Need to Fire Up Your APM’s Consumer Strategies? Start Here

written by Theresa Hush | October 27, 2022

You’ve read it and you’ve experienced it: consumer frustration with an impersonal health care bureaucracy offering few conveniences, difficult navigation, high cost, and lack of transparency. Even as some organizations try to move forward with consumer-focused strategies, these are often still fledgling efforts with little overarching structure that fail to attract consumer attention.

Beyond implementing an EMR patient portal, traditional providers have been slow to develop the consumer focus necessary to generate trust and loyalty. Meanwhile, consumers are welcoming an abundance of health apps and other resources that enable them to manage their health and, if sickness strikes, get quick access to minute clinics or other urgent care providers.

For an APM, that means your patients are leaning toward out-of-network services as well as potential referral to specialists, or attachment to networks other than yours. It guarantees frustration for your providers and playing catchup with patients—if they decide to stick with you.

Knocking at your gate are equity-backed competitors that embrace consumers. Blending a concierge front door with coverage under APM agreements, some corporate medicine competitors appeal to consumers with conveniences like home visits, texting with providers, and after-hours care. They broadcast accountability and reliability, multiple contact paths, and convenience.

Mini-Strategies Won’t Fix Fragmented Health Care—or Your APM

The problem with most consumer-directed strategies is that they are piecemeal and isolated. A single organization may have a wealth of separate tactics, such as the patient EHR portal, but the patient can’t use it much for self-management. Perhaps your EHR allows patients to schedule appointments, but only with providers they have seen before.

We’ve focused on many essential consumer-focused strategies previously, such as:

- Improve patient access to records and patient ownership of data;
- Broaden communications and target marketing by consumer segment;
- Ensure bi-directional communication;
- Improve health literacy and access to research information;
- Incorporate patient device info and other patient-reported data;
- Implement cost transparency;
- Help clinicians understand consumer and patient needs.

These are all important separate initiatives, but here’s the issue. Unless they are pulled together via an overarching strategic plan that is built on the value of consumers and patients, they will not be enough. You may talk patient-centric, but are your patients and consumers really at the center of your APM entity? Even if you can respond *Yes!* for the APM, is the same true throughout your clinical structure and administrative machinery?

The need to address patient centricity in our health care system also means we need our provider engagement strategies to make similar adjustments. In particular, that requires APM supportive training of patient care teams to build connections with patients:

- Motivational interviewing for physicians and other clinicians;
- Recognition and correction of bias in gathering patient information;
- Health literacy initiatives;
- Improved shared decision-making processes;
- Focus on patient self-management rather than directed orders /management;
- Value and assistance in patient-conducted research.

Fix the Front Door for Your Patients and Consumers

The best starting place to boost your overarching consumer strategy is your front door. Improving access to care leads logically to the broader context of redirecting attitudes, clinical care, and coordination activities with consumers.

So, what *is* your front door? It’s how *both* consumers *and* existing patients get to you when they need health care. Many organizations may consider the front door as their website plus a call-center or call desk. But that’s far from the full picture. Your front door sets consumer expectations from the get-go, from how easy it is to find parking and to access the building, to whether your receptionist or intake person is helpful and welcoming; from comfort of the waiting area to length of time spent there, and so on.

In a telemedicine environment, the front door incorporates convenience of appointment time and ease of online access (does the patient get the link in advance or have to scramble at the last minute?). Whether the provider is on-time (and if they're running late, whether the patient is notified) as well as how much time is budgeted for the appointment—all are part of how patients perceive a welcoming attitude at your virtual front door.

When the need for care is urgent, sending established patients through a call-center to try to reach their doctor is a huge front door gaffe. Patients, understandably, resent slogging through a call center and waiting for a call-back that may not happen. Some physicians, aware of that logjam, privately hand out cell numbers so their patients can actually reach them in an emergency. But it shouldn't be necessary for a physician to fix the front door.

How to get value right? Show first and foremost that you respect consumers and your patients by making sure they can reach you when they need to. That tells them everything they want to know about whether they must navigate their own care or that you are there to help them navigate your environment. It tells them that you will take their concerns seriously, that you value them as customers, and that you have also trained employees to respect them. In a truly patient-centric environment, they can articulate concerns and be heard. If you want growth and consumer loyalty, demonstrate value by working from the front door inward through the technology, clinician, and service area. Start by opening the door.

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Image: Garrett Sears

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3 Ways to Engage Physicians to Lead Transformation in Your APM

written by Theresa Hush | October 27, 2022

Doctors leaving medicine spells trouble for health care. And there's real reason for concern. A few weeks ago, the Mayo Clinic released its most recent study on physician burnout, revealing the highest rate in the survey's 10-year history. Sixty-three percent of responding physicians reported one or more characteristics of burnout, with many noting depersonalization, an inability to maintain a work-life balance, and career dissatisfaction. The Mayo story was significant enough to be picked up by *The New York Times*. This worrisome trend creates a real quandary for Value-Based Care and adoption of Alternative Payment Models (APMs), since their success or failure hinges on physician engagement to transform health care.

Paradoxically, the biggest migration of physicians—often to corporate medicine—occurred in 2021. Physicians who were disillusioned over volume goals left private practices and health systems, in favor of employment in environments that appeared more financially- and technology-supportive, and that were aligned with physician goals. Those goals, it turns out, often blend well with Value-Based Care’s emphasis on care coordination and population health—taking pressure off physicians and still providing better care to patients.

Clearly, physician burnout and engagement are in conflict. You cannot hope to engage physicians who are disenchanted and no longer believe in your vision. To enable engagement, we must address the environment in which physicians are currently working.

But here’s a hidden truth that escapes many APM-transitioning providers: The role of physicians in the future will also be shaped by technology and discoveries that will fundamentally redesign health care. We are already adopting those now. While we must address current problems in the clinical workforce, we must also help physicians to shape their evolving role. These two perspectives must work together to achieve maximum benefit for physicians, patients, and APM Success.

Let’s examine the factors at play, and how to craft strategies and models to retain physicians and address their concerns. Only then can they be advocates in the transformation process.

New Data and Technology are Revolutionizing Physician Roles

Technologies like Artificial Intelligence (AI) and Genomics are both rapidly redefining health care. The world of radiology and imaging is increasingly transformed by AI, with machine eyes capable of identifying patients with future disease or risks long before any symptoms emerge. This capability is now working its way through clinical flows to primary care and specialty physicians.

Laboratory markers in conjunction with genomic or imaging data will reveal patient prognosis and speed of disease advancement. So, too, will treatment programs, combined with patient health data and genomic information, identify best clinical pathways based on clusters of characteristics and risks. These technologies will empower clinical and administrative interventions in APM entities to achieve better outcomes with more efficient use of resources. Consumers and patients are eagerly pursuing DNA testing to identify relatives and disease risk. As they become aware of their risk factors, they will also insist on integrating their data with their medical records and want to pursue in-depth discussions with physicians.

The availability of patient EHR data has done little to advance physicians' understanding of their performance metrics. Few organizations have disbursed the comparative analytics and cost information needed to give physicians the Value-Based Care information they need. This includes metrics that show each of their patients compared to benchmarks and to all patients in similar settings, as well as the physician's position relative to cost variation and patient outcomes across all other physicians. The implementation of value-based technology, especially if it includes episodes of care, enables a surge of performance metrics to physicians, helping them focus on improvements such as clinical interventions for their patients.

The new data and technologies, coupled with the market's focus on value and health equity, are already profoundly impacting physicians' roles. Accountable care assumes the existence of a physician-patient partnership, in which both engage and decide together on the course of care. This assumes that the physician is not just a clinician directing or prescribing services, but has these additional roles:

- educator;
- motivator to help patients modify lifestyle risks or adhere to treatments;
- clinical expert on research related to patient's conditions;
- guide or navigator of the patient's health journey;
- coordinator and participant in the patient's care team;
- interpreter and synthesizer of patient's health care results from all data sources (labs, imaging, AI algorithms, genomic, patient-reported data);
- participant in shared decision-making.

The future will involve a multi-level, multi-disciplinary care team to help the lead physician handle these functions—patient navigators/case managers, nurses, patient coordinators, social services, and so on.

General Strategies for Physician Engagement

Most discussions of physician engagement focus on the significant issues of communication and inclusion. These are foundational strategies that can jump-start the process of engagement; but in the end, much more is needed. Structural strategies include:

- Share performance data with physicians including scorecards, cost variation, cost metrics like readmission rates, process

statistics, clinical documentation improvement queries, and clinical resource consumption.
- Involve physicians in boards, committees, and task forces to be part of decision-making.
- Develop training programs for physicians in critical areas, like motivational interviewing and shared decision-making.
- Align compensation incentives with value-based goals, so that physicians are not conflicted with meeting production goals. This sounds easier than it is. The real task is to align communication and the entire reward system toward quality, health equity, and costs. You will need to translate ideals into specific goals that your APM hopes to reach in patient care, how they will be measured, and how physicians will be rewarded for their contribution to its success.

Even these initiatives will not be enough to fully engage clinicians in an APM. Here's why: All of them embed a hierarchy in which the physician remains an actor in the enterprise, but who is directed in the play by someone else. Their role is essential, but insufficient.

3 Models of Deeper Engagement Strategies to Help Physicians Lead

Consider deeper engagement strategies that will launch better benefits for your APM, your physicians, and patients. Take advantage of the full capacity of your physicians to engage in care redesign and build on their expertise of collaborating that was fostered by their group training.

All these models assume that you have the value-based care technology needed to create condition-based and procedure-based episodes, and that you embrace the concept of clinical care teams composed of all the physicians and other clinicians involved in a patient's care.

1. Deploy a "Physician Activation" program.

Create a series of initiatives that, while similar to the engagement strategies listed above, are more expansive, strategic and physician-led. There are many different variations on this theme, but one of the most interesting is described in a 2020 article in *Clinical Orthopaedics and Related Research*, which highlights several possibilities for physician-led rethinking of clinical care delivery, organizational strategy and structure, and how data should flow to physicians. The central concept is that we should enable health care to return to a model in which physicians take ownership of outcomes, safety, patient-centeredness, and value.

2. Empower physicians through Lean Management to generate care innovation.

Lean Management concepts are focused on eliminating waste in each step of the health care process. As a physician engagement strategy, Lean Management puts physicians in charge of patient-care delivery redesign to eliminate redundancies and complications that stand in the way of efficient and effective care. Out of this process, "breakthrough" innovations are achieved by some organizations. Like Physician Activation, it also rests on physicians' ability to use data and technology to enhance collaboration, as well as political clearance to deal with the organizational culture.

3. Use multidisciplinary pathways as a tool to engage physicians in higher value care.

Most complex care involves patients with multiple issues and more than one physician. Although care pathways could clarify the process for both patients and physicians, their use is not universal. One third of physicians surveyed indicated that they do not use pathways approved by their organizations.

Guided by episode of care data for conditions and procedures, physicians engaged in care team delivery pathways that involve not just one physician specialty would be a huge advancement. It could enable the evaluation of multiple approaches to pain, outcomes improvement programs, cost amelioration, and so on.

Multidisciplinary pathways have been undertaken in cancer care and advanced systems, but APM entities could help participating physicians engage in this approach. It's a model that could lead to connections between community-based and university-based systems to conduct research on treatment protocols, resource sharing for patient self-management programs, and community connections for financial and social services.

Physician engagement is often misunderstood. Asked following a recent presentation, how I would engage physicians in stop-loss discussions for their ACO, my response was, "Why would I want to do that?" Instead, engage your physicians in their very best skills. I love the term used in the referenced article in *Clinical Orthopaedics and Latest Research*: "Top streaming—maximize clinical staff to work primarily at the top of their license." Physicians have the expertise to work us out of the muddle of value. if you don't act to let them do it, you will lose them to those who will.

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Image: Arseny Togulev

Eight Key Strategies for APM Contracting Right Now

written by Theresa Hush | October 27, 2022

Are you considering entering into APM contracts with private payers? Bravo! Teaming with commercial health plans and employers is a strong opportunity for growing patients through APM arrangements. Expanding your APM agreements into all payment types will be essential to back the incentives you build into your workforce for performance-based pay. But those contracts must align with your APM strategies and support your goals.

Our focus here is on APM contracts with health plans. Health plans may be eager to adopt these arrangements with you, if their analytics of your organization demonstrate good outcomes and reasonable costs. Population-based payments, which proved to keep many providers afloat during the pandemic, may help you financially and enable you to incrementally explore those benefits in a smaller number of patients.

Expanding your APM contracting to the private market should be a priority as soon as feasible. That said, there are many issues you should consider, both before and during the process of negotiations.

While employers have also greatly increased contracting with provider organizations, that’s a topic for the future. Employer arrangements are often between one employer and one health system with specified services, and thus uniquely arranged. It’s hard to assess their APM value in general, as they are too new and customized to have a track record.

Prepare for Private APMs, Because Failure is Public

Your pivot to private APMs should not be a feasibility test. The stakes of failure are too high for your market reputation, so be sure that you are ready. You must have data sufficiency and infrastructure as well as experience improving performance in patient outcomes and costs. For a private APM, part of that data sufficiency will require negotiation with the payer.

Experience is one reason why we suggested starting your first APM with Medicare, which has positioned APMs to be beneficial to providers:

- Proposed rules, if finalized, will help fund ACO efforts for new entrants.
- You may have more latitude to choose how much downside risk and how fast, and to level up when ready for population-based payments.
- Claims data always comes with the Medicare ACO option, and that data is critical to your ability to identify costs.

> With private payers, it’s a negotiation.
> If you are a specialty organization and considering a specialty care APM, participation in one of Medicare’s specialty care programs is a good foundation for similar private market initiatives.

But let’s say you’re ready. Let’s get into your strategies for organizing and negotiating APM agreements.

Eight Strategies for Supporting APM Contracts with Health Plans

To negotiate successfully with health plans—meaning, you agree on terms that are mutually beneficial—you must clearly represent the best option for a successful APM, and you must specifically insert your own requirements into the agreement. You will find that not all your work is done negotiating externally; you’ll also need to negotiate internally to identify your best product to sell to the health plan.

1. Examine your size and market positioning before finalizing your Contracting Entity (CE).

There are two significant issues to consider in the development of your CE. One is your size and marketing position. If you are small or not preferred, it may be difficult for you to achieve the best APM arrangements. If that’s the case, consider your options of joining with other organizations. Consolidation has been a phenomenon in the market for years so that providers could gain an advantage in negotiations with payers. But here the issues are not solely financial, but also involve access to important tools, like data and safeguards.

2. Construct your CE carefully around APM accountability for costs and patient services.

Your CE composition must include participating physicians and practices who will share risk. Many ACOs were organized around local politics rather than accountable care. In pre-risk days, that helped the organization get started and attract other providers. But under risk, inclusion of specialty practices, in particular, makes it difficult to proceed with population-based payments, correctly align attribution to primary care providers, and examine referral costs.

Carefully consider whether you need specialty proceduralists to be included in the ACO contracting entity for private APMs, or whether you organize a narrower accountable network. Also examine how your organization's Tax IDs work for a risk-based APM business. Centralized data, infrastructure, and improvement programs can be built on a broad, clinically integrated network, with a smaller contracting network as a subset of that network. Separating the referral base could benefit both the APM and specialists by minimizing friction over risk, while enabling data sharing and initiatives with both components.

3. Specify the patient attribution methodology.

Medicare has an attribution algorithm that can negatively affect your costs if your ACO participation is multispecialty. Private payers have their own varying methods. Negotiate your ability to track attributed patients by accountable provider/organization, with a prospective date of attribution. Stipulating the methodology and transmittal of information in the agreement may protect you from costs accountability. Your organization will need dedicated staff to monitor and reach out to new patients.

4. Ask payers for patient-identified claims data that is all-inclusive.

If you cannot see the services that your patients use outside of your organization, there is almost no way for you to improve costs and outcomes. You need to know the diagnoses that were made elsewhere, and the treatment plan (with medications) to be able to help the patient improve. Claims data is so important that negotiating an APM contract with population-based payments without that is ill-advised. Select your health plan candidates appropriately, but you will still need to work through the many alternatives for overcoming historical hesitancy, privacy issues, and bureaucracy. Just know that some providers are getting this data, as are employers. Help the health plan understand what you will do with the data, how you will protect it, and how it will mutually benefit the arrangement.

5. Require all your providers to contribute EHR and practice management data to the APM entity, in return for inclusion in the CE.

You need clinical data and practice data, along with claims, to support all of your outcomes, cost, and health equity activities. In particular, this should include your specialists, even if they are not participating in the CE—hence the major advantage of a clinically integrated network and a subset contracting entity for the APM. There should be agreements with referral physicians that are mutually beneficial in collaborating on cost, spelling out referral and expected communication practices, and, where appropriate, reimbursement rates to specialists where the CE subcontracts.

6. Negotiate coverages and tools that you need for innovative and effective care, population health, and interventions.

These could include your priorities. Possibilities include coverage for supporting community mental health arrangements, digital health or physical therapy apps to support patient improvement without more expensive services, continuous glucose monitoring, diabetes self-management support, and so on. In addition, discuss common insurer practices around medications for obesity and other pharmaceuticals that could contribute to better patient care. Request funding for specific improvements and interventions.

7. On quality performance, negotiate quality measures and request use of your own APM reporting of performance.

Scored performance need be not generic and could help you enhance your own organization. You could also benefit by scoring on meaningful improvement trends, if you have clinical interventions to improve outcomes. Request use of your own APM reporting to avoid plan-calculated, claims-based data that may not accurately reflect patient performance on quality. You will be able to access more data sources to represent the patient status than claims can generate.

8. Consider prospective, population-based payments only if you have the data to model them for their financial effects and can identify and agree on outlier costs.

If you cannot undertake this analysis because you don’t have the data or can’t get it from the health plan, primary care-only payments may be considered if you have access to experience data from the plan (again with risk scores and outlier information). You must know the level of costs and patient risks to enact non-Fee-for-Service APM contracts. Even incentive plans are meaningless unless the health plan or your own data can provide you the solid evidence of historical and predictive costs.

There are myriad stop-loss agreements, exclusions, guarantees and other provisions that go into health plan agreements, and providers are so familiar with these that we’re not addressing them here.

Moving into APMs in the private market is a key turning point. It’s not an accident that these eight strategies equally address health plan requests and organizational transformation. From competitors to traditional providers—big ACO enablers and equity-backed practices—all have built their prowess by meeting these transformational goals. That’s why they are gaining physicians and practices.

Your Catch-22 in the legacy health care world: until you achieve those same feats and create an APM entity that positions you for population-based payments, your savings will not be what they could be. Move quickly to overcome those obstacles, so that you can adopt population-based APM contracts before the market makes those decisions for you.

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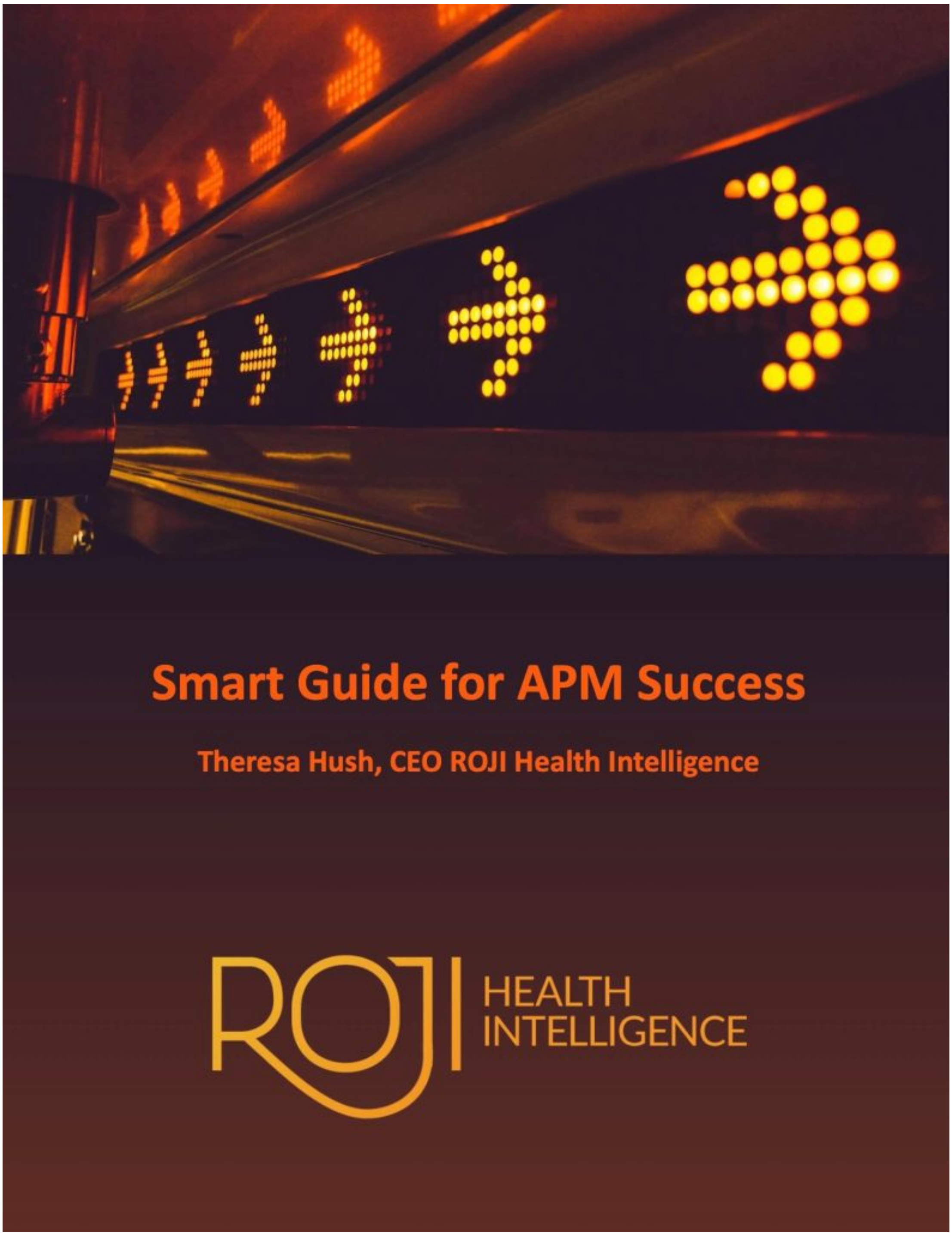
Image: Jarosław Głogowski

Your Smart Guide for APM Success

written by Theresa Hush | October 27, 2022



In the next several years, one of two things will happen: Either traditional health care providers will make the largest, make-or-break transformation of health care system economics and delivery of care in U.S. history, or the legacy health care system as we know it will not survive, but will be absorbed into the new corporate business of health care. Successful APM adoption will make the difference.

What is driving this transformation? Three forces are responsible:

First, the urgent cost crisis in health care demands that providers become more accountable for costs and better patient care, and adopt value-based payment models (Alternative Payment Models (APMs) to reverse the current volume-based incentives in Fee-for-Service (FFS) reimbursement.

Second, emerging corporate and private equity-backed health care competitors are already drawing physicians and patients away from legacy health care organizations, and are more than willing to engage in APMs.

And finally, the forces of consumerism are engaging patients by providing better access to services and information, as well as tools of self-management—part of the draw of big corporations with health care products or services, like Apple, Google, and CVS Aetna.

Crucial Decisions Ahead About APM Adoption

Not-for-profit and for-profit local, regional, and national hospitals and health systems, consolidated health networks, and traditional physician groups of all sizes and specialties all face crucial decisions. The most crucial? When and how fast they will adopt APMs that put them at financial risk for patient care expenses that exceed benchmarks or pre-determined payments. Less than 7 percent of current reimbursements currently fall into this category; it's a steep hill to climb in a short time frame.

Most traditional health care has been slow to adopt APMs, mainly because risk-based APMs could have serious consequences for their bottom line. And to be frank, there is no playbook for this magnitude of financial transformation, especially one that also requires a huge cultural and technology infrastructure to achieve success. That's why we've written our *Smart Guide for APM Success*.

Our Multi-pronged Strategy for APM Success

If you've been dabbling in population health on a small scale, or if you've just begun your digital transformation to create infrastructure but have no APM agreements, this guide is for you. If you're farther along but need to ensure that your complete transformation is successful, this guide is for you. And if you are already an ACO but trying to stay on the basic track, this guide is for you, too.

This free eBook will guide you through the transition process to APMs. We lay out the substructure to guide your decision framework, how to look at your data and infrastructure, and how to choose your initial starting point. Then we dig into the structure of your APM entity and develop guidelines for how you transition the business to APM financing. How much risk can you accept? How do you negotiate payer arrangements? How will you deal with Medicare Advantage? How will you appeal to consumers? What is your framework for cost transparency?

This guide is not hypothetical. It's based on experience. We created Roji Health Intelligence on the heels of a huge transformation of our academic medical center and its thousand employed and private medical groups, transitioning to full population-based payments in many of our private insurance agreements—resulting in successfully growing patient volume and keeping our physicians on board. As employers, we built data infrastructure from claims payments to create health programs for our self-insured populations. We negotiated contracts with payers that gave us that data.

We know what it takes to foster major institutional change and how to avoid pitfalls along the way. As you'll learn in Roji's *Smart Guide for APM Success*, our expertise is just what you need to ease your path to APMs and ensure that your transition is highly successful.

Click here to learn more and download your free copy of *Smart Guide for APM Success*.

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Three Key Decisions to Direct Your APM Adoption Strategy

written by Theresa Hush | October 27, 2022

How you ramp-up to full-scale APMs is crucial. Even if your multi-specialty group or health system receives some value-based payments with downside risk, your success hinges both on financial viability and retention of your clinicians and patients. If you delay APM adoption only after reviewing the potential on your bottom line, you’ll need to pay more attention to the competition that is lapping at your foundations of your provider network and consumers.

Here are three key organizational decisions that will determine how your APM adoption proceeds:

- Should we own, enter into a joint venture, or participate in APM(s)?
- How much risk should we adopt, and with whom?
- How can our network strategy lead to APM success?

1. Maximize Your Risk-Reward APM Strategy Via Ownership, or Choose Participation

The huge advantage of value-based payment models is that they give you the opportunity to ingest the “winnings” if you succeed. Unlike managed care models of the last go-round of HMOs and other payer-driven choices, you are in the driver’s seat under Value-Based Care—if you choose. You can organize an APM yourself, if your size and the infrastructure support it, or you can join with other provider organizations in your market to do so.

The difference between the two is that under a joint model, it may be more difficult to direct strategy and keep providers on board. Because the APM will distribute money, determine the flow of patients, and make the rules that govern your providers, a joint APM can create trust issues for clinicians and administrators.

A strong, centralized APM organization, either one or multiple entities, must create the buy-in necessary for everyone to act according to a central set of rules. Those rules must create growth and financial viability, so they should push the APM entity to play hard. That will translate eventually into a higher level of risk to increase marketability to payers and employers.

Whatever the initial setup, both single and joint ownership entities should move quickly to become the single APM contracting entity for all agreements with payers. Pre-existing relationships may dictate otherwise. There may be a Medicare APM and a variety of private insurer products that are separately negotiated. Or one group may have a Medicare Advantage plan. These flexible arrangements could easily erode the strength of the central APM entity to achieve goals, so settling them is important.

Your biggest determinant of a sole versus shared ownership is how big you are:

- If yours is a large health system with a good primary care base, your task of APM ownership through an ACO is the easier and natural course. If that base does not exist, you need to fill the geographic and reputational holes in your network or partner with other organizations.
- Smaller hospital-based systems, single-hospital-based groups, and primary care groups face bigger obstacles to single ACO ownership. Lack of expansive provider networks, insufficient infrastructure and data, competition and politics could dissuade your organization from independent ACO ownership. Joint ventures are the next viable option, or

a smaller ACO, which may be a good option depending on your market position. The high investment in implementation and infrastructure is a hurdle.

Multi-specialty groups come with a large range of APM-readiness, and if yours has the technology and market power along with a solid primary care base, the decision to go the ACO APM route may be optimal. Specialty-heavy groups should be wary of ACO participation, however, since Medicare's attribution of patients puts specialty groups at a disadvantage of unanticipated patient costs. Unless your group is operating under separate legal practice names that could accommodate separate tax identification numbers, reconsider the options. Other APM possibilities for multi-specialty groups could be Primary Care First (future openings not known, and not currently available everywhere), Bundled Payments for Care Improvement (BPCI, limited and not currently open) and Specialty Care Models (even more limited and not open).

Your biggest ownership-related hurdle with all these options: timing. With most of the available Medicare options closed except the MSSP ACO, you can pursue that avenue, private insurer APM agreements, or participation in an existing APM entity.

2. Determine How Much Risk Is Safe for You, and With Whom

FFS reimbursement has a bull's eye on its back, as the market is quickly moving toward alternative risk-based reimbursement models. Even MSSP ACOs will eventually lose the option to have upside-only shared savings. Learning to manage outcomes and costs through data is your quickest path to be able to participate successfully under any ACO strategy. How to get there is a question, because evaluating your risk potential prior to APM application requires a full review of the expenditures of participants in the APM. Unfortunately, it’s unlikely that you will have the data to do so. That requires historical claims data that includes costs outside your participation network.

So how do you decide with whom you will negotiate your alternative payment arrangements? That’s hard, because if you choose to go small with a less influential payer, you will not get the momentum internally to address change, nor the data to proceed.

It may sound like a huge risk to instead try your biggest single payer, probably Medicare. But Medicare offers you the most secure base to start, if you are not tolerant to financial risk through the MSSP ACO. And if you are experienced and confident of your infrastructure and clinician engagement, start with MSSP ACO and transition to ACO REACH when it is available to you.

Under the MSSP ACO, you have a selection of both payment model type and level of risk. You can start at Level A, which involves no downside risk, but every year you progress up to at least the next level of downside risk. ACO REACH, which replaced Direct Contracting, offers population-based payments.

Alternative payment models with population-based payments offer the greatest financial opportunity in your future VBC strategy, even if that is not now. CMS has already indicated a desire to experiment with specialty negotiations between the ACO and specialty clinicians. Under a global payment, this means that the ACO can focus on the substantial portion of specialty-driven services and costs. It can create financial rewards for specialists while improving patient access and services, communications between primaries and specialists, and enhancing data-sharing.

3. Craft Your Clinician Strategy to Ensure APM Success

Your providers are the entry point for patients, driver of patient services and costs, and ambassadors for your health system or group. With a lot of other organizations competing for them, your APM adoption plans will naturally focus on engaging them in the transition. Clinicians should be able to count on their own financial security under alternative payment models—whether they are employed or not—to support them both financially and administratively. There are signs that this has gradually improved in consolidated health systems, with the result that clinicians are becoming more open to alternative payment models.

Before your draft ACO or APM Participation List, establish your clinician strategy. It starts with relationship-building for a new future with changed roles, different reimbursements, and a redefined plan for use of resources. Even if you believe you've done this, the competition for your physicians requires a redo to build support for an APM transition.

Building trust with physicians must reach beyond obvious candidates in the hierarchy and include grass roots efforts throughout the organization. This starts with sharing information. You should create the mechanism to share as much clinical, strategic, and financial data with clinicians as feasible, but certainly start with insights about their own outcomes and clinically relevant data. If you have created the infrastructure to support an APM, your data should be able to compare episodic data with physicians, either through individual portals or, initially, through dedicated learning sessions. Their own patient data, which they will recognize and with which they'll have an emotional connection to patient histories, will do more to give them an understanding of key indicators than any aggregate report can do.

Part of your APM Adoption Strategy must also involve clinician compensation and support. Like the organization, there must be benefits to physicians for moving outcomes and addressing costs, and a plan for supporting them in their new role to guide patients. How they share in the success of payment models, or the losses, should be part of the inquiry process.

As for any business, practical realities dictate your transition to APMs: the models you will adopt, how much risk you will accept, and who will participate in them. But these realities also illuminate the lead time you will need from when you decide to adopt APMs to their actual start-up. Beginning now to deal with the timeliness of decisions and laying groundwork with your clinicians will get you started with the essentials you need for your adoption strategies.

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Image: David Heslop

CMS 2023 Proposed Rule Accelerates ACOs, MVPs

written by Dave Halpert | October 27, 2022

CMS just set off summer fireworks, amping up incentives to adopt Value-Based Care in its just-released, 2,066-page 2023 Proposed Physician Fee Schedule Rule. By encouraging formation of new ACOs, the Proposed Rule establishes a pathway to expand beneficiaries' access to accountable care.

Last year, CMS committed that every Medicare beneficiary will be in an accountable care relationship by 2030, to ensure quality and total cost control. Its October 2021 Innovation Center's Strategic Refresh identified issues with provider adoption of accountable care networks and alternative payment models (APMs). It also identified two objectives: to drive providers into Accountable Care Networks, and to Advance Health Equity. The risk of financial losses and the lack of provider infrastructure, however, caused ACO volume to plateau, stalling beneficiary volume in accountable care.

The CMS 2023 Proposed Rule addresses those obstacles. Here are nine key takeaways, including four major initiatives for advancing ACOs and five developments in MIPS Value Pathways:

1. Advance Shared Savings (AIPs) Accelerate New ACOs

In an extremely rare move, CMS is allowing up-front advances on shared savings payments for new ACOs. This provides a new ACO the opportunity to invest in its "Day 0" needs, including staffing, strategies for addressing Social Determinants of Health (SDOH), and Healthcare Provider Infrastructure. Healthcare Provider Infrastructure includes partnerships with Clinical Data Registries that have the ability to aggregate disparate sources of data and analyze the results.

The payments are substantial. Under the CMS 2023 Proposed Rule, new ACOs may receive one up-front lump sum payment of $250,000, followed by additional quarterly payments in the ACO's first two agreement years. These quarterly payments will be calculated on a per-beneficiary basis, and will vary by beneficiaries' risk factors (dual eligible status and an Area Deprivation Index, calculated from census data).

2. More Time for ACOs to Adopt Downside Risk

New ACOs will be able to remain in a one-sided track with no downside risk for a longer time. In fact, new ACOs can remain in a one-sided model for the entirety of their five-year agreement period—a significant increase from the two-years allowed under today's BASIC Track. CMS also proposes slowing the glide path for existing ACOs without performance-based risk experience; they could capitalize on this retrospectively. For performance years beginning in 2023, participants in Levels A or B of the BASIC Track can remain at their current levels for the remainder of their agreements.

CMS gives more latitude to ACOs with more experience, as well. For ACO agreements beginning in 2024, ACOs in the BASIC Track could remain in Level E in perpetuity, rather than move to the ENHANCED track, which offers higher rewards but also higher risk. As an added enticement, there is a proposed sliding scale for shared savings and losses, rather than the current all-or-nothing approach. This is key for low-revenue ACOs, which would be able to share savings even if the Minimum Savings Rate was not met. These proposals are a major departure from the previous Pathways to Success Rule.

This CMS shift defers to existing ACO participation patterns.

In the 2022 performance year, 41 percent of ACOs are participating in a one-sided model (Level A or B in the BASIC Track). Of the remaining 59 percent, nearly half have advanced to the two-sided levels of the BASIC Track, with the remainder in the ENHANCED Track. The final level of the BASIC Track (Level E) and the ENHANCED Track qualify as Advanced APMs, allowing providers to avoid more arduous MIPS quality reporting in favor of ACO reporting. Even when given the chance, however, 89 percent elected to stay one-sided in 2021, and 74 percent have chosen to remain one-sided in 2022.

Combined with the loss of the 5 percent lump sum for participating in an APM in 2023 (this benefit has expired), CMS expressed concerns that, rather than moving up, an ACO may choose to drop form the program altogether. While allowing that the two-sided model is the only way to achieve a value-based care environment, CMS addresses concerns about requiring downside risk too quickly by reevaluating how the ACO program can achieve long-term viability.

3. Rewards for ACOs Reporting Quality on all Patients

In prior rule-making, CMS indicated that it will shortly require ACOs to report on all patients (i.e. Traditional Medicare, Medicaid, Private Health Plan, etc.) through the Alternate Payment Model Performance Pathway, or APP. ACOs immediately raised several issues, one of which was that reporting on patients on Medicaid would be detrimental to their quality performance. Through the CMS Web Interface, ACOs only submit a sample of Traditional Medicare patients. ACOs fear that incorporating a population with historically high levels of chronic illness would put the ACO’s shared savings at risk.

To alleviate these concerns while still promoting Health Equity and accountable care arrangements for beneficiaries, in the 2023 PFS Proposed Rule, CMS introduces incentives for early adoption of all-payer reporting, in advance of the closure of the CMS Web Interface. For ACOs with a greater proportion of patients with Medicaid or historically poor access to health care, CMS has proposed awarding bonus points to those ACOs who report at the all-payer level through the APP. The intent is to promote a single, high standard of care for all patients, and to prevent ACOs from receiving poor performance scores when reporting quality measures on the very population that CMS is targeting for Health Equity. It is noteworthy that, in 2021, only 12 ACOs reported eCQMs/MIPS CQMs, using the CMS Web Interface instead.

4. CMS 2023 Proposed Rule Improves ACO Costs Benchmarking

CMS creates ACO benchmarks based on estimated appropriate expenditures. However, the calculation method can negatively impact ACOs that perform well. As successful ACOs’ expenditures decrease, these lower costs are figured into CMS’s algorithm for calculating future benchmarks. An ACO can sabotage itself in the future by performing well in the beginning, but potentially pivoting from savings to losses over time.

Regional expenditures are also used to calculate ACO benchmarks. In cases where an ACO cares for a majority of the regional population, an ACO’s reduced costs will reduce the overall regional expenditures, magnifying the impact on an ACO and potentially curtailing savings.

To mitigate these benchmark pitfalls, CMS has proposed to incorporate an administrative growth factor called the Accountable Care Prospective Trend (ACPT) into the ACO benchmark formula. The ACPT, in combination with both regional and national spending trends, would correct for false-negative results that occur when an ACO’s lower costs lead to unachievable benchmarks. Also the benchmark would remain the same throughout an ACO’s entire five-year agreement period to create stability and predictability for the ACO.

5. Focus on MIPS Value Pathways but No Official Phase-Out of Traditional MIPS

CMS has stated that “Traditional MIPS,” the standard level of MIPS participation, has been confusing for providers, offering too many options for participation. In addition, an anticipated dove-tailing of the Quality, Cost, Improvement Activity, and Promoting Interoperability components has not occurred. In the 2022 Final Rule, CMS floated a potential phase-out of Traditional MIPS in several years. That phase-out is not included in the proposed rule, but the focus is very targeted on MIPS Value Pathways (MVPs) and ACOs rather than Traditional MIPS.

For the immediate future, providers may continue to fulfill Quality Payment Program requirements through the Traditional MIPS track. Compared to the development and guidance accorded to the MVP and APM tracks, however, Traditional MIPS updates are on a maintenance scale. Providers should prepare to make a move to another method of QPP participation.

6. More Financial Drawbacks Under “Traditional MIPS” in Proposed Rule

The minimum threshold (the lowest score before incurring a penalty) is dictated by the mean score in a prior year. CMS has proposed using the same period that they used for 2022 (the 2017 performance period/2019 payment year) for the 2023 benchmark—once again at 75 points.

Unfortunately, the second performance threshold for Exceptional Performance is no longer applicable, as the Tier and its corresponding incentive payment has expired. This is a double whammy for Traditional MIPS participants. Not only is the opportunity for earning additional incentives lost, but also it will be more challenging to avoid penalties in Traditional MIPS in 2023 than in 2022.

In the Quality category, many providers have been able to submit extra Outcome measures, High-Priority measures, or measures without any manual intervention (“end-to-end”) to earn extra points. These opportunities to earn bonus points all expire in 2023. For specialties with limited measure availability (or limited availability of measures with benchmarks that are not topped out), the loss of these extra points has the potential to drop a quality score by 10 percent, even when year-over-year performance is the same.

Beyond that disadvantage, in the CMS 2023 Proposed Rule, the agency suggests removing the 3-point floor protecting providers from low-volume or low-performance measures. The floor ensured that providers could gain a score of 3 points out of 10 on any measure, as long as at least 70 percent of the denominator was reported, even if there was no existing benchmark, there were fewer than 20 cases, or if performance was lower than the 3rd performance decile. Removal of the 3-point floor in 2023 means that measures without benchmarks (excluding new measures) or with fewer than 20 cases will have zero points in 2023 for practices with more than 15 providers, and measures at the low end of the performance scale will earn one point.

The 1-10 performance scale may seem appropriate, but consider this: In the 2022 MIPS Historical Quality Benchmarks, a measure for a Plan of Care for Patients at Risk for Falls has an average performance rate of 92.3 percent. But, anything below 94.3 percent falls below the 3rd performance decile. By performing at the average level, a provider would only earn 3 out of 10 points in 2022, and only 1 or 2 points in 2023.

There are also some shake-ups in Promoting Interoperability (PI). First, CMS will no longer automatically reweight NPs, PAs, CRNAs, and CNSs for Promoting Interoperability. CMS also proposes to require the Querying of the Prescription Drug Monitoring Program (PDMP) measure in 2023, rather than one that earned bonus points previously. Finally, Public Health and Clinical Data Exchange requirements are heavier, requiring clinicians to attest to their level of “Active Engagement” with the clinical data entity in question.

7. Reaffirmation of MVPs with 5 New and 7 Updates

In the 2022 Final Rule, CMS defined its MVP policies and outlined an initial list of seven. In this rule, they’ve made updates to that initial list, which are primarily updates to available Quality Measures and Improvement Activities associated with the MVP. For 2023, the full MVP list is as follows:

- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Advancing Rheumatology Patient Care
- Improving Care for Lower Extremity Joint Repair
- Adopting Best Practices and Promoting Patient Safety Within Emergency Medicine
- Patient Safety and Support of Positive Experiences with Anesthesia
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Cancer Care (New)
- Optimal Care for Kidney Health (New)
- Optimal Care for Patients with Episodic Neurological Conditions (New)
- Supportive Care for Neurodegenerative Conditions (New)
- Promoting Wellness (New)

8. Retention of Subgroup Reporting for MVP Participants in Multispecialty Groups

The CMS 2023 Proposed Rule makes no changes to subgroup reporting, nor does it alter the requirement that, by 2026, subgroup reporting will be mandatory for MVPs. Until then, CMS still encourages subgroup reporting, To determine whether a group constitutes a multispecialty group, CMS will use Part B claims data, rather than PECOS (the option originally proposed).

CMS defines several of the “real world” processes of MVP reporting in the proposed rule. First, a subgroup must register with CMS between April 1 and November 30 of the year. The exception to this timeline is if the specified MVP includes a CAHPS survey. In those cases, registration must be completed by June 30 to be consistent with the CAHPS survey registration deadline. Clinicians should note that they may only participate in one MVP per TIN. If a multispecialty group has one subgroup participating in the Promoting Wellness MVP and another in Optimizing Chronic Condition Management MVP, a primary care provider in the TIN would need to choose to participate in one or the other, even though they are both relevant.

The Proposed Rule addresses open issues, such as how subgroup reporting would work for Promoting Interoperability, and will calculate those pieces at the affiliated group level. So, even though a provider may only participate in one subgroup per TIN, that provider may indirectly contribute to the score of another.

The Proposed Rule attempts to assuage concerns of early MVP adopters by specifying that those who register for subgroup MVP reporting, but do not actually submit data, will be held harmless. CMS does not want to discourage those from getting on board early and anticipates some subgroups to abort an early attempt at MVP participation. In addition, CMS will still take the best score for the provider, even if the subgroup’s MVP performance is less than the full group. In other words, registering for reporting an MVP at the subgroup level does not lock a clinician into that subgroup’s MVP score.

9. CMS Requests for Feedback via RFIs

CMS has embedded several Requests for Information (RFIs) in the CMS 2023 Proposed Rule. These include:

- What should CMS do to mitigate the transition from a lump sum 5 percent APM incentive payment?
- How should CMS develop and implement health equity measures?
- Can measures can be implemented to address amputation avoidance in diabetic patients?
- Should Third Party Intermediaries (like Qualified Registries, QCDRs) have the flexibility to support only certain measures within an MVP?
- Should CME Organizations be able to submit Improvement Activity data directly to CMS?
- How can CMS incentivize participation in the Trusted Exchange Framework and Common Agreement (TEFCA)?
- How should Digital Quality Measures be standardized and implemented through FHIR?
- Would changing Qualified Participant (QP) status to an individual determination encourage specialist providers to further engage in APM performance measurement?

Like other Proposed Rules, there is a 60-day comment period on this rule, which may be accessed at https://www.regulations.gov/. Follow the "Submit a comment" instructions and refer to the file code CMS-1770-P. The comment period closes on September 6, 2022, so get your comments in before then!

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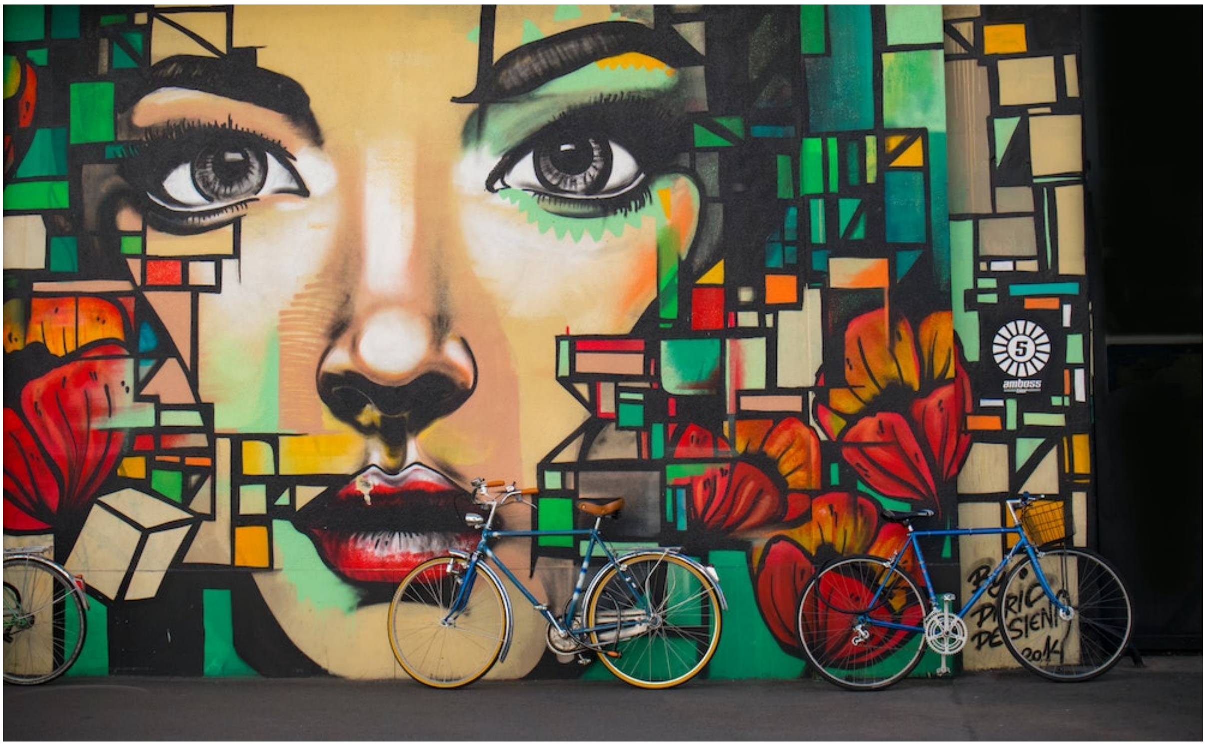
Image: Jason Chen

5 Imperatives for Your Value-Based Technology to Support APMs

written by Theresa Hush | October 27, 2022



After years spent transforming your health care technology, you may feel like you're almost done. But Value-Based Care Technology requires a different mindset. With reimbursement scaling to a tipping point for APM adoption, think “reboot” instead. Your health system or group has a long way to go if your aggregated and integrated data cannot support person-centric care and data-directed population health, quality, and health equity strategies.

The Value-Based Care Technology game is no longer focused on implementing an EHR, or even population health. Those are basic ingredients that make it possible to do more. Now it’s about bringing all the systems and data together to create value for your clinicians and your patients, a view that experts are beginning to advocate. Your ability to drive better performance in outcomes and costs will depend on radical improvements in data sufficiency and how that data lines up in your systems for use by stakeholders.

Consider this: for your clinicians to develop an optimal clinical plan with each patient under care in an APM, they must first understand the patient’s long-term outcomes and events, plus the patient’s own social needs and preferences and costs. Much of this is data clinicians never see now, even if they are using an EHR. Understanding and sharing this data makes it possible to help patients self-manage conditions and participate in prescribed therapies, and to feed information back to their clinicians. Across the organization, this is what drives better care and lower costs.

Data sufficiency is the number one issue most health systems and groups contemplating APMs must tackle. But it’s not the only data issue you have. Let’s unpack what your new APM world requires for getting and utilizing data.

Number One Mandate for APM Adoption: Data Sufficiency in Value-Based Care Technology

We've written before about how ACOs, especially those with multiple stakeholder groups and organizations, must develop a common data infrastructure. Data poverty limits your possibilities of rolling out even the most basic clinical interventions to improve outcomes and cost performance.

The bar for enough data, however, keeps getting higher. CMS has articulated a broader vision for quality and health equity, and has also recently outlined its vision for capturing and using specialty data between independent groups.

The recipe for creating the data you need to inform your APM starts with your own health system's or APM participating groups' data systems. But to gain a holistic view of your patients, eventually you must integrate outside data for services that you have referred to specialists or outside providers. Even if you have HIPAA-compliant data sharing agreements to get this far, there will still be gaps. Services provided to your patients that they selected or were outside your referral networks, as well as patient-held data that reflects outcomes and self-management (such as device data), will still be unknown, unless you have agreements to capture claims payment information from payers and arrangements to incorporate patient-held data.

How your own systems contribute to this scenario may go way beyond what you might have considered. EHRs in use by providers, transactional and financial information, managed care claims or insurance-negotiated rates many of which are not currently contributing to an APM data structure—are all essential. The EHR feed should include as much clinical information as possible, especially diagnostic and lab values that are critical to staging or categorizing level of conditions, diagnoses, procedures, symptoms, outcomes, medications, and so on. To address health equity, collecting patient information on Social Determinants of Health is critical for inclusion in the EHR data. Ultimately, your goal is to provide a full view of each patient’s clinical status and social barriers to improvement, along with patient risk and cost information.

In addition to data sources, data sufficiency also requires that all modes of care—outpatient setting or facility, emergency facility, urgent care, virtual appointments, and care-at home—can also eventually be included in the data. If this information is not currently being captured in your EHR, that is a required build so that it can be incorporated in your EHR feed.

It should already be obvious that the EHR is not the end point, but a source to the person-centric repository to facilitate data analytics, artificial intelligence, and performance improvement. In turn, data essential to the clinical experience should loop back into the EHR for action, be ported to population health for other interventions and into physician insights when activated.

Technology Build Differs from Historical Health Care Systems

You are most likely organizing your technology within organizational boundaries and then by functionality. But the result is that data cannot talk to each other from one entity and system to the next, nor produce the needed information to stakeholders, such as person-centric outcomes, generalized data analytics that compare care teams in quality, and health-equity measure results.

The future will focus APM technology on person-centric results and demand that the entire care team is invested in the results and the path to reaching them—through data analytics and data-driven interventions, and the patient and patient’s support group. In short, the future systems are upside down from where we are now.

While building this will take time as well as modifications in regulations and systems, and further developments of APMs that skirt current obstacles imposed by regulations, anti-trust, and competition between provider entities, you still need to set your sights toward data and technology that is very different from today.

Six Imperatives to Enable APMs with Value-Base Care Technology

Let’s assume that you have already invested in aggregating sources of clinical and financial data into a repository. Where should you go from there?

First, let’s examine what you need to manage the current environment. Your most immediate problem is identifying cost and helping to steer patient outcomes in a positive direction.

Your systems must aggregate the data and have analytics that tell you, by person, whether their clinical trajectory is on course or requires change. The data on what adjustments in the patient’s plan are needed must be accessible at key decision points for every care team member, the patient, and the patient’s support network. Those decision points happen when you can engage both the clinician and the patient and/or patient’s support network. Clinical decisions are normally made iteratively over time in response to new information—and not always at a visit when a clinician is reviewing a patient’s EHR record with the patient.

With the need for time- and team-variation in mind, your technology needs to have these key attributes:

1. Build technology to be person-centric, with capture of longitudinal transactional data from all systems (clinical, financial, administrative), and the functionality to view patient episodes of care.

Only through episodes can you evaluate the course of care individually and compare like events of care across people. Episodes can capture general conditions, specialty conditions and procedures, and multiple-condition episodes for conditions that are treated in combination, such as metabolic disease. Episodes can define discrete outcomes, cost profiles, quality measures, and interventions for improvement.

2. Support collaboration of care team members involved in a given episode based on shared data, regardless of whether or not they are in the same health care organization, and provide the mechanism for communication and input in the patient’s outcomes and clinical interventions.

Value-Based Care Technology is the starting point for driving change in clinical results as a result of data and insights from data. A big change in culture for clinicians, the beginning stages of Value-Based Care adoption will consist of building trust, learning, and using data.

To be comprehensive, data from all venues of care—including, increasingly, the patient’s home— should be captured. Primary and specialty, primary and behavioral health provider, and primary and community social service organization or home care provider are just a few of the permutations that will be involved with individual patients. Creating a plan that will involve multiple parties as well as the patient requires a common “system” in which every clinician (and the patient) can see outcomes and can contribute to the plan.

3. Provide the vehicle for patient engagement, patient-reported outcomes, patient self-management, and cost transparency.

Current systems are top-down and built for providers. Patients should be equal participants in new technology with a purpose of partnership. Along with many other changes to address health care consumer needs, the hierarchy of systems and their data must change. The idea that provider data is superior and consumer data is suspect or of poorer quality prohibits you from seeing the full scope of your patients' health. In particular, prohibitions against inclusion of data from patient devices and patient-reported outcomes should be lifted and the data included in the technology so that they can inform members of the care team.

4. Provide the measures and tools to improve health status. Value-Based Care technology should measure health status improvement by positive changes in longitudinal outcomes and avoidance of low-value procedures, and by health equity measures.

The tools should ensure that findings loop back to views in all prominent technology—including but not limited to the EHR and population health—where data activates interventions for the care team and patient.

Note that while costs are not specifically noted for inclusion in technology, the APM is intended to meet that objective. The inclusion of cost information will be essential for providing patients with transparency and for giving physicians an understanding of downstream costs. We need to understand that, currently, comprehensive data is often unavailable. While all insurance agreements should be negotiated to obtain claims data to support cost analyses, you don't have the time to wait until cost data materializes to adopt Value-Based Care Technology for APMs.

There is another reason why costs can be treated separately and judiciously. Your care teams can achieve greater results if your path is clinical and patient-focused. You can prevent problems that cause the patient to need higher resource care by helping them manage risks or improve their condition- and age-risk management capabilities through data-driven population health programs tied to these risks. Clinical interventions are the most powerful tools for correcting the patient's cost trajectory and engaging them in sound medical decisions.

5. Manage downstream APM payments.

For APMs embarking on a full risk strategy that involves downstream payments not only to primaries but also to outside providers, Value-Based Care Technology must have the functionality of claims payments, contract management, and population and network management that is tied to various insurance contracts. At-risk contracts are expected to grow 9 percent annually from 2020 to 2025.

Even CMS is beginning to understand that until APMs such as ACOs can fully collaborate with specialty care through data sharing and reimbursement mechanisms, their ability to manage costs is limited, a perspective that we have frequently promoted as a means for ACOs to improve outcomes and better control costs. One of the advantages of the ACO Reach global payments options is that the payment mechanism facilitates collaboration with specialists, an advantage over the MSSP ACOs, which must rely on interest from the specialty group to generate engagement in collaborative sharing of data on outcomes and costs.

Data-driven strategies give you the ability to take on the future of Alternative Payment Models. But today’s current systems are still set up to support Fee-for-Service and cost distribution more than they are devised to redesign clinical care. Value-Based Care requires us to rethink how to organize the fundamental systems we use to create effective, accessible care to patients. And, this effort does more. While it starts with data sufficiency, the bigger challenge is to imagine how to redesign and reconstruct systems to highlight the value of our services: better outcomes, more access to care, and lower costs.

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Image: Timon Klauser

Six Ways Competition Must Shape Your APM Strategy

written by Theresa Hush | October 27, 2022

Now that you've made the decision to start your path to Alternative Payment Models (APMs), what's the first thing you need to consider? Hint: APM revenue calculation does not top the list.

Obviously, APM revenue generation vis-à-vis traditional Fee-for-Service is critical. But those calculations assume constancy of two essential “assets”—clinicians and patients. Your competition is working hard to grow these same resources for their own operations. The easiest place to get them from is your organization. If you are following the growth of practice acquisitions from investor-backed health care companies and MSOs, payer practice acquisitions and retail giant investments in primary care, the numbers should stagger you.

You must support the pillars of your organization if your APM is to be successful. If you can’t retain your providers and patients, you can’t generate revenues under any revenue model. So, your first task is to assess your competitive environment and determine how your APM strategy can reinforce and grow at the expense of the competition’s.

Let’s face it: In 2022, you are already running to catch up to the competition. It’s time to get to know who they are and what they’re bringing.

Traditional Competition Is Under Attack, and New Competition is Here

In past years, most health systems and groups usually carved up the market by community geography. The competition was “friendly” if distant, as long as everyone stayed in their confined neighborhoods. Consolidation broke many of these boundaries, as health systems encroached or directly competed in closer proximity. The target of everyone’s maneuverings was payer contract advantage, with higher rates rewarded to “must have” groups and health systems in insurance negotiations. Higher contracted rates were the perfect fuel for the FFS volume-based revenue engine.

At the expense of consumers.

Numerous studies have shown that the effect of consolidations have raised costs. Additionally, consolidation has fragmented service delivery, especially for diagnostics, imaging, and ancillary services provided outside of consolidated network providers, resulting in higher out-of-pocket costs and surprising billing for patients. Across the board, consolidations have come under fire for increasing costs to patients as well as governmental and private payers of health care.

The mounting pressure for traditional providers to adopt value-based models such as APMs—which frequently incorporate population-based payments—is happening during a financially stressful period for providers recovering from the pandemic. While consolidation is still occurring on a very large scale among regional systems to expand nationally, there is also new competition duking it out in communities where traditional health systems and groups deliver services.

The new competition may be locally situated, but its backing is big. Amazon, Walmart, Google, investor-financed large-scale MSO/ACO organizations, retail pharmacy operations like CVS/Aetna and Walgreens, and payers like United Healthcare’s offspring Optum are setting up or purchasing provider operations to play in Value-Based Care, many currently in APMs.

What’s Different and Advantageous About the New Competition?

The new competitors have business models that target Value-Based Care. Unlike traditional competitors, in general, they

- Have money backing, and thus local competitors are less confined by current financials.
- Have business models focused on making money through Value-Based Care APMs.
- Tend to be primary-care focused, which is less expensive.
- Maintain a singular approach on providing services; don’t support teaching and research.
- Have common systems, analytics, and population health.
- Don’t have facilities like hospitals that are resource-intensive and costly.
- Can create population health programs for patients to avoid downstream specialty-driven costs.
- Can offer attractive practice acquisition or exit deals to physicians discouraged by traditional health systems.

The new competition is aggressively leveraging resources to expand its market and compete for consumers. Retail pharmacies are springing from vaccine programs to outreach for primary care, using neighborhood locations to compete with harder-to-navigate health system settings for basic services.

How Clinician Changes Affect APM Strategies

Physicians, individually and in their practices, have struggled with the shifting health care market. The FFS revenue engine has not been kind, forcing them to heel to patient volume targets, increased documentation requirements of EHRs, and consolidation that has often created a hierarchy where clinicians are part of the operations but not the strategic team. If they are in private practices, the delayed services of the pandemic often damaged their financial standing.

As a result, physicians are selling practices or individually migrating to employment scenarios in record numbers. They are moving to organizations, especially investor-owned environments, where the future is spelled A-P-M. In these environments, staff and infrastructure support their clinical roles, but don't demand that they manage it all.

How Consumer Changes Affect APM Strategies

While paternalism in health care still lives in traditional health care settings, your patients are joining the groundswell of health care consumerism. They are shopping for providers, with more than half of consumers using the internet to find and read reviews of clinicians. Are your appeals to consumers based on your specialized expertise drawing them in? Probably not. According to recent Press Ganey surveys, only 16 percent searched for providers based on symptoms or condition and were twice as likely to search on their own for a primary care provider, instead of accepting a physician's referral.

Survey respondents are looking for doctors in their networks with availability and good reviews from other consumers. You need to stack that up against the traditional health systems' slow development of consumer-focused strategies.

In addition, consumers are more willing to use retail pharmacies for primary care because they are quick, provide online appointment scheduling, and appear able to handle most routine medical needs.

Six Ways to Support Your APM Strategy While Outdoing the Competition

The news is not all bad. Traditional medical practices and health systems have advantages that could work to effectively outdo the competition, even while playing catch-up. Your hospital-based or independent multi-specialty group has likely made substantial investments in data and infrastructure, has practices with a natural internal referral system, and possesses the depth of administration that can support cost-effective “clinically heavyweight” APMs. To do so, however, you must take the lessons of competition seriously.

These six strategies envelop the major actions that should be front and center in your APM development:

Clinician-Directed Strategies

1. Align your compensation packages for clinicians to put the value on APM outcomes and growth. Your providers need to see that your priorities are shifting to reward value over volume. Link your shift to value-based reimbursement to progressive adjustments in compensation, with levels based on key performance indicators recognized by payers—and don’t forget building in incentives for feedback from patients.

2. Support new roles that clinicians must take on to work with consumers as patients, such as educating patients in medical decision-making, cost expectations and cost transparency, and use of additional sources of data (e.g. device data). The health system or group must do the heavy lifting of providing

the data and messaging to consumers, so that the clinician can properly counsel the patient.

3. Implement practice transformation to integrate and streamline care delivery, so that integrated care teams facilitate service continuity, especially for complex patients and their support people. Use the advantages of a health "system" to navigate patients through the complex process of diagnostics, treatment (including self-management curriculums and population health), and recovery. Behavioral health integration models will also be essential to evaluate and adopt as part of practice transformation.

Consumer-Directed Strategies

4. Create a consumer-friendly entry point to your organization, while avoiding closing doors to urgent communications between providers and patients. If you have a call center to create appointments, that's fine. If your patients or new consumers can schedule appointments online, even better. But—if your patient must use the call center for an urgent illness that requires their physician, that's a big hurdle, because they have no way to respond when they don't get the return call—except to return to the call center. Now that is a mark against you. You must make it easy to get critical, immediate services—this is what is driving patients to retail pharmacies for care.

Consumer-friendly entry points also include navigating new patients into your system without overwhelming them, easing the process of choosing a doctor, making appointments seamlessly, simplifying e-registration, and facilitating where or how to complete their next step in diagnostics or treatment. They don’t need 100 choices, but they do need an easy, guided system to get an available, acceptable clinician.

Finally, reevaluate your brand messaging from the consumer perspective. Make your marketing and messaging about them, rather than about you, because the research clearly shows that almost all of the time, they aren’t deciding on you because of your self-promotion.

5. Make it easy to get consumer feedback, not just surveys you send out. Remember that people are reviewing others’ reviews online. Consider how you might bring your own reviews online, so that you can build transparency and trust. Why not have ownership over your own reviews, so that you can respond to negative reviews and build solutions with consumers who are happy or unhappy with an experience? Remember that you can also use positive feedback to report back to your clinicians on what is going right.

6. Respond to consumers with the information, processes, and communications they need in a partner. Tying to practice transformation (#3, above), it’s essential to work out the patient part of the process as well. What do they need and at what point in the care process? Navigating the patient flow is not the same as the clinician flow, but just as important if you want to keep them with you.

Your APM strategy is a business model change, but it is also a segue toward redefining your future in a different health care market. With business, pharmacies, and giant retailers all trying their best to offer health care solutions that are targeted to specific service segments or populations, your strategies can encompass the full breadth of health care expertise and services, by engaging both clinicians and patients.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Braden Collum

Wanted: Better Script for Health System and Medical Group Transition to APMs

written by Theresa Hush | October 27, 2022

Health care has been suffering for a while—just ask any participant, including patients. You will hear about burnout, pressures to perform, changes in the market, pressures of new technology, fiefdoms, consumerism, and to top it off, the buildup of competition between traditional health care enterprises and new corporate health care businesses. Then there’s the pandemic, which may be sidelined publicly but continues to ravage health and the business of health care.

Value-Based Care and its sidekick, Alternative Payment Models (APMs), continue to pressure health care finances. Providers, who have played cat-and-mouse with APMs for a while now, are beginning to recognize the need to capitulate and start moving into the APM mode.

Here’s the problem: There isn’t an easy way to transition. Multiple payer contracts, Medicare and Medicaid, and health care systems and processes are built to one type of specification—volume drives revenues and growth for the whole enterprise. Facilities, practitioners and the various systems that track their performance are set up to measure their costs, but not “health care costs” as defined by the market, which actually are costs to the payer and patient. While there are many people with strong opinions, it’s rare to find people in health systems with experience in population-based payment, change agent capabilities, and data skills that are needed for APMs.

As a company that specializes in data-driven change technology—formed by people who have actually worked in capitated provider systems—we believe it’s helpful to develop a script for the great transition. In a new series of articles, we will dissect the design of APM requirements, analyze what the competition and consumers will demand, and explain how to create the path from A to Z. There is no set route for all, but there are choices along the way that can be customized.

Here’s why we think a new script is essential.

Health Care Might Be Stuck

Value-Based Care (VBC) has been a headliner in health care for at least 12 years—longer, if you include previous Pay for Performance iterations. Channeling announcements and reports like CMS strategies and rules, announcement of new ACO types, heath system articles on their innovations in patient care and savings, mergers and acquisitions, white papers, and conference agendas, you might assume that Value-Based Care is operational throughout our health care system, and Alternative Payment Models (APMs) are the predominate reimbursement type for provider services.

But it would be naive to believe the hype. Health care is not operating in a Value-Based Care mode. Not yet. That is worrisome because many organizations are losing physicians and patients to new, aggressive competition—the new corporate health care business.

Slow Adoption of APMs

The truth is that many health systems and medical groups have not moved forward in adopting APMs, the hallmark feature of Value-Based Care. The latest data from 2020 (reflecting 75 percent of all U.S. health care payments) demonstrates almost zero change from 2018 in the proportion of straight Fee-for-Service (FFS) reimbursement, at 39.3 percent. More optimistic, data shows a slight uptick in APMs with either shared savings or downside risk during that period, combined at 34.6 percent. However, only 6.7 percent of total reimbursements were based on population-based payments, up 0.4 from the previous year.

In fact, if health care seems a little stuck, it's not surprising, given the upheaval over the past two years. Most health care organizations have one toe in the water of Value-Based Care: either they are preparing for the VBC future while operations are paid through a traditional financial model, and services are delivered through traditional settings, systems, and relationships with consumers and patients; or, they are experimenting with small-scale APMs like Primary Care First. It is extremely hard to give up on a well-oiled revenue machine that has fueled your growth, industry consolidation, practice purchases, and financial stability. Health care is, after all, a business. And business has been extremely tough for traditional health care during the pandemic.

APMs Are Still Outweighed by Volume-Based Fee-for-Service Incentives

Why is the lack of APM payment models important? With FFS payments still predominating, FFS incentives reinforce the status quo. Investment in all the necessary components of Value-Based Care suffers. Failure to reinforce the goal of Value-Based Care drives administrators and physicians alike to still respond to old system incentives that reward them via compensation, resources, and reputation. The “value” goes to those who are still feeding the engine that emphasizes volume. A recent Deloitte analysis based on surveyed physicians reveals how mixed messages block changes to good physician-patient communication on costs, delivery of care according to adopted clinical pathways, and physician engagement in the opportunities for VBC.

The result: persistent health care cost escalation, little change in health care outcomes, and health inequities.

Health Systems Have Underpinnings to Support APMs

Numbers on APMs don’t reveal that health care systems have taken steps toward that goal. Efforts to align data, physicians, and payer contracts together is a massive undertaking. Readiness for APMs is determined by two essential changes that must be in place, and evidence that progress has been made:

Digitized clinical and transactional health care data from EHRs. Since 2010, use of electronic health records (EHRs) by office-based physicians has moved from 28 to 72 percent (it actually declined in 2019 from a previous high of 80 percent), and in hospitals from 9 to 96 percent. Nevertheless, one of the issues we see in digitized data is the quality of EHR implementation, an issue that will stymie good information to fuel the next step.
Data-activation into a Value-Based Care Infrastructure, designed to conduct clinical as well as administrative interventions. Data must be aggregated, activated and curated to be used in identifying outcomes, cost drivers, and performance metrics. Larger health systems have invested in data repositories and have either collaborated with vendors or created their own solutions for Value-Based Care, and mid-sized hospitals and systems are at some point in the process. But one issue is that data is not obvious—and this becomes crystal clear when you give data back to practitioners! In order to make data useful for improvement in cost and quality performance, it must be packaged and subjected to scrutiny by conditions, patients, risk level, and so on. Engaging clinicians in data analysis and infrastructure redevelopment is an ongoing process. Organizations must determine whether this part of the APM strategy is "build" or "buy," but data-activation and infrastructure are not optional if the APM is to be solvent and fuel growth.

Waiting Is a Losing Game When the Health Care Environment Is Changing

Physicians, at the center of the health care vortex, have become disillusioned and burned out by the pandemic and, realistically, by the volume-driven machine. Financial losses for practices under the pandemic led to the biggest single year of physician migration to employment in 2021, with 74 percent of all physicians now employed and over half of all medical practices owned.

Meanwhile, the environment around traditional health care has changed considerably, partly due to pandemic experience and partly from a hot financial market. Business is on the move in health care. Walmart, Amazon, CVS Aetna, Walgreens, Apple, Google and others are all active on the health care front. And there are other new entrants into the acquisition activity: payer purchases, capital-backed practices, and the growing hybrid of MSO-ACO are competing with traditional providers for physicians and patients. Not to be left behind, employers are also buying practices or purchasing ready-made capabilities that compete with services of traditional providers in the interests of cutting costs and avoiding hospitalizations.

With practice ownership almost equally split between hospitals and corporations, it is easy to miss how much the last few years have been won by health care corporations, which grew their physician employees by 86 percent over the last three years.

Physicians Are Voting for their Future by Moving to Employment

By making employment decisions, physicians are showing their alignments with APMs and Value-Based Care by choosing employers. The half of medical groups owned by hospitals is generally (not always) aligned with a slower ramp-up to higher risk APM payment models. The other half, and growing faster, are practices acquired by corporations (including insurers, employers, and equity-backed practice companies), most of which are deriving their market value from APM growth strategies. The practices that agreed to those purchases believed in embracing the APM future.

Consumers and patients are not only receptive to new avenues of care, but also eager for them. The convenience, ease of getting data, and self-management focus of non-traditional providers feeds into the growing health care consumerism trend.

A Better Script to Transition to APMs for Health Systems with Medical Groups

There is no instructional manual for building a new growth engine fueled by new reimbursement types, while tightening the bolts on excess short-term or long-term costs. But it is time to craft a detailed script. In coming weeks, we will address these key factors:

- Breakdown of the competition and what it implies for the overarching APM strategy or its components;
- What your market wants: payers, employers, consumers, governmental players, traditional patients;
- Data sufficiency and infrastructure you need to identify cost drivers, understand outcomes, prevent avoidable events, and create improvements;
- Payer contract negotiations, conversion strategies, and APM features/safeguards;
- Consideration of APM alternatives that fit your medical group/health system strengths;
- Medical network development and engagement;

Improvement activities;
Health equity initiatives;
Development and marketing;
Consumer-focused strategies.

We invite your feedback as we lay out ideas. If you think we’re on target or if there is another angle to consider, we’d like to hear from you. Please contact us at info@rojihealthintel.com.

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Image: Aris Subowo

More Health Care Transparency Means Provider Conversations Need to Change

written by Evelyn Herwitz | October 27, 2022

New federal laws and regulations focused on improving health care transparency are giving consumers significant access to essential health care information, particularly regarding costs. In a recent interview with Erika Grotto at HFMA, Roji CEO Terry Hush explains why that means the conversations that providers are having with their patients need to change.

Listen to the podcast, and read the full transcript here.

Read the blog post by Erika Grotto here.

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Image: Tom Hill