How to Involve Physicians Effectively in ACO Population Health

written by Theresa Hush | November 15, 2018

In a recent post, we addressed the many types of population health initiatives and some guidelines for creating the most benefit. Now let's take a closer look at one of those guidelines: integrating population health into regular or routine care of patients—specifically, with greater involvement and communication by the patients' physicians.

ACOs and their participating physicians have an opportunity to break with the historical obstacles between the physician's employer organization and the physician, especially in hospital-directed ACOs. Even in physician-led ACOs, working seamlessly with physicians to achieve better health for ACO patients is key to achieving both quality and cost goals. Either way, the movement toward financial risk will compel ACOs to use efficient mechanisms like population health to ensure changes across the patient base, rather than duplicate efforts one patient at a time. Population health will also be the key program for driving changes in outcomes in populations with difficult, socially-determined health issues.

So, how should population health be implemented to achieve goals for patients? Even though population health is the standard bearer of Value-Based Health Care, it remains an obscure concept for most physicians, largely because population health technology and initiatives have sidelined physicians and their interactions with patients. Physicians aren't even universally sure about what population health means, nor what role they are supposed to play.

Physicians Must Understand Goals to Be Population Health Partners

Physicians may be only vaguely aware of their ACO's patient outreach and similar population health initiatives that target particular clinical needs, especially gaps in care. If the patient shows up at an appointment to receive missing services, there is an expectation that physicians will identify and deliver those services. For many physicians, however, this encounter marks the first time that they become aware of systematic efforts to follow patients, as well as unmet patient needs.

Other population health projects may be directed at cost reductions in emergency room use, post-acute care services and readmissions. The physician may not be involved at all in such initiatives, a lost opportunity for discussion at the next patient encounter.

Regardless of specific initiatives, it would appear obvious that physicians cannot be partners in achieving population health goals if they aren't aware of those goals or don't understand them.

ACOs and health systems may well intend to help physicians by unburdening practices from running population health initiatives, but leaving physicians out of the loop has risks. These include a deteriorating bond between physician and patient that erodes communication and agreements about shared goals, making it actually more difficult to achieve better outcomes. Also, by favoring administrative ease over cultivating the physician's relationship with the patient, organizations can actually exacerbate physician burnout when

their providers feel like mere cogs in the wheel.

Recognizing that population health initiatives require more time and logistics than physicians can provide on their own does not negate physician involvement; it means, rather, that these initiatives should be better integrated into physicians' delivery of care and the technology they use in the process .

Physicians Can Play Three Key Roles in ACO Population Health

Physicians have valid and essential roles to play in the development and execution of population health initiatives, which fall into three main categories:

1. Routine population health initiatives to address high risk patients, immunizations and other care needs.

Physician involvement should be structured to take advantage of their clinical knowledge and build upon their bond with patients. This could include:

- Participation in the development of population health goals and prioritization of strategies;
- Guidance regarding clinical and non-clinical criteria for selection of patients for initiatives, and creating the exception process for patients who should be excused;
- Delivery of medical services and clinical communication with patients as part of population health initiatives.

2. Population health initiatives that represent public health priorities.

The nature of population health and its targeted initiatives needs to evolve beyond personal health into public health. Curiously, this has been absent from most discussions. By virtue of their clinical knowledge and direct provision of care, physicians are the best ones to guide this shift. Clinicians could develop and run population health initiatives to address public health priorities within physician control:

- Antibiotic conservation, including systematic tracking of and changes in physician prescribing patterns for routine infections as well as standing orders for antibiotic use;
- Opioid prescriptions and monitoring.

3. Population health initiatives that help physicians change specific health conditions and behavior of their patients.

With training in motivational interviewing, physicians could supplement their clinical skills to help patients improve their health status:

- Obesity;
- Smoking;
- Addictive behaviors and behavioral health.

No doubt many will point to trends in antibiotic overuse and the opioid epidemic as evidence that physicians cannot be effective guardians of public health-oriented initiatives; nor has there been historical success with encouraging patient lifestyle changes. However, in neither category have

structured, clinician-involved and *data-facilitated* initiatives been the norm, nor have physicians generally had the tools to improve. Complex clinical population health projects must be carefully designed with physician involvement and be supported with analytics, specific training, administrative support and technology integrated with the physician clinical systems.

Supporting Physicians in Population Health Is Essential to the Partnership

Involvement is important, but so, too, is restraint when it comes to physician responsibilities for population health. With a looming physician shortage and a majority of physicians reporting burnout, ACOs must strike a fine balance between demanding too little or too much.

Here are the most common questions about physicians involvement in population health initiatives:

How much should a physician need to document?

The answer should be very little. There are easy and passive ways of gathering clinical information from systems, plus other methods of allowing patients to self-report outcomes, preferences and additional data. Where it is necessary to provide patient information for physician consideration, support staff (such as patient coordinators) should gather and input data into the record, programmed for easy viewing by physicians. There is no reason why a physician, apart from normal clinical documentation, should have to do much more than validate the provision of counseling or information to patients.

Who should produce patient informational materials?

All population health projects should have centrally produced patient informational materials. Patient preferences should be gathered in a streamlined pre-visit process when possible or made easy to collect and document during the visit.

How much data should physicians see?

Physicians should have the ability to see a variety of two to four comparative analytics that show key population health metrics, such as outcomes and trends over time. The data should not only compare their results against those of their peers but also provide optional drill-downs into patients' individual data . Some physicians want to validate the information by viewing patients and should have that ability.

Should physicians be responsible for selecting or eliminating patients?

There is no reason why this should be required, if ACOs can monitor the characteristics of patients in both categories. It provides a false sense of involvement in the project, and unless physicians encounter issues with patient lists, they should not be involved in busywork once the criteria for patient inclusion are set.

Physicians Should Be Rewarded for Population Health Involvement, Not Sanctioned for Failure

Many ACOs or clinically integrated networks attempt, too soon, to sanction physicians for "failure" of population health initiatives, just as they do for quality measures. This only

serves to distance the physician from partnership and the initiatives. Organizations must foster an environment of learning, exploration and support. Population health represents an entirely new role for physicians as they transition from providing patient-at-a-time service to taking on responsibility for patients as a whole. A soft start is essential to allow physicians to learn, experiment and train themselves to operate in a new environment.

There is no easy path to establishing worthwhile population health initiatives, either with physicians or with patients. Neither responds well to management of their choices or to additional work. To succeed in this endeavor, ACOs should appeal to physicians' mission to do well, respect their integrity as clinicians, and support them with the time and resources to make population health work.

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Image: Eddie Aguirre

The Final 2019 Quality Payment Program Rule: A Slow (but Steady) Push to Risk

written by Dave Halpert | November 15, 2018

Brew a pot of coffee! CMS has released a 2,378-page Final Rule covering the 2019 performance year for the Quality Payment Program, including the Merit-Based Incentive Payment System (MIPS).

Those who dive into this document will gain insight into CMS's vision for the future. It seems tortuous to suggest "reading between the lines" when there's already so much laid out in black-and-white, but recognizing the context within the rule enables you to prepare for the future—spelled R-I-S-K.

The Final Rule is very close to what was proposed back in July and has been similarly justified—CMS continues to cite Meaningful Measures, Patients Over Paperwork and Reduction of Clinician Burden as primary policy drivers. Elements in these initiatives are visible within the Rule, but providers and administrators must avoid being lulled toward inaction by these

terms. They are not justifications for reducing effort or for dismantling the program—rather, they form the foundation for Value-Based Health Care.

Six Signs that Risk is Coming

CMS's push to Risk may be slower than hoped, but several key program updates for the 2019 performance year (the 2021 payment year) illustrate that Risk is coming. Those who believe that Patients Over Paperwork excuses them from Value-Based Health Care are in for a rude awakening; in turn, those who see Risk on the horizon can begin to plot their course.

1. MIPS participation will be greater than expected.

CMS estimates that nearly 800,000 providers will participate in MIPS in 2019, approximately 150,000 more than they anticipated in July (p. 885). Part of the reason is that CMS is expanding its definition of MIPS Eligible Clinicians to include Physical Therapists, Occupational Therapists, Speech Language Pathologists, Audiologists, Psychologists and Nutritionists/Dietitians.

Even though CMS has added another component to the low-volume threshold (providers who perform 200 or fewer Medicare Part B services, in addition to having $90,000 or fewer allowed Part B charges, or 200 or fewer Part B patients), MIPS participation is still expected to increase. CMS has finalized a provision that allows providers to voluntarily participate in MIPS for 2019, as long as they exceed at least one of the three low-volume thresholds (p. 949). Those who elect to participate will receive performance feedback from CMS and be more prepared for

future Value-Based initiatives than those who prefer to sit on the sidelines.

2. There will be more penalties, but also higher incentives.

In the initial "transition" year of MIPS, 91 percent of providers avoided penalties (p. 884). Reporting one item was enough for a "test" submission. In 2019, the minimum performance threshold to avoid penalties will be 30 points (p. 928). This is double what is required in 2018. The increase is significant, as it means that, unlike 2017 or 2018, fulfilling Improvement Activity or Promoting Interoperability requirements or intermittently reporting quality metrics *will not be enough to avoid a penalty*.

Since the program must be budget-neutral, incentive payments must be drawn from penalties. For this reason, incentives earned through 2017 performance were small, especially when compared to the Value-Based Payment Modifier. With 91 percent avoiding penalties, there were fewer incentive dollars to go around. In 2019, increased participation, higher penalties (up to 7 percent, approaching the revenue-based nominal amount standard for an Advanced APM), and heightened performance requirements will mean more penalties. Those who avoid penalties can expect to see increased incentives, particularly those who qualify for the Exceptional Performance Bonus. Make no mistake—the field is getting more competitive, with a lot more at stake.

3. Quality cedes ground to Cost.

This is the most telling piece of the Rule. The requirements

for fulfilling the Quality component are the same. The scoring methodology—comparing performance against a CMS benchmark—carries over, as well. However, even though the obligations are the same, the Quality component will be worth less than it was in 2017 and 2018. Once again, that ground is ceded to the Cost component.

MIPS Cost requires no additional data submission, as it is calculated by CMS through an analysis of its claims; but again, those who think of this one as a "freebie" are fooling themselves. Over the next several years, the Cost component will be worth anywhere between 10 and 30 percent of the total MIPS score. Although 2019 remains modest (15 percent, as proposed), the upward trend, combined with additional cost measures, is indicative that MIPS will continue to score providers with an APM-esque focus on expected costs compared to actual costs.

4. New cost measures target specialists.

As proposed, there are eight new cost measures, all based on Episodes of Care. These mark the first expansion in Physician Fee Schedule (PFS) cost measures since the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures were used for calculating the Value-Based Payment Modifier. The measures are divided into acute and procedural episodes (pp. 1054, 1069):

- Elective Outpatient Percutaneous Intervention (PCI) – Procedural
- Knee Arthroplasty – Procedural
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia – Procedural

- Routine Cataract Removal with Intraocular Lens (IOL) Implantation – Procedural
- Screening/Surveillance Colonoscopy – Procedural
- Intracranial Hemorrhage or Cerebral Infarction – Acute
- Simple Pneumonia with Hospitalization – Acute
- ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI) – Acute

Aside from clinical specificity, attribution for these measures has also become more focused. Attribution will drill down to the provider level, rather than just the TIN. In other words, CMS is ratcheting up its analysis to identify differences in providers' outcomes, *even if those providers are in the same practice*. CMS will attribute procedural episodes to the MIPS-Eligible clinician who renders a trigger service (the CPT/HCPCS procedure code). Acute episodes are first attributed to the TIN that bills at least 30 percent of the inpatient Encounter and Management claim lines in the hospitalization, and then to the MIPS-eligible clinician who bills the initial inpatient Encounter and Management code during the trigger inpatient hospitalization.

CMS field-tested these measures previously, releasing feedback reports in late 2017. It's a safe bet that the field-tested measures whose results were released in October 2018 are under consideration for MIPS in future years. If the eight new measures don't apply to you, consider giving additional scrutiny to your patients' costs; episodic care cost measures that apply to other specialties are merely delayed, not avoidable.

5. Promoting Interoperability requirements are tightened.

The option for reporting on “transition measures” will end in 2018. In this rule, CMS has mandated that providers must fulfill Promoting Interoperability (PI) requirements using Certified EHR Technology (CEHRT) that meets the 2015 Health IT Certification. In an Advanced APM, at least 75 percent of Qualified Participants must meet this standard in order for the APM to fulfill CEHRT obligations.

The PI scoring methodology has also become more stringent. The concept of a “Base” score, worth half of the possible points, supplemented with a separate performance core and bonus points, has been eliminated. In its place, PI metrics have been categorized into four categories (p. 1136):

- E-Prescribing;
- Health Information Exchange;
- Provider-to-Patient Exchange;
- Public Health and Clinical Data Exchange.

Clinicians will report a selection of measures within these categories, and each measure will be scored individually. A Security Risk Analysis is still required, but earns no points (p. 1134).

Despite the more challenging reporting requirements and restrictive requisite technology, this component continues to count for 25 percent of the total MIPS score. As is the case with other categories, the same level of effort in 2019 will earn fewer points.

6. The big ACO question is deferred, but CMS's commitment to ACOs is clear.

The question of mandatory financial risk for ACOs is not addressed in this rule; that answer will come in a subsequent rule. However, there are ACO provisions within this rule that signify CMS's intentions.

First, ACOs whose terms are set to conclude at the end of 2018 will have the opportunity to voluntarily extend their agreements for six additional months. Since the application process was derailed by the MSSP proposed rule, these ACOs were caught in an awkward spot. The provision in this rule enables them to continue to participate in the ACO without interruption. The reporting and scoring provisions for this six-month window are yet to be determined, which is to say that CMS is so anxious to maintain ACO membership that they are willing to handle certain aspects "on the fly," to avoid jeopardizing the program.

Second, ACOs will not have to report as many measures. Once again, Patients Over Paperwork presents itself as a safety valve; but remember the catch—the decrease in measure reporting may ease the short-term burden of compiling charts, but does nothing to mitigate the ACO's goal of reducing costs.

The Difference Between Quality Reporting and Quality Care

Cost may be comparably smaller than Quality when it comes to MIPS scoring, but consider this temporary. The end game for Patients Over Paperwork, Meaningful Measures and reducing burden on clinicians is that quality reporting's stature will

diminish the focus on outcomes. But remember, these outcomes are measured in costs and will become the scoring standard. Through this rule, CMS has confirmed it has heard the cries of "let me treat patients," and is slowly moving its performance measurement strategy towards Value-Based Health Care reimbursement.

Indeed, VBHC reimbursement based on cost performance as well as outcome indicators is the Final Rule's emergent theme. While physicians may be able to dodge ACO participation and other risk-arrangements next year, forgiveness for costs that exceed comparative norms is vanishing as CMS adds more measures and performance criteria into MIPS. As a result, providers will need to choose whether to live under one of two Value-Based Health Care Scenarios—reimbursement coupled with unpredictable penalties under MIPS, or more predictable risk arrangements under ACOs and Medicare Advantage. Either way, CMS has made its intent clear: Provider payment will be Value-Based.

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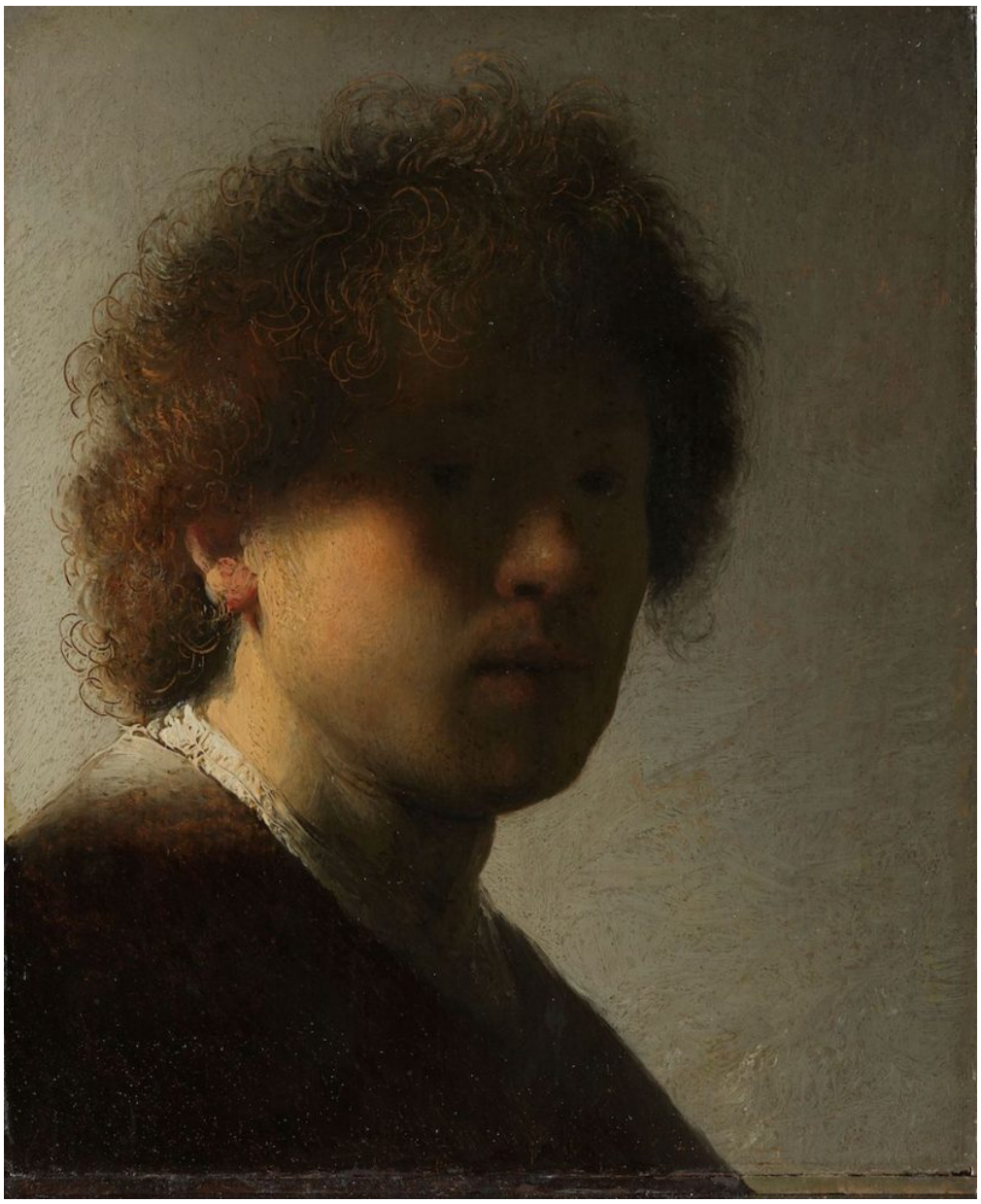
Image: Jordan Heinrichs

ACO Population Health Best Practices: More Respect for Physicians and Patients

written by Theresa Hush | November 15, 2018



How important is it to agree on principles and best practices for population health? More important than most providers believe, and here's why: Population health can be a powerful engine for improving patient outcomes and cost performance in Value-Based Health Care.

Failure to create a standard of population health practices means that every ACO or health system scrambles independently to create initiatives, without the benefit of broader experience and results. The outcome? ACOs make similar

decisions or duplicate others' programs with meager results. They may also inadvertently consign population health to safer territory as administrative instead of strategic and innovative initiatives. Or they may adopt initiatives once used by health plans for medical management that had limited, if any, success. They may believe it's prudent to do so; but as financial risk models expand, that weak strategy will cost providers both money and patients.

Many Providers Don't Understand What Population Health Can Actually Accomplish

Population health is more enigmatic than it should be, because few people agree on what it means. That's because the meaning of population health depends on who is advocating for it.

Ask any ten health care organizations or ACOs about their activities in population health, and you'll undoubtedly find that several programs are deployed for that purpose, but with very different goals. Further complicating matters, since technology is often used to support population health, some providers view the very concept of population health as synonymous with technology and analytics instead of health care improvement. Rarely are overall initiatives organized into a set of goals for population health.

Here is a sample of four initiatives that fall under population health, with distinct, far-reaching objectives:

- Patient outreach to fulfill gaps in care—vaccinations, screenings and diagnostic tests appropriate for their condition;
- Medicare Wellness Visits to ensure attribution of services

to ACO primaries;
Post-emergency room patient contact to establish a bond with a primary care physician;
Post-admission outreach and services to avoid readmissions, usually specific to certain conditions.

Population health also covers disease management programs and outcomes-improvement initiatives that target patients for case management or other services.

The popularity of certain initiatives is not accidental—population health projects are often also designed to enhance revenue (additional patient visits) and to increase competitive edge (create attribution to ACO versus others). In fact, initiatives are often "sold" to create a "return on investment" in business terms—rather than to improve patient health.

Population Health Is a Misnomer—Grouping Patients Should Lead to View of Individuals

The term "population health" is appealing because it sounds both simple and holistic. The simplicity, however, is pure fiction. There is no one population to act upon, but, rather, many diverse groups of patients with different needs.

The origins of population health are philosophical and economic: shift the role of providers from simply delivering services to taking responsibility for health of their patients. But here's the key: *there isn't one universal population of patients with similar needs.* Patients have very different attributes and circumstances, along with distinct clinical needs. So, too, must be the solutions to improve their health

status.

In today’s consolidated health care environment, where business concerns influence health care strategies, population health frequently becomes oversimplified. That is the appeal of large “fill the gaps in care” programs. All too frequently, these and other programs are focused less on patients in the population, and more on how to achieve double duty by raising quality scores while increasing patient volume and related revenues.

To effect a real improvement in patient health, however, providers must differentiate diverse patient subgroups and examine whether group action can facilitate individual patient responsiveness. Efforts to document barriers to care, understand clinical implications for different groups of patients, and create effective programs for improving health must be woven into a panoply of initiatives aimed at clearing pathways for individual patients to achieve better health.

No Guidebook for Population Health? Start with Values to Achieve Trust and Loyalty

Without a guidebook, how can ACOs succeed with fewer resources? They can organize their efforts around two fundamental goals:

- Ensure that population health initiatives support physician-based care to improve patient health, making partners of their physicians; and
- Respect patients and their right to choose, while increasing the tools they have to do so, making partners of their patients.

Population Health Must Work With—Not Against—Physician-Provided Care

The purpose of population health should be to balance and support physician-patient care. Some ACOs, disappointed with results, work against their physicians, creating sidebar communications with patients that are not interwoven with physician-patient interactions. Physicians can be unaware that patients were contacted because population health technology may be documented elsewhere in the EMR or via independent technology that the physician doesn't see in the patient visit template.

Patients will be the first to notice lack of coordinated messaging or incongruent recommendations, and that botched communication will abrade trust in both the physician and the organization. No matter how small or isolated it may appear, every population health initiative requires a tie-in to the patient's physician so that the physician can affirm the objectives, respond to questions and cement trust with patients.

This means that any communication to patients must come from physician offices or under physician names rather than central organizations; physicians must be educated about the process and buy into the goals of various population health initiatives. Case management services, if adopted, must be coordinated and not independent of physician care, and results transmitted for physician view in the EMR. Additionally, when third parties such as case managers or patient coordinators gather patient information, physicians should document that they have read and validated that information with patients.

In other words, population health cannot be solely an ACO or organizational effort. It is a team-building exercise with team results.

Population Health Must Cultivate Patient Decision-Making, Not Compliance

Population health initiatives may cover a range of outcomes or performance improvement goals, selected strategically by the organization. But organizations should be wary of adopting programs with simple goals of increasing patient compliance or demanding that patients schedule visits. Patients, especially younger ones with a savvy consumer instincts, are quick to cast these as revenue initiatives rather than improvements in patient care. Providers should carefully reconsider how to render services in order to reduce cost and improve convenience for patients.

Population health should include efforts to improve patient health care literacy and alignment of their goals for better health. These can include:

- Tools for communication and information-sharing between physician and patient;
- Access to telemedicine visits, email and other means of remote communication;
- Shared medical decision-making processes;
- Support networks for vulnerable patients, including activities to connect family and community safety-net systems into the patient's care;
- Resolution of financial issues, including transparency in pricing and bundled pricing for patient comparisons.

The common theme for population health initiatives must be to treat patients respectfully, reduce bureaucracy and increase dialogue on health issues as well as costs so that the patient can make informed choices.

It’s inevitable that some patients will fall through the cracks. Event-based projects to follow up on patients with frequent ER use or recent admissions should be included in population health, but the context is important. These initiatives are more powerful if they are integrated into overarching initiatives to improve physician-patient connections and communication.

Population Health Roadmap Should Be Flexible, Based on Tested Results

Concepts of patient responsibility and even patient outreach are relatively new in health care, and they are emerging at a time of high distrust and antagonism between consumers and health care institutions. All the more reason for providers to create a population health strategy based on these key elements:

> Develop a thorough understanding of the patient population derived from data and analytics—but with additional patient feedback on issues of access, trust, quality and cost;
> Collaborate with providers to construct models that build upon, rather than disrupt physician-patient care;
> Pilot and test results, and evaluate all initiatives regularly with a variety of tools—with input from both physicians and patients

As we proceed down the path toward Value-Based Health Care,

it’s time to abandon the simplistic ideas of population health, management of patients and their outcomes, and physician or patient compliance. The best future, built on a foundation of good data, will be defined by collaboration and partnerships.

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Image: Self-portrait, Rembrandt van Rijn, c. 1628, courtesy of the Rijksmuseum.

Consumers Want More Value from Value-Based Health Care: Why Providers Need to Listen

written by Theresa Hush | November 15, 2018

The dramatic rise in personal costs for health care services and coverage, sharpened by political battles over affordable care, is driving consumer health care activism to a new level. Voter projections indicate that health care will be the largest single voting issue in the 2018 mid-terms, with 30 percent of voters saying their decisions will depend on where Congressional candidates stand on health care coverage. While there may be a strong partisan split regarding the solution, broad dissatisfaction with the current system crosses party lines.

Health care today takes a huge bite out of most Americans' personal finances. It is now the rule rather than the exception to see high-deductible employer-based health care coverage, plans with limited benefits or choice of providers, or those that include no dependent coverage. Medical debt at an all-time high and still escalating, while wages remain stagnant.

And how do consumers assess their high-priced medical care? Numerous surveys point to dissatisfaction with health care experiences, cost of premiums and services, and lack of convenient technology and services for consumers.

Consumer Attitudes Are Reshaping Health Care Values

At the same time, Value-Based Health Care is moving providers toward financial risk, which raises the stakes for patient loyalty and satisfaction to make the economics work. Retaining healthier and younger patients in the system is crucial. Consumers' health care attitudes matter. What are they saying? Traditional health care is not consistently providing the value they want and expect:.

- Clear information about cost and affordability;
- Quality;
- Easy access and convenient services similar to retail shopping and online booking;
- More time with physicians;
- Better information for medical decisions.

Consumers now have more ways to access health care when they need it, through business-operated and pharmaceutical walk-in clinics—clinics that shave preventive-care and primary care revenues from health systems. In one survey, 40 percent of responders said they would trust health care services delivered by Walmart or Target, and one third would like Google or Amazon to deliver care. Consumers also appear to trust their own doctors less, with only one third placing trust in physicians. Why? They think business can deliver a quality product at more affordable cost than traditional health care.

Indeed, retail clinic visits are increasing—especially among the younger population that health systems want to attract. Those same patients are tracking their own health care activities with wearable devices, researching options via the Internet, and sharing information or seeking counsel from peers online. Also significant: they are accessing consumer ratings of providers online before choosing them. In short, tech-savvy consumers are on the rise, and they are putting value on saving money and time through digital connections with providers, convenient scheduling and telemedicine.

Divergent Health Care Literacy Among Consumers Creates VBHC Challenge for Providers

Not surprisingly, wealthier and more educated consumers are the ones most likely to access technology, use wearable devices and research health topics. Survey results show a slight bias in favor of younger, more educated consumers. By contrast, when health literacy is measured, the most vulnerable consumers are the ones with the least proficiency. Elderly people are significantly less proficient in health topics, and almost half of individuals with no high school degrees lack even basic proficiency. Individuals on Medicaid or Medicare also tend to be less proficient.

The combination of age, poverty and other social determinants—those at greater risk for chronic illnesses and who are less able to afford health care—adds complexity to implementing Value-Based Health Care. Providers cannot simply add technology and modern consumer conveniences for affluent and younger patients. *Consumers* with no ongoing serious conditions will perceive value differently than *patients* with

chronic issues. To improve their health, those patients and their families will need stronger and deeper connections with health care services, and providers will need to engage them in order to survive value-based reimbursement.

Whether patient or consumer, whether they express it or not, all need:

- Education about health care and their conditions via non-print mechanisms;
- Incorporation of preferences and circumstances in recommended treatments;
- Stronger community and family support involvement in complex care arrangements.

Five Consumer/Patient Strategies that Health Care Providers Should Embrace Now

Providers have been overwhelmed by changes from all directions—scientific advancement, technology, the business of health care and a raft of proposed solutions for Value-Based Health Care. Physicians protest lack of time and infrastructure to support what consumers want, and few have any interest in participating in telemedicine. The health care system does not seem to have the band-width or internal support to manage all the demands at once.

Given this contentious environment, what can providers reasonably do to meet consumer needs?

1. Package specialty care in episodes, starting with procedures, to create price transparency, quality measures and improvement, and consumer/patient education.

It is nearly impossible to give consumers what they want to understand costs without combining the various services into an episode of care. Surgical and medically-specific episodes provide the basis for price transparency. Providers can begin with Medicare procedural episodes, but will need to experiment much further with pricing models that can be applied to all types of care.

2. Create collaborative health literacy and educational programs for patients, beginning with high-risk conditions.

The first step to supporting better engagement and medical decision-making is to involve patients and consumers in education. Partnering with various businesses and community organizations involved in food, lifestyle and entertainment can be beneficial, as well as with organizations aimed at children and adolescents.

3. Work with physicians to implement telemedicine and support their communications and tele-health needs.

Adding telemedicine to existing physician workload won’t work without adding support and mechanisms to replicate information gained in a face-to-face visit, including the physician’s investigatory manner. Organizations need to plan and involve physicians as well as consumers and patients in the venture.

4. Establish patient panels to guide priorities for improving conveniences and customer-focused policies.

Online scheduling and other initiatives that consumers want, including two-way communication in the patient's record, can't be an immediate fix. It will take many months, if not a few years, to fully plan and implement the functionalities along with educating providers. It's extremely important to broaden input regarding what the program should accomplish, and what should come first, by talking to patients. They may want something simpler and less sophisticated than providers expect.

5. Address physician burnout, compensation and productivity incentives, and support for physicians in VBHC.

The tallest agenda item in VBHC goes beyond resolving consumer needs to revisit the front line that patients depend on—physicians. If physicians are not on board with changes, it's because they haven't seen the value or don't have the time to be involved. Physicians are the conduit to change and the emissary to patients. Health care organizations will benefit by clearing their paths to enable that work.

Providers have spent the last several years consolidating, adopting technology and creating systems to manage health care. The objective has been to embrace populations of patients coming via Medicare, commercial ACOs and other VBHC conduits from health plans. But those patients won't be coming—or staying—unless they have no other choice.

Historically, health plans and employers have been perceived as

the “customer” in health care. Adoption of consumer strategies is a relatively new idea. The current administrative health care complexes are big, but not always consumer-friendly, let alone prepared to handle customer retail interactions or offer education for knowledgeable consumers or patients. Now is the time, while health care consumer activism is still ascending, for providers to plan for a reliable, loyal base of knowledgeable patients.

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Image: *Een manier van vliegen,* Francisco de Goya, 1864, courtesy of the Rijksmuseum

Wise Patients Really Can Make Medical Decisions

written by Robert McNutt, M.D. | November 15, 2018

“The numbers in this blog are hard to believe. Why is the

medical profession recommending shingles vaccine? It is one thing to say that patients should be their own advocates. But why would medical professionals recommend a vaccine to their patient that has such a paltry risk/benefit outcome? After all, we go to doctors because we presume that they know more about medical conditions, prevention and treatment than we do. If they don't, what's the point?"

A wise patient reading my blog on the shingles vaccine made the above comments.

The adjective "wise" has been defined as "able to make good judgments." Good judgment leads to a good decision. Good decisions are the goal of prudent, discerning and knowledgeable medical care.

Patients are capable of being wise with their medical care. People, if informed about the consequences of a choice, become astutely aware of the tangible differences between compared tests or treatment plans. They can then balance added benefits and harms of one plan over another. This process of becoming aware of differences in outcomes for alternative plans, and then making their own decisions based on their preferences for trade-offs, leads to wise choices.

What Does It Mean to Be an "Informed" Patient?

Note that I say "informed about the consequences of a choice." Informed medical decision-making has some crucial requirements:

> *First*, a trade-off; one plan must be better in terms of outcomes of the disease condition, but that plan must also be worse in terms of side effects of the treatment. Hence, a

balancing must be done.
Second, an informed choice requires evidence from randomized trials showing that there is actually an added benefit and harm of one plan versus another. (If there is no added benefit or if there is an overarching public health decision to be made—for example, childhood vaccination—there is no trade-off, so decision-making is perfunctory). The bulk of medical decisions require an evidenced-based trade-off, and patients will need help to find and assimilate the evidence.

Only Patients Can Determine Value in Medical Decisions

I know the writer above is wise because that individual is making an informed decision regarding the shingles vaccine, balancing the trade-offs from a personal perspective. The goal of medical care, after all, is not to promote the same decisions for everyone, but, rather, to encourage variable decisions based on each person's personal assessment of the balance between benefit and harm.

Patients' ability to discern the meaning of differences in outcomes of alternative options for care from their unique perspectives allow them to be the wisest decision makers, more so than any statistician, researcher, epidemiologist, journal editor, guideline producer, insurance agent, politician or physician. Are these medical people wise? For themselves, yes, but for others, no, in my view. They are, certainly , purveyors of medical facts. But they are not able to perceive someone else's preferences for trade-offs, an essential component of most medical decisions.

Barriers to wise choices abound, however, despite best

intentions. Some barriers rest with the patient, and some with the business of medicine. Some barriers on the patient side include lack of understanding or emotional incapacity due to fear and anxiety, perhaps, or family members and friends bearing incorrect information. On the medical side, misleading advertising, clinicians and researchers with conflicts of interest due to financial arrangements with industry or poorly produced, irrelevant studies in the medical literature may rebuff wise choices.

In a sense, a patient is the only one who has the correct incentive system in medical decision-making. Patients wisely determine the value of information and then use their own outcome preferences to balance and choose. They, after all, are the ones who face the consequences of their choices. Those who hold the patient's best interest above all other factors should ensure that patients are properly informed and guided through the decision-making process. The third, crucial component of informed, high quality medical decision-making is that competent patients should and can make their own choices rather than have choices made for them.

Informed Patient Decisions Rest on Data from High Quality, Randomized Trials

When patients must make medical decisions, they need to know what options for care are available to them, and those options can only be revealed by high-quality, randomized, controlled trials that are relevant to the individual patient. When there is not adequate data or research to fully address the benefit/harm trade-off, physicians must make this clear to patients.

Patients may find it helpful to use a decision aid such as a table or chart to understand and compare the benefits and harms of each course of action. Patients and their physicians should work in partnership to review appropriate data, discuss trade-offs and arrive at the patient's best decision.

Physicians Should Guide Patients in Understanding Trial Data—but They Need Help

Physicians complain that they do not have the time for coaching patients through a medical decision-making process, let alone the time for reading and curating the latest research results. We know that physician burnout is a real problem, and that expecting physicians to be the data-aggregators will meet with pushback if implemented.

Every provider organization has the responsibility to facilitate the organization of a decision-making process to enable patients to be wise and make informed medical decisions. Providers need to ask these questions:

- Where is the accountability best located for organizing a patient's value-based medical decision-making process?
- Who should gather clinical trial information and evaluate its quality?
- Who should develop tables or other patient tools to evaluate their options?
- How should physicians be coached in the most fair and effective way to present data to patients?
- How do we document the options as well as the patient's choices, to make it easy for clinicians?

To facilitate the collaboration of wise patients with their

physicians, we must acknowledge the realities of physicians in practice and establish a system of support for good medical decision-making supported by data. We can’t push productivity and cost performance while expecting physicians to tabulate options for their patients. This is where the organization must step in to help. Specialty departments, practices, an overarching medical group, or even an ACO could all be appropriately involved in creating a structure that will work for physicians and their patients.

Provider Accountability for Presenting Options Is a Must, but the Process Should Vary

The scope of potential decision points is vast, and many will argue that it is impractical to support all medical decisions and every patient visit with lists of research, options and benefits/harms. But determining which decisions must go through a process of reviewing options is not easy or clean-cut. Dozens of decisions might be made in a single patient visit—pursuit (or not) of screenings, testing, vaccinations, changes in existing treatment plans. All of these should have data supporting the efficacy as well as risks.

It may be useful to prioritize decisions that require time, involve more complex processes for the patient and have life-altering implications. A decision to get a shingles vaccination does not involve the same scope of analysis as a hip replacement or cancer therapy. Physicians should be able to present information to patients for frequently presented health care issues along with known benefits and harms, and without undue bureaucracy or meddling—but with the involvement of the organization in establish consensus on the options and clinical

research data.

Entrusting physicians to independently provide patients with information for their decisions also rests on the expectation that physicians and their organizations review research and collaboratively set a standard of practice on the most recent results and research-driven therapies. This is a big undertaking that must be done by professionals who can review and validate research, because physicians themselves will not be able to take on this task.

Presenting data to patients will also require supporting a change in how physicians see their roles regarding guidance and education. Teaching them to educate patients on options and with data—without patients needing to ask—will be a significant shift.

Only a limited, defined number of decisions require an organizational process and standardized patient tools. These decisions should be of importance to both the patient and the larger organization that will need to shepherd this process along. The organization needs to have the authority and rationale to adequately engage the physicians and patients.

Organizations that are at financial risk or required to use cost measures (as part of MIPS) will have the impetus to centrally create and develop materials for physicians and patients to use for medical decision-making. The organization needs to curate high-quality, relevant medical research with the help of research-knowledgeable clinicians and scientists.

Helping facilitate patients' ability to make wise choices is

not “pie-in-the-sky” thinking. It is a critical step in the movement toward Value-Based Health Care and engagement of patients in medical choices. It is also a necessary correction from traditional and paternalistic medical care, incorporating health care consumers’ growing desire to balance their preferences, costs and benefits of treatment. As patients become more involved in the process of making medical decisions, we will also need continuous assessment of approaches to patient decision-making to identify the most efficacious processes and their impact on both patient-physician relationships and health outcomes.

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Image: Lubo Minar

Why ACOs Must Build Trust with Providers and Patients to Meet Goals

written by Theresa Hush | November 15, 2018

As ACOs develop approaches to Value-Based Health Care, they are

struggling with a key issue: lack of trust. How can providers commit to collective cost reductions that could have potentially negative revenue consequences for themselves individually or on their practices? If they don't believe that the other players or their ACO are operating in the best interests of all involved, how can they participate in the ACO's goals? Conversely, how can the ACO create effective leadership and collaboration if physicians are unwilling to commit to making the model succeed?

Likewise, ACOs have to work harder to earn patients' trust. Ask any ACO for their top issues and they're certain to mention the volume of out-of-ACO services. If consumers do not trust the ACO or its providers, they will not be loyal patients or necessarily follow provider-recommended treatment plans. Successful engagement requires trust.

Provider Concerns Reflect Historical Conflicts

On the provider side of the equation, lack of trust is rooted in a variety of historical and current issues:

- ACO providers worry that downside risk may hurt some more than others—and that the reasons for those differences will not be fair.
- Physicians in hospital-owned ACOs may feel blamed for ACO cost overruns and excess expenses that are attributed to them, while their employing hospital leverages compensation incentives and other rewards to maintain volume of patient services, diagnostics, referrals and admissions—in direct conflict with the ACO's goals to reduce costs.
- Specialists and primary care physicians in many multi-specialty groups compete for revenue and recognition

(through implicit as well as explicit benefits), especially in hospital-employed groups.

When the ACO is formed by existing systems or networks, it usually inherits the politics and personalities of its parent. Regardless of whether the historical group originated from hospital-based employed physicians or a network of primary care physicians, newcomers to the network—independent primaries or specialists—will be on the "outside" and may distrust the motives and initiatives of the founding network.

The ACO itself may not trust its providers to work toward change without a penalty structure in place; but this may cause providers to feel coerced and resentful.

A History of Trust Issues Between Providers Requires Reconciliation

Building a common vision and trusting alliances between providers requires strategies that were not needed in a Fee-for-Service world, where each provider's services and reimbursement were independent of others. By contrast, in an ACO environment, the cost of each provider is tightly connected to others by the ACO's total cost formula—and financial risk has upped the ante.

How each provider delivers medical care in the ACO, including the downstream costs attributed to that provider's treatment decisions, matters to everyone. So it's no surprise that every provider wonders whether he or she will be treated fairly in the ACO. This is a valid concern; providers have not always fared well in past instances in multi-provider groups and reimbursements.

Importantly, most ACOs are also built from prior networks, groups and relationships between providers. Past injustices and grievances swirl in the ACO mix and must be resolved in order to successfully integrate providers into a cooperative, collegial team with shared goals.

Whenever relationships are at stake, the players can only build trust by first acknowledging the validity of past problems. While providers must be willing to accept vulnerability to be part of a group risk-based reimbursement model, all parties must negotiate the terms of the relationship in advance to create a solid foundation of trust.

Consumers Also Have Legitimate Trust Concerns

For health care consumers, trust in providers has hit an all-time low. Indeed, only about a third of consumers trust American health care. Consumer trends as well as personal histories play a significant role in diminishing trust:

- Consumers are bearing a much larger portion of costs, yet providers have produced little or no transparency in pricing.
- Providers blame patients for not following treatment plans, but patients' preferences and barriers to such treatments have often not been discussed or considered.
- When asked for alternative treatments or evaluating options, providers have often given few research-based facts on treatments, benefits and harms, even in cases of efficacy. This could stem from either lack of provider awareness or belief that patients can't understand or shouldn't make medical decisions.
- Consumers don't have a mechanism that gives them

comparative, valid information on providers or their quality, outcomes, cost or issues of concern (such as communication and convenience), leading them to base provider choice primarily on relationships or practicality. When patients seek other providers or try to evaluate other options, their current providers or institutions place expensive, time-consuming obstacles in the way of ready access to personal medical records.

Confronted by the increasing bureaucracy of health care, the difficulty and time required to schedule and coordinate their own services, long wait times to see physicians, and the need to research their own medical concerns, consumers are effectively told that their time and money is less important than the system's.

Employer and other coverage have forced frequent changes in providers as health plan networks changes, so consumers have learned that they cannot count on having long-term relationships with their physicians.

While ACOs are hoping to engage consumers—in part by favoring tools that make it more difficult for patients to seek out-of-ACO services—any exercise of power by the ACO may well backfire. If the proposed CMS Rule goes into effect that permits ACOs to send letters to patients explaining their ACO enrollment, many patients will interpret this information as curtailing their choices, just as once-common HMOs limited provider options—even if that is not the case.

Trust for Consumers Must Be Spurred by ACO Action

Often, a patient's closest health care relationships are with

his or her own physicians. For those who place their health in their physicians' hands, a serious medical issue can leave them feeling vulnerable, physically and emotionally. That bond may cause them to hold their own physicians harmless for any infractions of trust and blame the system. Consumers who don't have such close relationships with their physicians will likely hold both their providers and the system responsible for any issues they encounter.

To create the foundation of trust for effective engagement between consumers and their providers, and with the ACO itself, ACOs must take action. The ACO plays a major role in fixing historical lapses between consumers and their health care organizations, between providers, and between providers and ACOs. In addition, they need to support their providers with tools to improve consumers' ability to make value-based medical decisions, for the benefit of all ACO stakeholders.

Ten ACO Actions: An Agenda to Re-Establish Trust

1. Create accountability for cost and quality that is shared between administrative and clinical leadership, so that providers are included in decision-making.
2. Build transparent criteria for cost and patient care performance that are shared with all physician stakeholders.
3. Create a non-punitive process for both primary and specialty providers to participate in review of their performance data and respond to questions.
4. Create standardized methods of comparing cost through episodes—mostly procedural with some limited diagnosis episodes—for which physicians have validated the inclusion

and exclusion criteria.
Build and discuss distribution formulas for incentives/rewards and risk paybacks in open forums and reach consensus.
Educate providers on shared medical decision-making and help them understand their role in guiding and educating patient choices, facilitated by data.
Create central support for value-based medical decisions for key procedures, chronic illnesses, cancer care and health screenings, so that physicians and their patients have research data and appropriate criteria for reviewing key treatments, costs, benefits and risks.
Working with physicians and consumers, establish processes and instruments for transmitting validated quality of care and outcome information to help consumers choose providers.
Implement transparent pricing for episodes of care with highest volume and highest cost medical and surgical procedures, to share with consumers. Include consumers in the development.
Review consumer touch points for the ACO and its providers to adopt streamlined scheduling and access to providers.

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Image: Ciara Hillyer

Five Strategies for Specialists: How to Safely Navigate ACO Arrangements

written by Theresa Hush | November 15, 2018

Amidst the furor over health care access and affordability, most consumers believe that the exceptional quality of America's health care is due to specialty medicine. But Value-Based Health Care may well dramatically change specialty practice by putting specialists under financial risk arrangements. That's because the most prestigious and flourishing providers in health care are also the most expensive for ACOs and health plans. That makes them a target for cost control.

We have spoken about the need for ACOs to evaluate specialists carefully and ensure that specialists have input into ACO assessments of their cost and quality. Here we address specialists and specialty practices: *What should you do* to strengthen your position with ACOs and health plans under VBHC, and *how do you develop an understanding* of your market performance profile—and your options?

Specialists Unprepared for Move from Fee-for-Service to Per-Case Fees

ACOs, Medicare Advantage Plans and other health plans have an objective: eliminate reimbursements that reward volume of services and replace them with fixed fees per-case or per-patient. Bundled payments are likely to be the future norm for specialists, based on procedures or diagnoses that cover all services or only professional fees, depending on the organization. Medicare has already moved some procedures, such as total hip and knee replacements, into a mandatory bundled payment reimbursement. Other procedures and some diagnosis-based episodes will soon follow.

Here's the problem: few specialists have data and processes in

place to examine episodes of care for their specialty or to understand cost variations by patient. They know their own procedural fees, of course; but how those calculate into a cost-per-case is more complicated. One of the difficulties is that some data for services is outside their scope of care, like those of other specialists or facilities. Accurate measurement of episodes is also challenging, along with the variation caused by different patients, risk levels and incidental services.

The biggest shortfall of all: most specialty practices haven't begun the process of creating episodes or pulling together their cost performance information. And some have only captured quality or outcome data through MIPS or other reporting methods.

Specialists, who have depended on a flow of patient referrals from primary care physicians—in addition to patient self-referrals—are already scrambling to figure out how they should be participating in organized provider arrangements. Some are worried that competitors have already taken the best partners; to overcompensate, these specialists are acting precipitously to enter arrangements that could harm their patient flow, revenues or scope of services.

Specialty Practice Spectrum Requires Strategies Tailored to Each Group

Specialty practices can range from small, independent, single-specialty groups to large, consolidated, multi-specialty practices operating in academic medical centers. The market reach differs, as well. Each type of group has distinct challenges and benefits for ACO or other risk arrangements, so

the ACO negotiation strategies must be tailored not only to specialty type, but also related to their market strength and size, practice scope, structure and their tolerance of risk.

Single-specialty groups will have an easier time organizing services, because they are more easily packaged. If they have significant volume, they are well-positioned to participate in ACOs for specialty referrals, because bundled payment reimbursement can be focused in discrete areas and on fewer procedures.

Multi-specialty groups (except for the rare handful of nationally recognized names) are more diffuse and have a harder time establishing the brand and identity they need to compete. The ACO may have a desire to pick and choose specialists, which may be both financially and logistically difficult for the group. Because the group will compare costs by procedure and/or diagnosis and by specialty, multi-specialty groups should be prepared to be flexible with multiple types of risk-based reimbursement, including capitation payments.

Hospital-owned multi-specialty practices have the advantage of closer facility connections to address the total cost of care versus limited professional fees, as well as resources that are usually greater than those of independent groups. These groups may find the benefit of negotiating bundled payment episodes, including multi-specialists plus facility fees, most lucrative—even if the distribution of funds is extremely difficult.

Academic groups have credentials, but can suffer when converted to full-time equivalent clinician staff, so many providers generate lower volume services. This makes it difficult to entertain episodic risk. Even when they do have

good cost performance—and some do, because they can be large Medicaid providers—their attractiveness to ACOs and other risk-based plans is diminished by the diffuse goals of the academic center. That challenge can be made worse by the small procedural volumes that make it difficult to accurately price. Like other large groups, they may find the easiest scheme to be capitated payments that are then actuarially distributed to specialties and specialty groups.

Five Pre-emptive ACO Readiness Actions for All Specialty Groups

Specialists must recognize the shifting social-to-business transition that is occurring quickly because of financial risk. The personal and collegial relationship, once the foundation for primary-to-specialist referrals, will be severely limited by the addition of financial risk. The metrics of cost, quality and patient experience (outcomes and satisfaction) will determine whether specialists will have patient flow. Even hospital-owned ACOs in the future will be leaning more heavily on their own specialists to cut episodic costs, because revenues will depend on achieving expenditure targets.

Given the tendency for ACOs, hospitals and health plans to want to "score" physicians, just as they have done with quality incentives, these metrics have the potential to discourage and anger physicians. Therefore, physician groups and hospital-physician groups should engage in pre-emptive strategies to control their data, facilitate sensible episode and bundled payment developments, and be involved in processes to support physicians in investigatory—not punitive—processes of understanding cost variations in total and by patient.

Regardless of size and structure, here are five steps that all specialty physician groups should follow:

- Take control of the story and the numbers. If you are up to speed on how ACOs and health plans are using data to calculate specialty provider costs, you will realize that you can't be passive and accept external numbers. You will need to compile your costs, your volume, your claims data (to extent available) and to evaluate existing comparative data from prior Medicare QRUR supplemental reports, to examine costs by diagnosis as well as cost outliers for the specialty group.
- Collaborate with an ACO or another partner in examining your cost structure and your specific per-case costs. Groups that have resisted cost sharing in the past should recognize that there are provider-identified sources of claims data that health plans and others are purchasing for comparing providers. It's a new day, and if you can collaborate and share the costs of data and analytics, you are that much farther ahead.
- Create both procedural and diagnosis episodes for use in tracking costs over time by patient and provider. Why? Because you need a common standard to compare variations of care across patients and providers, as well as to capture patient risk and other factors along with the episodic transactional data. These episodes—mostly procedures—will reveal both cost and data issues to explore. Diagnosis episodes, in general, are not well adapted to bundled payments, except for per patient/year payments for major chronic diseases; the data embeds diagnosis-coding disparities between providers, which makes cost calculations difficult.

Establish key core quality and outcome measures—including complications, redo's, readmissions, mortality and patient-reported outcomes that are evaluated in each episode along with cost metrics. It is not enough to use MIPS process measures because the objective is to identify quality of the episode along with costs. That's the story that must be sold for every specialty practice.

Distinguish your practice by what you do better and differently with more data, especially gathered from patients. Like any business outside health care, you must create a reason for people to choose you. Important components of this choice have to do with functional outcomes that can and should be reported by your patients, along with patients' stories and your practice improvement programs. Specialty practices can't rest on past accolades when data is being used for specialty selection.

The most important strategy for specialty providers to undertake now: get started, and work collaboratively with risk-bearing entities. Specialists are in a unique position to contribute to the understanding of costs and, in particular, to analyze variation in costs per patient. Active participation in developing the practice metrics will create a learning environment within the practice, if pursued carefully and without punitive goals. Physicians must lead this effort if they want to avoid inaccurate conclusions by non-clinicians regarding efficiency and effectiveness of specialty care.

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ACOs Under Risk: Select Specialists Based on Collaborative Audit Process

written by Theresa Hush | November 15, 2018

ACOs have tiptoed into developing a physician network based on value. Building a full lineup of primary and specialty physicians to serve their patient population presents a daunting challenge. Even more relevant, until downside financial risk arrangements become mandatory, ACOs have been able to keep their physician networks inclusive; managing cost of care has been a lower priority than maintaining volume of patients or physician relationships.

All that is poised to change as ACOs come under downside financial risk. The threat of budgeted expense levels that mandate repayment to Medicare or forfeiture of revenues to health plans will change traditional ACO provider affiliations. ACOs will be forced to examine all their costs, targeting not only facilities and post-acute care, but also the specialists who generate those costs.

ACO Network Composition Reflects Historical Affiliations Rather Than Value

Historically, most ACOs have formed their networks from traditional relationships, rather than from a value-driven analysis. As a result, the network follows the structure of the ACO. In hospital-based ACOs with employed physicians or a clinically integrated network, for example, the network includes everyone, both primary and specialists. There may be additional selected independent specialists if needed, based on relationships with the hospital or physicians, sometimes as participating physicians and sometimes as "other entities."

In physician-driven ACOs, by contrast, primary-care-centric ACOs may keep the membership restricted to primary care physicians, so that specialists can be individually selected. Multi-specialty groups, however, usually include all group physicians regardless of specialty, making their selection process more akin to hospital-based ACOs.

The point is that existing networks are usually built on prior referral relationships and little—if any—data. There are some bold exceptions. But the norm is that communication between primary and specialists about patients—otherwise known as coordination of care—has formed the foundation of ACO relationships.

That may be one reason why hospital-based ACOs, as a group, fail to achieve the savings achieved by physician-led models. The latter place less burden on physicians to be inclusive and are thus able to create a stronger central organization to achieve ACO goals. They also have more clout with physicians to keep the focus on ACO cost performance.

Savings from “Coordination of Care” Are Tactical, but Are They Significant?

There is frequent discussion, even in regulatory reports, that ACO savings are derived from a higher level of care coordination. While savings will be realized if a care team improves patient hand-offs between settings and shares data between entities and systems, however, this is not the main explanation. Why? For one thing, avoidance of duplicative and other non-performed services cannot be and are not measured. But the message that coordinated care is effective sounds good to patients and to providers. Making the ACO appear less threatening to both groups downplays the specter of controlling costs by more aggressive tactics.

More aggressive tactics, however, will be required of ACOs to control costs. Rather than coordinate care, the task is to organize care. Coordination is achieved on a patient-by-patient basis by providers *who are already organized into a common set of goals.* Those goals focus on providing a standard of patient care and costs. An ACO’s network strategy should reflect this by how it selects its participants.

The major savings, as providers well know, come from steering patients into more efficient and effective health care. ACOs that have concentrated on post-acute services, for example, have found that significant savings can be achieved by developing contractual relationships with post-acute providers based on quality and cost. While patients referred into such care can be considered “coordinated,” it is the measurement of value and pre-determined post-acute arrangements that engineers lower costs.

Savings are also realized by steering patients away from some services or by making those services more difficult to obtain. Therein lies the harm of having no sound network strategy that evaluates providers based on ACO goals. We need to ensure that when ACOs are at risk for losing significant amounts of money under financial risk arrangements, their organized networks will deliver affordable care at a high standard—and not limit patient choice or services.

Strategies for ACOs to Create Value-Based Network

ACOs can create a thoughtful, data-guided process for assessing fit between their organizations and their specialty network. The evaluation process should incorporate all four components of specialty physician value: cost, quality, patient services and coordination with primary care physicians.

Few ACOs will have the expertise to be able to accomplish this without help, but there are health care IT companies, such as QCDRs, that can provide the infrastructure and consultation to undertake the audit process.

Key to the evaluation are two important processes that will ensure greater validity as well as acceptance of results by both specialists and the ACO:

- The cost data must be specialty-specific and standardized by a valid unit cost standard, such as procedural episodes of care and medical episodes that are defined by patient parameters of diagnosis and risk. Packaging services in episodes of professional services and all services permit better comparisons across practices, as long as patient risk

is also presented.
Specialists must have the opportunity to participate in the evaluation process and validate the specific results or to explain them. Data never tell the story alone, but provide the basis for conversation and mutual goal-setting.

The ACO should design network needs based on meeting a majority of specialty services/diagnoses/historical procedures required by its patients. This will clarify the particular specialties for recruitment, and whom to include in organized referral arrangements.

ACOs that adopt these strategies will ensure the highest level of consideration about network formation to further their organizations' success:

1. Measure and compare specialty costs.

Sources of data from claims, provider source systems, and Medicare or health plan data files will support the cost audits and are critical to the process. All of these are available to ACOs either through the specialty practice or through their own operations, but the data must be aggregated and patient-centric, where feasible, to provide the highest value. The evaluation should result in metrics on the cost of care by procedure or diagnosis. In addition to cost performance, ACOs should be able to measure complications, redos, and readmissions incidence with claims data, and examine benchmark data from Medicare to compare costs by diagnosis with reports available from practice downloads.

2. Evaluate quality and outcomes for core specialty areas.

A QCDR or registry can use the source system data collected for cost audits to evaluate the practice performance in quality. Understanding how the practice performs for all patients, not just a Medicare sample, is necessary to avoid surprises when the sample doesn't match historical patients. The evaluation of quality should also match specialty volumes and patient risk profiles for those served in the past to ensure that the coverage is available for ACO patient services.

3. Obtain patient-reported functionality and outcomes.

No data speaks louder than patients; evaluating specialists requires at least a sampling of responses from patients regarding their experiences with those physicians.

4. Conduct primary care physician evaluations of specialists.

Responsibility for patient care is vested in primary care physicians, and they must feel confident that their input is considered when determining referral sources. Surveys constructed to examine a variety of issues regarding referrals will spot potential issues. These surveys can also reveal issues that should be addressed in the primary care network.

This process of ACOs selecting specialists may sound contentious, because it affects individual physicians as well as their futures. Specialists have a legitimate reason to feel threatened. Therefore, the ACO, acting in territory once

occupied only by payers, must ensure that it offers services and support for specialists as they try to transform their relationships.

Specialists who enter into referral arrangements with ACOs should be able to depend on mutual data sharing, participation in benchmark setting, and valid contributions to the creation of episodes and risk stratification. They should be respected for their contributions and invited to help the ACO and primary care physicians understand the factors that contribute to patient risk and better outcomes, so that these can be addressed in ACO projects and process changes.

Selecting specialists in a data-driven way upsets the existing hierarchy of relationships among physicians in health care, and alters the financial arrangements for all parties in ACOs. But the success of physicians of all specialties depends on working collaboratively to achieve common ground.

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Image Credit: Denny Luan

The ACO Challenge: Your Essential Reading List to Prepare for Risk

written by Theresa Hush | November 15, 2018

The concept behind Accountable Care Organizations remains

reasonable: Groups of health care providers take responsibility for total cost and quality of care for the patients and receive, in return, a portion of any savings they achieve.

But as CMS Administrator Seema Verma made clear in announcing the Proposed ACO Final Rule last month, “Medicare cannot afford to support programs with weak incentives that do not deliver value. ACOs can be an important component of a system that increases the quality of care while decreasing costs; however, most Medicare ACOs do not currently face any financial consequences when costs go up, and this has to change.”

We’ve been writing a lot about ACOs over the past year and following trends closely. There is no longer any doubt that in order to survive, ACOs will have to assume more risk.

To help you both to understand the issues involved and to develop effective strategies for your own organization, here is a collection of our best content on transitioning an ACO to risk for long-term success:

Download our free eBook

How to Achieve ACO Cost Savings: Innovative Strategies for Performance Improvement April 2018

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Ready or Not, Providers Will Face Risk Under ACOs or Medicare Advantage

written by Theresa Hush | November 15, 2018

In any other industry, companies work hard to interpret

purchasing and regulatory trends, and adapt quickly in times of change. Swift action is a hallmark of competitive business; those that linger risk failure. Examples of business adaptation are everywhere: a move to digital applications that help consumers and other purchasers connect and build loyalty; acquisition or spin-off of business services to enhance growth; immediate response to negative press.

But in health care, the pace of change at the industry's core—healthcare organizations and health systems—is slow and barely responsive to the market. Case in point: while government and private health plans are moving to risk-based reimbursement, and health care costs continue to escalate beyond affordability, healthcare organizations are re-inventing revenue cycle strategies and initiatives to optimize Fee-for-Service revenues and investing in consolidation plans that push costs higher. They often still lack an understanding of patients as their customers and offer few conveniences to them or individualized plans of care to accommodate finances or barriers.

Late to the Party, Can Providers Still Be Ready for Financial Risk?

To many health care organizations, financial risk may be a future possibility rather than present reality. They haven't prepared for this reality by measuring cost performance. In fact, a good number of Medicare Shared Savings Plan (MSSP) ACOs—a plan intended to move into risk-based reimbursement—now say they will quit rather than accept losses that will require payback to Medicare.

That vision of reality is myopic. It is hard to see a future

where participation in Medicare is truly optional for many providers, with an aging population and Medicare enrollment headed toward 80 million beneficiaries. With the release of the Proposed Rule on ACOs last week, CMS also removed any doubt that they intend to push providers into financial risk.

Providers not reading signs of change in the market will be caught short when the switch flips to financial risk. Private sector-Medicare ACO partnerships are poised to rise, following a penetration of private health plan ACO enrollees that already outpaces Medicare. Along with the shift in costs for health care consumers, the trend promises to push consumers into plans that cap their costs and provide more benefits. These are, of course, risk-based plans.

There is no longer any doubt that a provider stand-off on risk acceptance—including spending targets, capitation and paybacks in payer contracts—has little chance of success. In fact, the percentage of payment at risk is likely to increase over time, along with the power of risk-based entities and payers.

Given that reality, the key question is whether providers still have the time to create ACOs and make them work or, for that matter, create a successful venture under any risk-based reimbursement.

Tougher Future for ACOs Under Proposed Rule, but Some New Advantages

The new Proposed Rule requires that ACOs move to financial risk faster, and a longer contract term ensures that they are serious about making it work. “Practice time” for achieving savings will be minimal if they don’t get it right from the

beginning; however, there's no break from Medicare—providers can't avoid losses by reorganizing an ACO, and even if they break up, payback of losses to CMS is still required.

ACOs will be able to offer some financial incentives to patients to maintain health services and can inform beneficiaries of their ACO enrollment. How the ACO handles this outreach and other customer services will determine whether patients see this feature as positive or negative.

Many hold-out organizations will still find ACOs too risky an endeavor. But don't worry, because if providers are unsuccessful or don't participate, CMS already has a back-up plan—Medicare Advantage (MA). Indeed, CMS is signaling its support for higher Medicare enrollment in MA.

Providers will have to decide which path is better for them in the future: an ACO, where they have the potential to keep and distribute savings earned through their own innovations and initiatives, or Medicare Advantage, where they are participants in a plan with dictated rules and their future is still based on cost and quality.

Medicare Advantage Plans Are Getting New Rewards from CMS

Medicare Advantage is really the natural fit for an administration that would like to cap costs and minimize regulations. MA is the "privatize Medicare" solution, but the difference is that it's already happening. A little known fact about Medicare Advantage: MA plans have experienced such rapid growth over the last several years that they now account for a third of all Medicare beneficiaries.

In fact, some project that MA will overtake traditional Medicare within a decade. However, the state-by-state coverage differs dramatically, with top states like Florida at 65 percent market penetration, and others in the Midwest at 11 percent. While a payer market strategy is partially at work, there is another interesting metric that may be having an impact—areas with high ACO activity have lower MA enrollees.

CMS is pointing to MA plans as successful experiments in controlling costs. Even in the opening sections of the recent Proposed Rule on Shared Savings Plan ACOs, there is favorable language regarding MA: "If these changes are finalized, we will continue to monitor the program's ability to reduce healthcare spending and improve care quality to inform future program developments, including whether the program provides beneficiaries with the value and choice demonstrated by other Medicare options such as Medicare Advantage (MA)."

Providers should see this as a warning that ACOs will be measured against the benchmark set by Medicare Advantage plans. MedPac, the advisory body on Medicare reimbursement, is also watching MA as a comparison to ACOs and suggests that ACOs' transition into Medicare Advantage plans is likely, since it will ensure the enrollment (and better control) of patients and their services and costs.

MA plans were also recently awarded additional advantages for their participation in Medicare, to further motivate enrollment. They will be able to offer additional benefits to Medicare beneficiaries beyond traditional Medicare such as home modifications and help to allow seniors to stay in their homes.

Finally, under Proposed Rules for MIPS, CMS is granting providers a free pass on MIPS reporting if they participate in a MA risk-based plan.

Paths Open to Providers to Participate in Medicare—with Revenues at Risk

With decision time fast approaching for providers to determine how to participate in Medicare Value-Based Health Care, what options are promising? There are essentially five paths that organizations can take if CMS adopts the Proposed Rule as currently structured, described below.

But here's the catch—playtime is no longer available. Organizations that still want to have ACOs should heed three pieces of advice:

First, build on existing network and market strengths. There is no time, for example, to turn around a big specialty ship to become a primary-care centric ACO model. Instead, a specialty-rich organization should build on its strengths to participate in other ACOs and risk-based reimbursements through specialty-appropriate risk models, such as episode-of-care fees.

Second, ACOs must be ruthless about choosing their member physicians and practices in the network. The days are gone when specialists can be automatically included because they are salaried members of a hospital-based group. In fact, hospitals should already be separating out multi-specialty groups with single Tax Identification Numbers (TINs) to improve chances of ACO savings. This doesn't mean specialists are out—they can participate as the referral network, but patients attributed to them under ACO

attribution rules will not improve ACO finances.
Third, hospital-based ACOs have particular challenges and by-and-large have poor cost results. Consolidated networks must embark on a different strategy, inventing ACOs that can act like a physician-led enterprise. We have outlined how this innovation might work in a recent article on developing ACOs.

The following five paths for participating in risk focus on physician strategy, because this is the key to how ACOs work. Patients are attributed to primary care physicians based on an algorithm of their historical services. Costs of care are assigned to the ACO based on a formula. But with time running out to make such a simple proposition save money, providers must develop a strategy that has the best chance for success, immediately.

Note that for specialists, membership in an ACO under the first two paths is not beneficial. Specialty risk will only make sense under a plan of episodic payments for procedures. In addition, there is not yet enough data or experience to establish reimbursement for complex medical management of chronically ill patients or those with multiple risks performed by medical specialists.

With those caveats and context, consider these pathways:

1. Develop an ACO or other APM to incrementally move the organization safely into financial risk.

This assumes that the health care organization has a

substantial enough primary care network and the infrastructure to manage ACO initiatives or, alternatively, a Primary Care Medical Home (PCMH). Because CMS removed the option to continue a shared savings plan with no revenues at risk under the Proposed Rule, the entity must be positioned for savings from Day One. This means having tight coordination of patient services as well as data and infrastructure at inception, and the attention of specialists and facilities for referral arrangements that will be critical to cost performance.

2. Participate in another ACO or APM with acceptance of its financial risk.

The Proposed Rule makes this an important distinction from the first path because, once created, an ACO cannot reorganize itself to dodge repayment of cost excesses to Medicare. Organizations that fear the long term impact of an ACO may choose to participate in another as long as there is the possibility of exit, but that flexibility will be unlikely if the organization is a dominant player in the market or the ACO.

Again, this pathway should only be considered by primary care physicians—full membership in an ACO by specialists should be carefully considered by both the ACO for cost reasons, and by the specialty group for reasons of regional market referrals. And it goes without saying that no primary care group should join an ACO without first vetting the ACO's potential for success and having validated information about their partner groups in the enterprise. Success and failure of an ACO occurs as a network and is dependent on the participants.

3. Participate in Medicare Advantage Plans.

Both primaries and specialties can participate in MA plans, negotiating arrangements like any managed care agreement. MA participation does not negate the possibility of developing an ACO, but it will impact your network and patient group. Apart from potentially lower fees, this option allows providers to participate with the least disruption to their organizations. Do not be fooled, however—MA plans will increasingly depend on financial risk to cap expenditures, just like ACO plans, returning to capitation for primary care and episodic payments for specialists. Many MA plans already reimburse in these ways.

So, if your objective is to create your own ACO in the future but you aren't ready yet, MA has both pros and cons. In particular, if the MA plan contracts with a multispecialty group and pays capitation, a big downside requirement is a claims shop to pay specialists. Another disadvantage is that participation in MA could syphon off the patient population that would otherwise be attributed to your ACO, because the benefits and capped costs are a strong MA enrollment incentive.

4. Develop a Medicare Advantage Plan.

ACOs can eventually develop their own MA plan. There is discussion around this concept in policy circles, and the potential for greater cost control and enrollment will appeal to some ACOs. However, being a MA plan cannot make up for a poor network, lack of cost performance monitoring tools and initiatives, and provider engagement. A MA plan should be considered after success is already achieved as an ACO. As a MA plan, both primaries and specialists could participate in the network, but specialists may be contracted separately and

referrals, controlled.

5. Create Specialty Episodes and Fees.

Specialty/multi-specialty organizations and academic centers have the most difficult and uncertain future under Value-Based Health Care. Most lack a large enough primary care network to live from inside referrals; they are regional players with a wider geographic draw of patients. The best path for most specialty organizations is to create episodic payments coupled with a contracting strategy that will achieve targeted savings. But to get there is difficult, demanding that initiatives be established in each specialty to create procedural or medical management episodes. Nevertheless, future payments using this structure are inevitable, and specialists should at least be monitoring episodes with data and technology, if not actually selling those packages to health plans such as MA plans.

It’s not too late for providers to organize and establish ACOs or other APMs, if they pursue it with a business perspective. That involves mitigating the risks of failure by creating a network with proven history of cost-effectiveness, and a customer services strategy developed with patients to keep them happy. The window is closing quickly, however, for providers to create their own solutions. The market is moving on, and financial risk is inevitable for all providers. Only those health systems and groups prepared to act like competitive businesses and respond to the changes now will be able to offer attractive solutions to consumers and patients.

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.

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