of the Obama administration, and it took some time to gather steam. Its requirements and incentives/penalties were relaxed during the pandemic, and CMS has focused on streamlining measures, including an upcoming plan to create a core set of quality process measures. The Quality component of MIPS has never achieved its potential, not only because of selective reporting of measure results, but also because these are process measures rather than outcome improvement measures. We should expect CMS to continue a reexamination of how MIPS works, but continue its framework while strengthening the requirements. CMS will be more transparent about its cost measurement processes, and more

focused on providing data and tools to improve performance.

Improvement Activities and Promoting Interoperability will be areas of focus beyond 2021, as efforts to help ensure progress toward health equities and improvement of data-sharing continue.

6. There will be more efforts to engage and inform consumers.

Spurred by COVID-19 and the vaccine, consumer education and engagement will be a big priority. The current administration took important steps to enable cost transparency, which providers have protested. While there may be some forgiveness on the aggressive schedule of the initiatives, the transparency requirements themselves may well remain in place.

But cost transparency is just the beginning. We should see strong support for an active consumer voice. Expect consumers to share their concerns, experiences, and stories well beyond current mechanisms, and weigh in on quality of care measurement in new ways. The cause of health equity alone will generate processes to ensure that consumers are heard.

Likewise, use of patient-reported outcomes plus technology that permits direct patient-to-provider clinical data for incorporation into EMRs will be established as part of measures and programs. Private industry and technology will play an important role for consumers, and the administration may create partnerships that legitimatize and expand their consumer-based applications and devices.

7. Efforts to strengthen the Affordable Care Act (ACA) will also bolster Medicare and Medicaid.

With the ACA partially gutted, coverage remains unaffordable or unavailable. The reluctance of some states to invest in expanding Medicaid is one factor. CMS is likely to begin evaluating Medicaid restructuring as part of a health equity, quality, and financial package that leaps beyond these limits while ensuring that states control costs of entitlement programs. A Medicaid restructure strategy may deploy Medicare's potential for centralizing health care reimbursement and payment models, while maintaining some decentralized beneficiary operations. However, if there is a public option, you can expect the inclusion of employers and private health plans in all-patient projects to demonstrate cost and quality.

As the lynchpin for ensuring the financial viability of the health care system as well as patients, the ACA will serve as a central platform to reinforce the tenets of quality, affordability, equity, and patient voice in Value-Based Health Care across all coverages.

While the road ahead will be full of twists and turns, here's one certain trend for 2021: the health care industry will be far from calm, but the journey promises to be full of interesting challenges and new opportunities.

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Image: Walter Walraven

The 2021 QPP Final Rule: A Warning Bell for ACOs and a Wake-Up Call for MIPS Participants

written by Dave Halpert | March 19, 2021

In a mere 2,165 pages, CMS has solidified the provisions of the 2021 Physician Fee Schedule and Quality Payment Program (QPP) Final Rule. The Final Rule strongly resembles the Proposed Rule, and the implications, particularly for ACOs, are staggering.

Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs) and the Alternate Payment Model (APP) Pathway

The most substantial change is that 2021 will mark the introduction of the Alternate Payment Model (APM) Performance Pathway, known as the APP. The APP aligns MIPS and APM participation more effectively in the Quality Payment Program (QPP). The APP is a pre-defined set of measures for all APMs, including ACOs, and will replace the 10 measures reported through the Web Interface. APMs will be scored on 2 utilization measures that CMS will score through an internal administrative

claims analysis, a patient experience measure, and 3 measures reported by the ACO or other APM:

- Hemoglobin A1c control for patients with diabetes;
- Blood pressure control for patients with hypertension;
- Screening for clinical depression and follow-up.

On the surface, a decrease from 10 reported measures to 3 sounds like a reprieve. The truth is, the manner in which the measures are reported and calculated makes for a dramatic shift.

As they stand today, ACO measures are reported through the CMS Web Interface, and CMS presents a sample of 248 patients per measure category. In other words, even the largest ACOs have a capped the number of patients for whom quality data must be reported, and this can handily be accomplished by teams of chart reviewers at the end of the year.

The APP only requires APMs (including ACOs) to report on 3 measures, but there's a catch: the measures are reported in the MIPS CQM (Clinical Quality Measure) fashion. That means three massive changes to quality reporting:

- Organizations must report on at least 70 percent of the TOTAL measure denominator.
- The measure denominator includes ALL patients—not just Medicare patients.
- The measures may only be submitted by Qualified Registries or QCDRs.

Let's look at this in practical terms. For a large ACO, a

measure for, say, depression screening (triggered by any office visit during the year) could mean tens of thousands of patients. This exponential increase from 248 patients is multiplied further, as these measures must be reported for ALL patients, not just patients with Medicare Part B coverage. When the measure spec says “all patients aged 18 years and older,” that is the literal denominator. So, even though the number of measures has decreased by 70 percent, the number of required data points has exploded.

ACOs will not be able to rely on a set timeframe for chart review based on a capped number of eligible patients; there is insufficient time to start at the end of the year, even if (and that’s a big if) all of the clinicians and practices within the ACO are documenting the three measures consistently, particularly the depression screening measure.

CMS did grant a brief extension on the availability of its Web Interface. In the Proposed Rule, CMS announced plans to remove the Web Interface for the 2021 performance year. However, based on stakeholder feedback, CMS ruled that the Web Interface will remain live for 2021, giving ACOs a one-year option of reporting the existing 10 measures before the mandatory shift to the APP measure submission.

While this may seem like a stay of execution, strategically inclined ACOs will recognize that running a tandem approach to quality reporting in 2021 is the safest decision. Here’s why:

1. It's been shown that experience is the greatest indicator of ACO success.

ACOs that have integrated data amongst their practices by using CMS claims files (as opposed to data collection and integration) will find this insufficient for meeting reporting requirements, as all patients are included in APP reporting. Those who begin working with Qualified Registries experienced in data aggregation from multiple EHRs (even if those EHRs aren't ONC-certified) can help identify gaps—whether they are gaps in care or gaps in data—that can be addressed before APP reporting is the only option. Those who don't meet this challenge in advance will find themselves playing catchup among their peers.

2. It will take longer than expected to set up templates for data collection.

To succeed in quality reporting under the APP, a blitz of end-of-year chart reviews is simply not feasible. This means that the only way to succeed at the end of the year is to collect data throughout the year. Providers will need to change their workflows in order to ensure that the information required for the measure is (a) present in the record and (b) documented in a manner that it can be transmitted via data interface. This means NO "FREE-TEXTING" in a notes section—the information must be collected in a discrete manner to be useful.

While blood pressures are commonly collected discretely (numbers entered into a defined field) and hemoglobin A1c may be captured via electronic interface with a lab (beware of scanned documents!), the biggest hurdle will be the depression screening measure. Providers will need to know how to collect

this information in a “machine-readable way,” and to understand why it is important—without their buy-in, the information will not be collected to the necessary degree. ACOs will need to factor in the time it will take to build and implement EHR templates, train providers, and identify issues. It’s going to take time, and trying to implement this process during the performance period is akin to fixing an airplane midflight.

3. New ACOs are given an incentive to report through the APP—they will be scored under a “pay for reporting” standard, rather than for performance.

In other words, as long as they meet the data completeness and case minimum thresholds, they will meet the Quality performance standard. Since an ACO may be terminated if they do not meet the Quality standard in two consecutive years or any three years within their agreement with CMS, having the option of a pay-for-reporting year is a huge incentive. Not only will the new ACOs be more prepared for mandatory APP reporting, but also they will have already identified areas for improvement going forward. Established ACOs who choose to wait must recognize that not everyone will go into 2022 as first-time APP reporters, and waiting for the mandatory year to begin puts them at risk for failing to meet the Quality reporting standard.

The Pressure Mounts on MIPS Participants

Interestingly, CMS begins its section on the Quality Payment Program and MIPS by describing its desire to move MIPS participants into Alternate Payment Models. CMS notes that, as it exists today, MIPS does not provide the sort of data-driven

comparisons required for meaningful performance measurement. MIPS Value Pathways (MVPs) are meant to address these two concepts. While COVID-19 has pushed MVPs back a year (finalized for 2022, rather than 2021), they will be a critical component as MIPS evolves.

The MVP timeline and structure is moving on as proposed, with some additional clarifications to the MVP definition. CMS has published a template for future MVP proposals from organizations, and clarified some of the MVP guiding principles:

- MVPs should consist of limited and connected measures and activities, which will reduce burden and align scoring.
- MVPs should generate comparative performance data that enables patients and caregivers to make informed decisions when seeking care.
- MVPs should choose measures that reflect the Patient Voice, if possible, while drawing from the Meaningful Measures framework.
- MVPs should use APM quality and cost measures whenever feasible, so as to prepare organizations for a jump to an APM.
- MVPs should support the transition to digital quality measures.

MVPs are designed as APP springboards, rather than mandatory frameworks. Of course, program rules tend to begin with voluntary participation options before advancing into mandatory requirements (or at least, as a necessary step to clear the highest tier for incentives). Savvy organizations will recognize this discussion of MVPs as an opening salvo, and

should prepare for mandatory MVP participation—even if MVPs aren't mandated by Rule, the question is academic; organizations are being steadily guided into comprehensive value-based care arrangements—whether MVPs or APPs—and will be reimbursed as such. Even though they will not be available for reporting until 2022, just like APPs, those who don't begin the process now will be doomed to chase the pack.

Even those who choose to forgo MVP participation for now face new challenges.

The performance threshold is set to 60 points, which was initially mandated in the 2020 Final Rule. This minimum standard was decreased in the Proposed Rule, but CMS reestablished 60 points as the minimum standard. Anyone who scores below that threshold is subject to a negative payment adjustment (read: penalty) in 2022.

In developing a MIPS strategy, a minimum threshold of 60 points will make it nearly impossible to ignore either the Quality or Cost portions of MIPS. In prior years, organizations could safely clear the minimum performance threshold without performing well on both Quality AND Cost. The prior 45-point threshold enables clinicians to score well on either Quality OR Cost (along with moderate performance on Promoting Interoperability and Improvement Activities) without incurring a penalty. However, in 2021, without scoring well on both Quality (40 points) and Cost (20 points), achieving the minimum 60 points will be a challenge, and the 85-point Exceptional Performance bonus will be nearly impossible.

Meeting the minimum threshold will become even more challenging

in future years, as Quality and Cost must each account for 30 points of the Total MIPS score by 2022. In other words, there will be a substantial step up in terms of Cost weighting next year, from 20 percent to 30 percent.

Key Takeaway

CMS is creating a backdrop that will substantially separate MIPS and APM participants, and there will be winners and losers. While a one-year reprieve from the close of the Web Interface may seem worthy of a sigh of relief, ACOs should recognize that delaying a move into the APP in 2021 could spell disaster in 2022. Likewise, MIPS participants who do not prepare for their MVP submission by defining their goals and identifying how they'll ask to be scored will face an uphill battle to remain competitive with groups who move from MIPS to APMs or develop data-driven strategies to succeed in MVPs. Value-based care is here, and to succeed in 2021 and beyond, organizations will need to plan and execute a long-term plan that begins with a short-term push.

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Five Strategies to Help ACOs and Independent Specialists Create Common Ground on Data Sharing

written by Theresa Hush | March 19, 2021

To successfully manage the 40 to 60 percent of costs of care driven by specialty physicians, your ACO must overcome one major obstacle when you begin to address specialty costs: the lack of information to guide your actions.

Although ACOs have claims data to calculate total costs per ACO patient and totals for specialty services, you can't compare those costs. Why? Claims are not organized into cases or "episodes of care" that include all providers and services so that it is easier to compare case costs between patients or providers. More importantly, the small number of Medicare patients seeing any given specialist is not representative enough to evaluate that provider's average cost per episode, because the Medicare patients could be more or less sick.

The small number problem is why CMS moved MIPS quality

measurement to an all-patient basis, in order to more accurately indicate how a particular provider performs against quality standards. That accuracy benefits providers—and ACOs under the proposed new rules—by providing actionable comparative data.

Specialty Practices' EMR Data Is Essential to Cost Performance Improvement

That's why it is so essential for ACOs to build the data and analytical tools to guide strategies for constraining costs. If you can't standardize a method of looking at cost, as quality measures do, you have no means for comparing case costs and identifying the reasons for differences. And, if your data lacks integrity because it's too sparse, it has little value.

Specialty patient data in practice EMRs hold the key to unlocking the potential for both specialists and ACOs. But unless the specialists are part of a group employed by the ACO or its health system, ACOs lack the data to determine whether specialty costs are reasonable and how to improve performance.

The lack of data is specific to ACOs where specialists are not employed or contributing data to the enterprise, a structure more common among physician-led independent ACOs. Health-system-owned ACOs with large multi-specialty employed practices have the data, although expertise is once again required to integrate that information with claims data and to organize care into episodes.

In this blog post, we'll address the specific issues of ACOs with outside specialists, and how to navigate strategies for collaboration. A future post will focus on the particular

problems of ACO organizations owned by health systems and hospitals with multi-specialty groups.

Will Specialists Provide Practice Data to ACOs?

How and what data specialists will provide to ACOs is an important question for ACOs and practices to navigate. Here's why specialists may oppose data contribution:

- Specialty competition within the ACO: In areas with a lot of specialty competition, that data causes potential risk of harm to the contributing practice—an issue that ACOs must be willing to accept and negotiate. If two groups of the same specialty are in your ACO referral network, the contribution of data could possibly put one at a disadvantage for referrals based on perceived costs.
- Broad Specialty Patient Service Area: Specialists typically get referrals from a large network of primary care physicians across a broad service area. The breadth of that geographic area will likely be an important factor in data sharing. Specialists could be more resistant if providing data to you prompts other ACOs to request data as well, with less favorable terms.
- Flawed or Untrustworthy Data: Cost variation and excess costs can be caused by a variety of factors that cannot be controlled by a specialist—including facility costs, schedules and protocols, patient risks, and other physicians involved in the case. Data can also just be wrong. There is a fairness issue at the heart of comparative analytics, and your ACO will be well served by carefully implementing data sharing in an environment of education and innovation. If your plan is to use data in a way that appears hostile to specialists, they are less likely to cooperate.

Unfair or Unilateral Action from Data: Some organizations move too quickly to score specialty efficiency or value, without really understanding what the data says. There must be time for specialists to work through their results and vet episode details. This is a new concept for health care. The level of clinical and financial detail, as well as conclusions to be drawn from the data, must be part of a dialogue and negotiation between your ACO and specialty practices.

Who Controls the Data: Specialists may be willing to share results but not the data itself. Does your ACO really need to see the actual volume of patients that the specialty practice is seeing, or the identity of those patients? Using an intermediary vendor to aggregate the data, much like an auditor does for financial data, could be a useful way to submit quality and cost measure data to the ACO but maintain overall integrity of the specialists' data—most importantly, privacy and financial details.

Five Strategies to Help ACOs and Specialists Develop Common Ground on Data Sharing

1. Consider how to meet specialty concerns by how data will be collected and used.

The options include:

a. Require specialists to have a data-driven process to create and evaluate episodes, while maintaining that data entirely under Specialty Practice Control. Under this option, specialists would send episode analytics and cost variation or cost measure data to ACOs, while maintaining full control over the data and patient details itself. The

data aggregation could be partially or fully ACO-financed, since there would be mutual benefits.

b. Use an intermediary to hold the data on behalf of the ACO, ensuring that you have access to the analytics results but not the underlying episode data. Simultaneously require network specialists to participate in ACO review processes on costs for mutual education and development of interventions.

c. Require specialists to contribute data to the ACO. Depending on competition in the area and the relationship between the parties, this can be realistic for some groups that are closely aligned.

2. Collaboratively design episodes of care to include both treatment and condition episodes.

Your higher cost specialty areas are priorities and will help get the program started. These typically comprise orthopedics, including joint replacements and spine surgery; cardiology/cardiac surgery; cancer; and kidney disease.

3. Create analytics that include both cost and outcome components, so that physicians can engage in clinical processes.

Roji Health Intelligence has targeted seven analytics as fundamental to episode analytics that provide a guide to what both ACOs and physicians need to see.

4. Implement data awareness and episode improvement processes for individual specialists and practices.

You will want to include a process for specialists to review a small sample of episodes each month and measure whether that occurred through your data vendor. In addition, there should be an overarching process in practices to review systemic reasons for higher costs that come out of the analytics. Both these activities should identify candidates for developing new clinical processes, streamlining care, examining patient selection, or looking at costs in different time-phases of the episodes.

5. Select episodes with treatment variations for developing physician-patient decision processes with patient-oriented data and cost transparency.

Extending the value of episodes from cost analytics into improvements in medical decision-making will help physicians and patients realize the potential of episodes.

Even in ACOs with independent specialist physicians, there are good reasons why episode analytics can be mutually beneficial. Improvement of costs—impossible for specialists without episodes that package services into a case and illuminate what drives cost differences—will help specialists become more competitive, have access to health plan contracts that reach more patients, and, possibly, open the field for employer-based agreements. For ACOs, engaging specialists in cost control strategies can determine whether you are successful in Risk. New options for conservatively collecting data can help both

ACOs and specialists improve health care affordability and their futures.

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Image: Claudio Schwartz and @purzlbaum

Video: How to Engage Specialists Through Centers of Excellence

written by Theresa Hush | March 19, 2021

Specialists will engage in cost performance improvement if they believe they can provide better care for their patients and

improve their own clinical excellence. Here's how to achieve that through Episodes of Care, and how ACOs and health systems can help. You'll find more details in last week's post, Five Ways to Manage Specialty Costs Without Bundled Payments.

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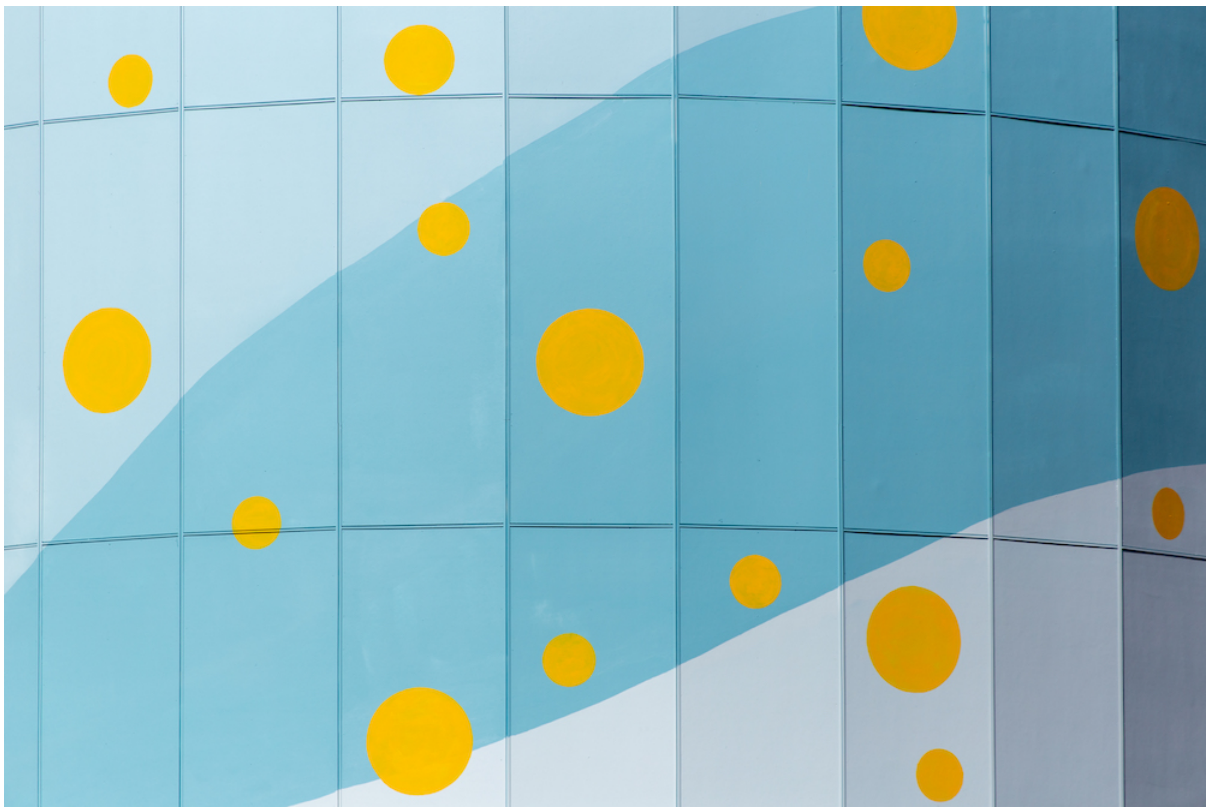
Five Ways to Manage Specialty Costs Without Bundled Payments

written by Theresa Hush | March 19, 2021



When health plans and Medicare propose controlling the cost of specialty care, expect that bundled payments will be the next suggested solution. With the introduction of every new specialty-focused payment model, an episode-based bundled payment model is involved.

But let's say you're an ACO with no interest in bundled payments arrangements. You may not even think you can put the topic on the table with specialists. Or, if you are a health system or specialty practice that is trying to control total cost of care for competitive reasons, perhaps you aren't yet willing to accept fixed fees. How can you manage specialist-driven costs for success in value-based arrangements without adopting bundled payments themselves?

Here is the bad news you may not want to accept. You *can* avoid reimbursement through bundled payments (for now). But you *can't*

avoid implementing the same underlying strategy to measure and reduce your cost variations, and to drive lower costs. Unfortunately, this will be both harder and potentially disadvantageous to achieve without the incentives of real bundled payments to engage the organization and physicians.

Let’s review the landscape and your options.

Bundled Payments Dominate in Emerging Value-Based Models for Specialists

Payers are leveraging provider reimbursement systems toward fixed fees like capitation and bundled payments. While they inject financial incentives into payment models to control the total cost of patient care (for the payer), providers bear the risk of cost overruns. Unlike the early ACO shared savings model, the incentives in value-based payment models depend increasingly on risk payment models like global capitation and bundled payments.

I’m using the term “bundled payments” to include any set amount for an all-inclusive, time-based patient episode of care. Bundled payments are equivalent to a capitated payment in primary care, but the parameters of services and time may be different.

Bundled payments power many Medicare value-based specialty care models, including the Oncology Care and recent End Stage Renal Disease Models, Bundled Payments for Care Improvement (BPCI) procedures and conditions, and Medicare Cost Measures. There is an initial selective implementation to evaluate the program design and cost effects in groups that have volunteered, after which the program can move into partial or whole adoption.

Commercial payers have negotiated bundled payment arrangements for years in high-volume procedures, and employers are also rapidly moving into direct contracting with providers.

Episodes of Care and Bundled Payment Are Completely Different

Mention “episodes,” and many providers immediately think “bundled payments.” But they are not synonymous.

Episodes are created to define the services and time frame associated with a particular procedure or set of procedures, conditions, or events for an individual patient. A few examples:

> A knee replacement episode will typically include all of the various procedures involved in a knee arthroplasty, but it will also include services leading up to the procedure and inclusive of imagery, ancillary providers and services during the procedure, and after-event therapy such as physical therapy and/or rehab.
> Oncology Care Model episodes are defined as the six-month period beginning with chemotherapy, and include all services, not just those directly provided to the patient.
> A condition-based episode for diabetes will include all visits, laboratory tests, pharmaceuticals, and services tangential to diabetes, including emergency room and hospital admissions, and depression screens or podiatrist services.

Patient episodes are a necessary means of calculating costs in order to establish bundled payment models. However, they are also the best way of looking at and evaluating both outcomes

and costs for types of specialty care. Because each episode is structured the same, it’s possible to measure key differences between individual patient episodes, create a view of cost variation, and identify outcomes or issues that have impacted low or higher cost episodes.

Manage Specialty Costs Through Episodes in 5 Ways Bundled Payments Can’t

Bundled payments are essentially a budget without navigation tools or detection systems. The bundled payment level is a dollar amount that is divided among various professionals and facilities. Within that fee only episode analysis can reveal what has driven actual expenditures above or below that level.

You can manage specialty costs through episodes with enhanced capabilities that a fee structure can’t provide:

1. Identify the specific services in episodes that tip costs toward higher levels, for discussion with physicians.

Episodes will have services in common and some that stand out in certain cases as higher costs. These could be a newer and higher cost anesthesia, a novel surgical approach, bundled procedures, or variations in post-event therapy. The variables that differ from episode to episode within the same procedures can become focal points for a discussion about the appropriate standard for care.

2. Establish the optimal care path that led to best outcomes while maintaining cost performance.

Physicians are free to create clinical advancement while there is still rigor around review of outcomes and cost. The transparency required for physician engagement in episodes should be designed to illuminate patient outcomes and excellence, and contribute to a standardization of care.

3. Create consensus among specialists about facility and administrative barriers to achieving best clinical outcomes for their specialty episodes, for action by parties to the episodes.

Scheduling issues, availability of house physicians, and selection of other parts of the care team are usually not in a specialist’s control, but impact cost and outcomes. Review of sample episode cases should also result in the discovery of administrative issues to resolve.

4. Form episode care teams based on best performance, not just availability.

The contributions of each of the episode care teams should be uniquely identified, when feasible. Collaboration and choice of episode teams could facilitate a drive for higher performance and clinical excellence, as well as help engage physicians’ typical competitiveness.

5. Re-energize Centers of Excellence to incorporate models of treatment based on demonstrable performance.

A few highly recognized groups have embraced episodes as a way of re-engineering health care product lines that deliver highest quality outcomes and cost, and are negotiating these with employers and payers. By focusing on what is producing the best performance, rather than meeting the bundled payment budget or marketing goals, providers can turn episodes into growth opportunities.

ACOs are often hindered by a vague and administrative role within their provider environment. Episodes have the possibility of expanding your capabilities and your "brand" to become an engine for positive expansion, while ensuring that your specialty network is engaged. Use your data to broaden your view of costs and quality, and examine real services delivered to patients. You'll be inspired by what you discover.

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Image: Gratisography

Video: How to Improve Specialty Spending for ACOs

written by Theresa Hush | March 19, 2021

Referral networks drive a huge part of ACO spending. Cut through the data to find how you can reduce costs through actionable information. Learn more about how your ACO should evaluate specialty referrals and costs using seven key analytics for procedural episodes of care.

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Seven Key Analytics to Direct Your ACO’s Specialty Strategies for Risk

written by Theresa Hush | March 19, 2021

As ACOs become subject to Risk arrangements, especially global capitation, specialty costs should be one of the first areas to examine for long-term savings potential. Optimal use of specialists and engagement with specialty providers will prove essential for cost management.

This is new territory for providers who have decentralized most decisions about specialty referrals and subsequent specialty medical decisions. Leverage for collaboration and examination depends on the ACO's strength position vis a vis specialty business and competition among specialists for ACO referrals. A primary ACO strategy for cost performance, therefore, must start with its market strategy.

Your ACO Competition, Medicare Advantage Plans, Are Already Going After Specialty Costs

As I've explained in previous articles, ACOs are most directly

in competition with commercial Medicare Advantage (MA) plans. With the advent of lower-cost/narrow-network MA plans for 2021 enrollment, commercial plans are signaling their willingness to choose specialists based on price. For ACOs, self-selected enrollment of healthy seniors in MA will pose further risk to your own cost structure. No amount of risk adjustment will fix that cost problem.

Fortunately, many specialty practices, often very focused on market competition, are hungry to examine avenues for achieving better cost and outcome performance. If your ACO is in a population-dense region, you need specialists who are willing to collaborate.

How Your ACO Should Evaluate Specialty Referrals and Costs

In the 1980's and 1990's, Health Maintenance Organizations (HMOs) forced an unpopular, strict review of specialty services by requiring pre-authorization, often including consults. Some primary care practices austerely managed their patients with heart and other problems internally, rather than refering them. Since data during this period was rare, it is now hard to assess the impact of these practices on patient outcomes.

Your ACO now has the capability to develop a much more focused and collaborative approach with specialists, for mutual benefit. What is your leverage to interest your referral network in this approach? Comparison of outcomes and costs. While this is more difficult with groups versus payers because of volume, you can overcome this obstacle for higher volume procedures and conditions if you have the technology needed to correctly examine costs.

Episodes of care, extensively discussed in previous articles, is the appropriate unit of measurement for cost of care for specialty services. Starting with procedures, claims data together with provider EMR data can provide the unit of cost measurement for the pre-, during- and post-trigger services for patient care associated with a procedure.

So let's say you have episodes constructed, and can map them along a cost curve and compare by physicians. Let's review key analytics that will help you identify what is driving costs, and how to create strategies that will change procedural costs long-term.

Seven Key Analytics for Procedural Episodes of Care

Where you start with episodes is important. Your first three analytics should focus on the areas most likely to bear fruit for cost performance, as well as provide traction for future efforts.

1. Episode volume and type. Begin with specialty services that are both high volume and considered elective (most of the time). Joint replacements and repair as well as other orthopedic or neurosurgery procedures are usually at the top of this list, along with frequent cardiac procedures, cholecystectomy, screening colonoscopy, cataracts. Conversely, you will also want to note providers for whom volume of procedures is very low, as this can correspond to poorer outcomes and should be part of specialist selection.

2. Variation in episode costs from an average. Variation will be a function of the range between each episode cost,

indicating variety of different approaches to surgery, clinical reasons for the procedure, or physician practice patterns. Cumulative costs over the average is also useful; in cost curves with high variation of episode costs but many episodes on the lower cost end of the curve, these cases bring down the average.

3. Volume spread of closely related procedures. Category assessment about how many procedures are performed in an open versus laparoscopic approach, among other variables to clinical approach, will reveal differences in cost that could be due to either patient risk or physician expertise.

After prioritizing episodes, your work will involve illuminating three overarching situations:

- Episodes (like trauma and cancer surgery) where there may be multiple procedures or organs involved, critical care services, and where options for improving costs are questionable.
- Procedures where there are multiple choices of therapies, such as shoulder repair and replacements or spinal surgeries, where costs and outcomes vary widely.
- Procedures where there are associated events that affect costs, such as complications or readmissions.

This analytic set includes:

4. Cost curve analysis to separate episodes into cost tiers and clinically-relevant clusters. All tiers will be reviewed to explore common elements and differentiators from other cost tiers.

5. Key notable observations that affect costs. Events that fall post-trigger may be costs that could have been predicted and avoided because of patient factors, or problems related to the procedure itself. Post procedure diagnoses, complications, sepsis, and subsequent procedures; readmissions; place of service; and major contributory costs, such as anesthesia type and imaging, are frequent candidates. There may also be unexpected associations of events that may look unrelated, like DVT, poor healing, and smoking status, that could drive costs higher.

6. Multi-trigger episode analysis. Episodes that overlap could represent normally sequenced procedures, such as certain cardiovascular episodes. They could also represent bundles of separate procedures for the benefit of the surgeon or patient preference. Because multi-trigger episodes almost always will push costs up, review of cases to examine outcomes and post-procedure events are essential.

7. Pre-procedure risk factors. Episode analysis will always reveal a small number of high cost episodes where a patient’s risk factors or condition might have eliminated the patient as a candidate. These episodes, however, are only evident in hindsight and should be clinically evaluated by the proceduralist.

It should be clear that cost strategies to manage specialty services require a collaborative and positive process between physicians and your ACO. There are many reasons beyond specialist performance that drive costs higher, and the magic solution is to identify what you can predict, what you can control in advance, and to establish appropriate clinical

criteria to tell the difference.

Working within a Risk arrangement, the best method of paying and rewarding specialists is important; you can’t fight volume-based incentives while you are trying to reduce costs. Finally, improved physician-patient decision-making for specialty episodes—with primary care input, review of alternative therapies, and cost transparency—should help ACOs create a more holistic strategy that involves the patient, specialists, and primary care physician in an effort to optimize services.

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Image: Aditya Wardhana

Video: Cost Transparency Gives ACOs a Competitive Edge Under Risk

written by Theresa Hush | March 19, 2021

While your ACO isn't subject to CMS's new rules about cost transparency, you'd be well advised to adopt this method to succeed under Risk through your own modified approach. As your organization establishes mutually beneficial relationships with providers, you can't avoid the choice to achieve savings by prioritizing strategies to focus on cost variations and areas of excess costs. To realize those goals, you'll need to navigate the battleground of cost transparency by involving patients and physicians in discovery of costs. Learn more.

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