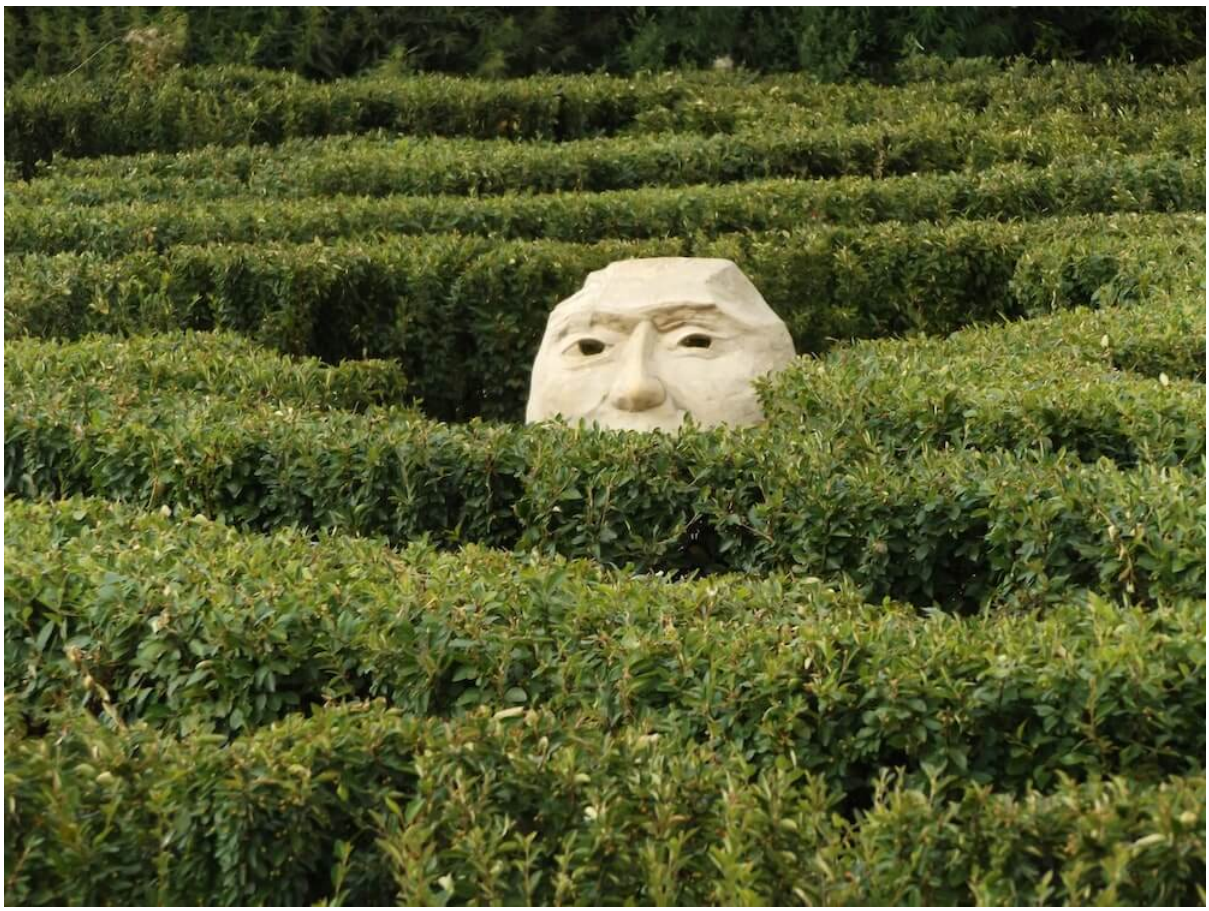
Seven Key Strategies for Health Systems and ACOs to Attract and Engage Consumers

written by Theresa Hush | February 10, 2022



Despite incredible work by health care workers during the pandemic, consumer and patient trust and belief in the health care system is dangerously low.

Why is this a big problem now? Because as pressure to implement Value-Based Care initiatives is intensifying and creating more financial pressure on your already-slim margins, your health system or ACO must depend on patient-consumers to shore up your enterprise and revenues. Without building better consumer relationships, healthier consumers will seek alternatives and leave you with less revenues and sicker patients.

In our previous post we delved into the reasons behind that breakdown in trust. Now let’s focus on what to do about it.

Consumer Strategies Should Match Your Plan for Clinical Services

Health systems have talked for years about embracing consumers, but few have really begun.

If you haven't broken ground, internal cultural attitudes could be one obstacle. If your terminology of health care includes "managing patients," "patient compliance," and "high utilizers," and your population health interventions involve group education or follow-up calls after events to educate the patient, you may need to rethink these old, ineffective strategies. The literature shows better results for supported programs of chronic disease self-management such as diabetes.

It's time to reframe the conversation.

Begin by identifying the objectives for your organization in patient services and Value-Based Care. Your consumer strategies should facilitate how you get there. For example, a typical health system or ACO may have these objectives, expressed as benefits for patients and consumers:

- Improved health status outcomes by self-management of chronic disease;
- Improved treatment plan adherence through shared health care decision-making processes;
- Improved utilization of services and fewer breakthrough admissions or ED visits for patients with chronic illnesses;
- Better evaluation of patient status through integration of consumer-derived data from wearables or devices with clinical data;
- Positive outcome and experience from services, as reported

by patients;
More new patients in planned growth areas of clinical services.

For your organization to meet these objectives, patients and consumers must be able to participate in health care discussions. They will need to understand their conditions and treatment plans, be able to converse about obstacles and alternatives, and engage in continual feedback and initiatives. This requires a minimum level of health literacy and interaction, and for some, there's a learning curve involved. Layer your consumer strategies to help consumers at different points along the continuum to improve their ability and willingness to communicate personal information, perform self-management of their conditions, and participate in making health care decisions.

Seven Key Consumer Development Strategies

1. Broaden your general communications to reach beyond patients to target the larger community of health consumers.

This includes your distribution of news, health advice, policies, and initiatives.

If you are directly messaging your patients through newsletters alone, expand your reach through blogs, podcasts, and video channels to a broader audience.
If you rely on messages sent through your patient portals to convey information, send emails, instead, to the universe of patients and family who have been involved with you. By the way, do you have CRM technology? You should.

If marketing is how you're talking to consumers, plan outreach to involve them proactively in the design of your initiatives, or establish messaging focused on health topics.

Is your social media primarily focused on marketing your organization? Do your pictures on Instagram all feature your health care team, or are you teaching consumers? If you're marketing and not educating, you're missing big opportunities to engage consumers.

What has been your COVID-19 communication strategy? If your existing patients don't know what to do if they have symptoms, or where to get tested, use the ideas above to fix that for them and the larger community.

2. Segment consumers and patients to target consumer initiatives to groups most likely to participate or benefit in specific initiatives.

Health care consumers are not all alike. To get maximum benefit from your consumer initiatives, use mechanisms to identify people who are eager to participate with you in distinct projects, as well as those who will require more cultivating.

Consider surveys of patients who respond to certain messaging with a short questionnaire about attitudes, technology, wearables, and health status (scores to be stored in that CRM mentioned earlier!).

Age is a common distinguishing feature of attitudes toward health care, and although not perfect, you might test a random survey among age groups to begin identifying consumers by segment.

3. Optimize bi-directional communication.

You have intentionally planned for physical layout and care delivery. Have you also evaluated data-gathering and decision-making points to optimize patient and consumer input on treatment preferences and obstacles to care, and facilitated improvements?

> Social determinants of health data and behavioral health data are still a data collection problem for many health systems and ACOs, with consequences for costs and poor outcomes. You should resolve how to capture data or there will be consequences to your consumer efforts and health equity.
> Collect patient attitude and preference data related to their conditions, treatments, and self-management. Ensure that this goes beyond advanced care plans. Repeat regularly and at care intervals.
> If you are designating that patient preference stipulations are defined exclusively in patient-physician encounters, you may miss the opportunities to collect objective information directly from consumers and to compare that with treatments and results. Physicians, like all humans, have biases, and these influence how they discuss options with patients.
> Organize shared decision-making processes in significant clinical areas, including oncology and specialty areas. Coordinate with physicians and clinical departments to standardize processes for communicating benefits and risks to patients and family members, provide patient materials, and establish timeframes for decisions. Health systems and ACOs must be able to provide written materials that convey data to patients, even at lower levels of health literacy.

4. Help improve health literacy in broader consumer community and patients.

If you cannot be understood, it is difficult to get results. Many consumers have never learned about health science and will have difficulty putting new ideas into practice. To improve your results:

- Tailor health literacy initiatives to fit within your population health initiatives.
- Use segmented consumer groups to target consumers by age or literacy to convey information.
- Increase frequency of consumer outreach through social media to promote your health agenda, for more feedback and consumer engagement.

5. Embrace data from wearables and devices, and directly from patients. Start now.

- Many consumers are eager to share their data and are looking to their providers to fill in the gaps of knowledge about how to improve their health. You can identify them!
- Integration of patient data, however, requires planning and overcoming obstacles. Where will the data be stored? Can or will your EMR collect wearable information, or will your repository be the means to provide that data to physicians?
- Entrepreneurial health systems and vendors are creating methods of incorporating standardized data for physician view. Stay ahead of the curve.
- Physician surveys reveal that they are interested in this patient data and generally willing to examine it—if incorporated into the EMR, a stipulation that some consumers might find imperious. Health systems will have to work to

overcome physician resistance to use of consumer data or find ways to accommodate it in the electronic record.

6. Help clinicians adapt to consumer attitudes and needs.

Most physicians are now accustomed to answering patients' questions about online research. But many clinicians will find the adoption of a broad-based consumer strategy uncomfortable. Some clinicians balk at a patients' role in medical decision-making. Even as health systems create the supportive tools and processes to maximize consumers' health literacy about their conditions and options for treatment, those same health systems need to coach and support clinicians who are held accountable for patient results and costs under Value-Based Care, so that they are versed in motivational interviewing and cost discussions. Additional resources outside the clinical encounter will be essential.

7. Prioritize the consumer's big ask: Real cost transparency.

No list of consumer-directed strategies can ignore their big requests. Consumers want to be taken seriously, to be respectfully treated when in clinical settings (and not kept waiting), to schedule appointments online, and to have cost transparency. The latter is the target of a major provider offensive, and few health systems—regardless of the final CMS rule requiring providers to establish understandable consumer-oriented pricing—have met the challenge. Understand this: Consumers will not believe anything else you say or do, if they believe your health system is hiding prices—especially as they're absorbing more of those costs.

It’s a huge agenda for health care to become consumer-focused. Many health systems believe that having a strong patient mission means that they already are consumer-focused, and that just the lingo is new. But there is a new and different consumer set of needs that must be taken seriously. Consumers have been called patients, assets, members of health plans, beneficiaries, encounters, and beds. But they have not been met on terms that they find acceptable for participating in—and paying for—health care: as partners.

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Image: Oleg Hasanov

Will Consumers Derail Your Value-Based Care Success?

written by Theresa Hush | February 10, 2022

Your health care organization may be on the tightrope of still coping with COVID-related illness and delivering essential patient care, amidst staffing and supply shortages. But in

2022, life is not poised to give health care a breather. Likewise, there is no slow-down to the expansion of Value-Based Care and payment models or development of further stages in 2022.

This year, providers in traditional Medicare will rack up stiffer penalties if costs are higher than CMS algorithms calculate. More ACO providers will progress along the path to Risk, and more will participate in alternative payment models (APMs). This will be the case especially for Direct Contracting and Primary Care First for primary care groups and the Kidney Care Choices (KCC) or similar models for specialists. Mandatory payment models, CMS has strongly suggested, are coming.

As you move forward with value-based strategies, however, you may not expect that a very significant group could derail the success of your efforts: consumers. Consumers are, in large part, directing how the pandemic continues to unfold. Their choices to vaccinate and take other actions to protect themselves and others—including you—are not much different than how they act when you are treating them as patients. But recognizing their enormous leverage as they move in and out of your system is key to your ultimate success in Value-Based Care.

This article will explore three key areas where consumers have momentum to directly affect your ability to succeed under Value-Based Care. Our next post will itemize strategies you can use to fortify your organization with consumer-directed strategies.

Why Consider Consumers Versus Patients? The Latter Have Trust Issues

To get a fresh start with strategies, think of those you serve as consumers rather than patients. Why? Because the concept of consumers envelops the elements of choice and preferences. “Consumers” make personal decisions based on information. Choice influences their health and their attitudes about health care as an industry, as a place to seek care, and you.

“Patients” implies responsibility on your part, and a historical, built-in hierarchy based on the premise that you decide or act on their behalf. But faith in your actions that reflect such responsibility—and the validity of your decisions—is not universally accepted by consumers. The fact is, they often don’t believe you. Don’t take it personally; it’s not just you. Maybe your older patients are more tolerant, but Gen X, millennials, and Gen Z cardholders are making up their own minds about all systems of authority.

Therein lies the root of trust issues that are rocking the foundations of the health care system. Trust issues are fueling volumes of research into how this factors into making health care work effectively—or not.

Another distinguishing feature of consumers is that they are always making choices, whether or not they are directly involved in treatment with you. What do you call your patients who see you once a year, at best, and the rest of time are making their own health care decisions? Those are consumers, doing what consumers do: making decisions that affect their lives and health all of the time, not just when they are under your treatment.

Value-Based Care is critically dependent on “patient engagement.” They must desire to improve their conditions while responsibly using health care resources. If you are not even aware of what is going on when they are not in front of you, it’s very hard to reach them. Your strategies must be broader to be effective and earn trust.

Health Illiteracy, Long Neglected, Has Come Back to Bite Us All

Science is complex, and constantly shifting as we know more. But as the pandemic made clear, people don’t like evolving or unclear messages. The CDC is coming under fire partly for continually changing its messages about the trajectory of COVID-19 and protective measures, failing to deal with ideas that vary from its chosen course, and, most recently, appearing to submit to political rather than scientific data in its advice to consumers.

We all know that health illiteracy is being weaponized as misinformation that affects the course of the pandemic, and the stakes are getting even higher. Burnout and staff shortages continue to get worse, and financial margins will deteriorate further for health systems.

The U.S. educational system has always failed to adequately educate children about health, health risks, and basic human biological development and genetics. In adults, there is little understanding about the incidence and results of metabolic diseases that develop over years and kill us or damage quality of life. The knowledge gap is too big for an underfunded public health system to even begin to fix it.

Thus, many experts believe providers need to play the role of educating consumers as part of their engagement in health care encounters, and to use their community presence to do more to educate. We will evaluate strategies like these in our upcoming article.

How Are You Engaging with Consumers' Health Information?

Alongside the "official" health care delivery system is a growing system of consumer-directed health information and guidance. The two are almost always completely independent from each other and don't share information. That is a problem for you because it feeds the divide between your patients' treatment plans and their status outside your data.

Adoption of consumer health care technology is growing fast, with 85 percent now owning smart phones and a majority of surveyed consumers owning smart watches or fitness trackers that they use to monitor activity. Health-minded consumers also splurged during the pandemic, buying fitness equipment and gadgets to conduct business and socialize while at home.

According to McKinsey research, 40 percent of the general population consider wellness a top priority in their lives. The number of consumers who reported using mobile health apps increased from 50 to 75 percent during the pandemic. As gyms have reopened, futurists are predicting a more hybrid model of both gym and personal training with the help of connecting technology.

Technology advancement in wearables and related devices is advancing rapidly. Smart scales can now do body scans and

project not just BMI, but estimated bone density. Smart watches can report on not just heart rate and steps, but identify falls, possible atrial fibrillation, and aerobic fitness. Some can measure blood pressure accurately. Coming soon will be more devices that measure blood glucose. Even ear buds are now being equipped with heart rate monitors.

Exercise equipment is connected via apps to general health applications like Apple Health, which may also, with patient consent, be connected to providers' EHRs, so that patients can access both their EHR results and personal data from one device.

What's key to the consumer health care technology increase, however, is that there is an industry that is now supporting these trends with medical and scientific advice. While available health research online still restricts consumers from accessing studies not funded by NIH, which are held behind specialty journal paywalls, there is now an explosion of websites, podcasts, and knowledge-sharing from entrepreneurial physicians and fitness experts, including metabolic disease experts, nutritionists and fitness coaches, physical therapists, and other health experts.

Besides fitness apps, consumers are storing their health information with websites focused on pain and symptoms, specific conditions, and general health sites. Consumers are not, however, usually able to store any of this information with you. As a result, you could significantly underestimate their capabilities, misdirect your guidance, and lose the advantage of their enthusiasm or willingness to participate in health.

Implications for the Divide of Health Care and Their Consumers for Value-Based Care

Health care that is missing consumer engagement because of mistrust, misinformation or lack of good consumer-based data will hurt the health care system. As private data platforms that cater to consumer interest proliferate, health-wise consumers will seek guidance there to self-manage health, using health systems exclusively for sick care. Higher average costs due to adverse patient selection, diminishment of primary care, and financial vulnerability will damage systems that cannot create strategies to help consumers cross the literacy, cultural, and data boundaries to understand and direct their services.

Too often, Value-Based Care has focused exclusively on payment model features to influence providers. The current priority on health equity may be a key exception to this and will hopefully prove to facilitate more holistic Value-Based Care initiatives. If all our efforts focus on inducing providers to make cost-effective clinical decisions or to use influence to change consumer behavior, the results of Value-Based Care will be disappointing. We need both providers and consumers to share the responsibility of effective health care. Now let’s create realistic strategies to get there.

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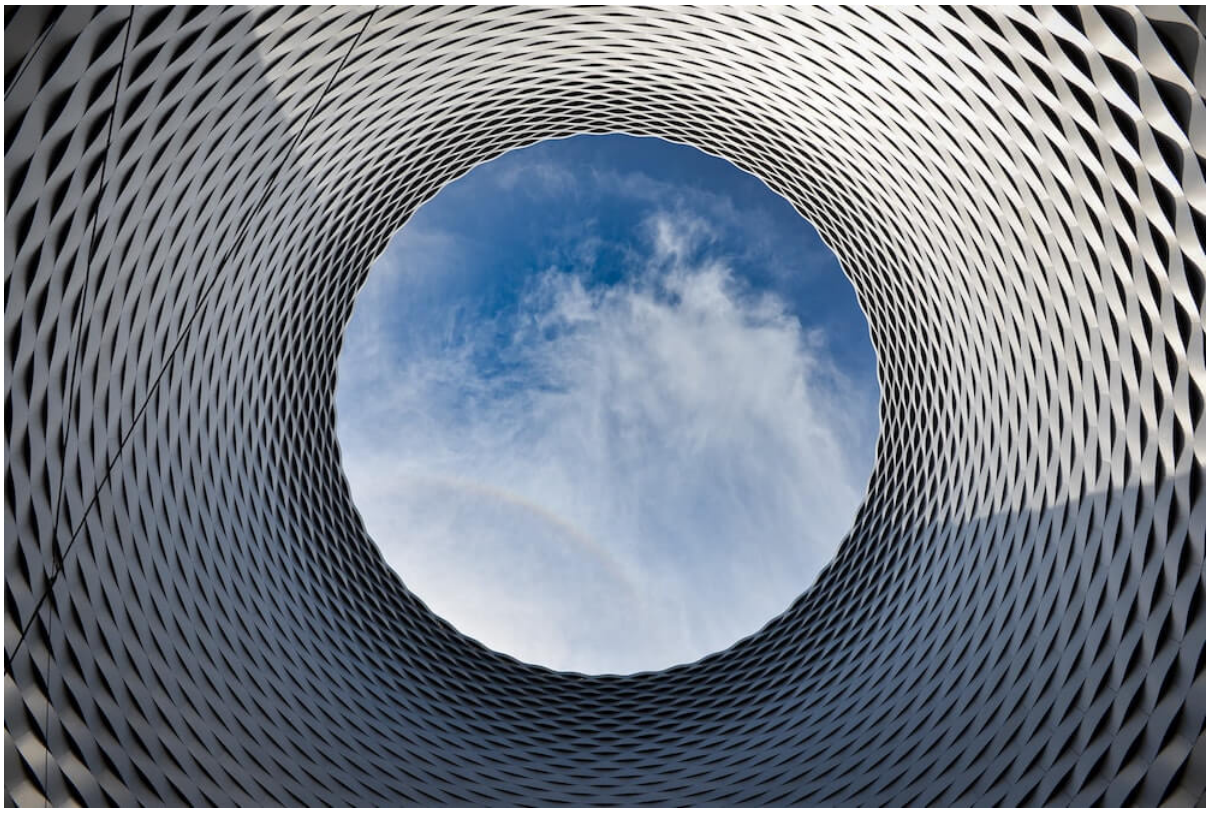
Image: Bruno Nascimento

Five Predictions for the Fate of Value-Based Health Care in 2022

written by Theresa Hush | February 10, 2022



Only a few days into 2022, it seems obvious that many predicted "trends to watch" floated in late 2021 won't, in fact, be what will matter most in this critical year for health care. Not that these issues aren't important, but they are not new (if you've been paying attention and, hopefully, planning your strategies). The major predictions are underwhelming:

> Telemedicine and other types of virtual care will continue to advance.
> Digitization of health care for consumers will disrupt traditional channels of information and engagement.
> There will be more collaborations and blurred lines between payers and providers, and even more consolidation among health care networks themselves.
> Health equity and behavioral health will propel changes in coverage, technology, services, and collaborations.

These trends will continue to unfold, whether or not you are watching. What providers really need in 2022, however, are the signals of what is to come as we transition health care toward greater accountability—under worse economic circumstances.

Perhaps these unremarkable predictions about health care in 2022 have been simply upstaged once again by COVID-19, the ultimate disruptor for futurists. But in fact, here's another prediction circulating: Value-Based Care will be sidelined in 2022, as regulators try to relieve stressed-out providers. And here's why that prediction is both remarkable and misleading.

A Case for Realistic Health Care Predictions for 2022

Without doubt, health care providers have weathered enough in two pandemic years to be entitled to wistfulness and wishful thinking. Everyone wants a return to "normalcy." But reading the Center for Medicare and Medicaid Innovation (CMMI) refreshed strategy, 2021 Reports from MedPAC and American Health Insurance Plans (AHIP), there is little room to question the urgency of stakeholders' positions about Value-Based Care.

More than at any time in the past, there is a strong consensus that Value-Based Care is the vehicle for implementing the reforms essential for an effective health care system. Value-based payment models are now envisioned to go beyond affordability and quality outcomes, and ensure health equity, access, home care, consumer health care rights, and even recovery from COVID-19 setbacks. Moreover, the central movement away from Fee-for-Service and toward alternative or value-based payment models has broad bipartisan consensus. Many of the programs being expanded were started in the Trump administration and have been enlarged in scope in the Biden program.

If you are a provider who doubts that 2022 will be the pivotal year for expansion in Value-Based Care, let's examine the evidence of the consensus for change and urgency.

CMS Has Publicly Laid Out a Detailed Timeline for VBC for the First Time

In an August 2021 article in *Health Affairs*, CMS laid out its vision for Value-Based Care over the next 10 years. Five key

points are worth noting: First, CMS will avoid proliferating multiple competing payment models with the same goals, in favor of piloting fewer models and growing participation over time. Second, health equity must be a part of every payment model, to ensure that quality health care resources can be accessed by everyone. Third, payment models must be designed to favor provider participation, and downside risk for providers must be based on providers having the tools (such as data) to change health care delivery. Fourth, the CMS strategy will go beyond Medicare, and expand into Medicaid as well as partnerships with payers, states, and communities. And finally, transition from Fee-for-Service and other cost reforms are central to the plan.

CMS officials also said that the agency may plan to make certain payment models mandatory. A few months later, CMMI released its full strategy "refresh" with more detail on specific initiatives and the time frame for roll-out.

Historically deploying both the carrot and the stick to influence action, the Physician Payment Rule released in the fall of 2021 is clearly intended to induce providers to move into alternative payment models like Primary Care First (PCF), Direct Contracting (DC), and Accountable Care Organizations (ACOs). Once providing incentives for traditional Fee-for-Service providers to report quality and implement improvement activities for cost and quality, the 2022 MIPS program now threatens providers with weighing the Cost component as 30 percent of the overall score, equal to Quality, with steep penalties up to 9 percent of revenues for poor MIPS performance.

The Private Market Is Also Expanding Value-Based Payments

Medicare has been the clear leader in promoting alternative payment models under Value-Based Care. But the private insurance industry also has implemented higher levels of payment model changes. In its December 2021 release of survey results for tracking alternative payment models, it reported that over 40 percent of health care payments for 80 percent of covered people were made under alternative payment models in 2020, during the pandemic. Almost 60 percent of health care payments for Medicare Advantage plans were tied to value-based payments in 2020. Across commercial insurance, Medicare and Medicaid, value-based payments are rising.

Predictions for Key Value-Based Care Developments in 2022

Here's the list of what we predict you should expect this year and beyond:

1. Medicare's Global and Professional Direct Contracting and Primary Care First will both expand as hospital and other multi-specialty groups seek to participate in value-based payment models under early favorable incentives. Primary Care First proved to be a safer first step for providers to test alternative payment adoption, while Global and Professional Direct Contracting was implemented on a smaller scale. Look to CMS and providers to be more receptive to expansion in Round 2, as many health systems have substantially improved their data and infrastructure for Risk. Some key provider players will see the advantages of avoiding MIPS penalties while implementing a provider-directed growth strategy through direct contracting

rather than Medicare Advantage.

2. CMS will increase emphasis on Medicaid Value-Based Care. Lagging Medicare in alternative payment models, CMS will motivate states to abandon volume-based fees. Why will this matter? Academic centers (some of which have higher Medicaid beneficiaries) lose money under low volume-based rates and can potentially do well under value-based payments. Often serving Medicaid beneficiaries with poorest health outcomes, many now have the infrastructure and broader network for providing Value-Based Care for poorer patients. Inner city hospitals, still very vulnerable, may also benefit from the predictability of population-based payments and alliances built across their communities. Look for Medicare's residency program support and disproportionate share payments to be tied to participation.

3. ACOs will remain stable or slightly decline in numbers in 2022, as organizations continue to transition their model toward Risk. Many ACOs continue to struggle with insufficient data and infrastructure as their participants straddle volume-based fees and Risk. ACOs will face a choice in 2022: take up the banner of greater Risk, participate in direct contracting efforts, and expand tools—or lose to other providers and Medicare Advantage.

4. Consumer-focused initiatives will greatly expand in 2022, with payers such as Medicare and health plans—and pharmaceutical companies—leading efforts to align patients with primary or specialty providers, help them navigate lifestyle and treatment changes, and use cost transparency to direct care towards affordable options. We will see direct-to-consumer initiatives from payers, employers, pharmaceutical companies,

and device companies seeking a direct line to help change patient behavior or change provider selections.

5. Business will up the ante to compete with traditional providers, as equity-backed practices and retail health care grow to be primary care hubs for patients. Business will use that advantage to participate in global or professional payments with Medicare and private health plans or employers, securing growth. Many of these businesses will start developing partnerships with traditional providers to broaden their reach.

This year won't be quiet on the Value-Based Care front, as some predict. The pandemic has heated the environment, not diverted attention from costs and quality, and has brought the vulnerabilities of the current delivery system to the fore. Providers would be wise to prepare for more realistic predictions for health care in 2022. Building the tools to be successful under risk-based payments requires a substantial lead time to create the available data, to engage with technology vendors or build internal capacity, and to develop cost and quality performance measurement. It's really past time to get started.

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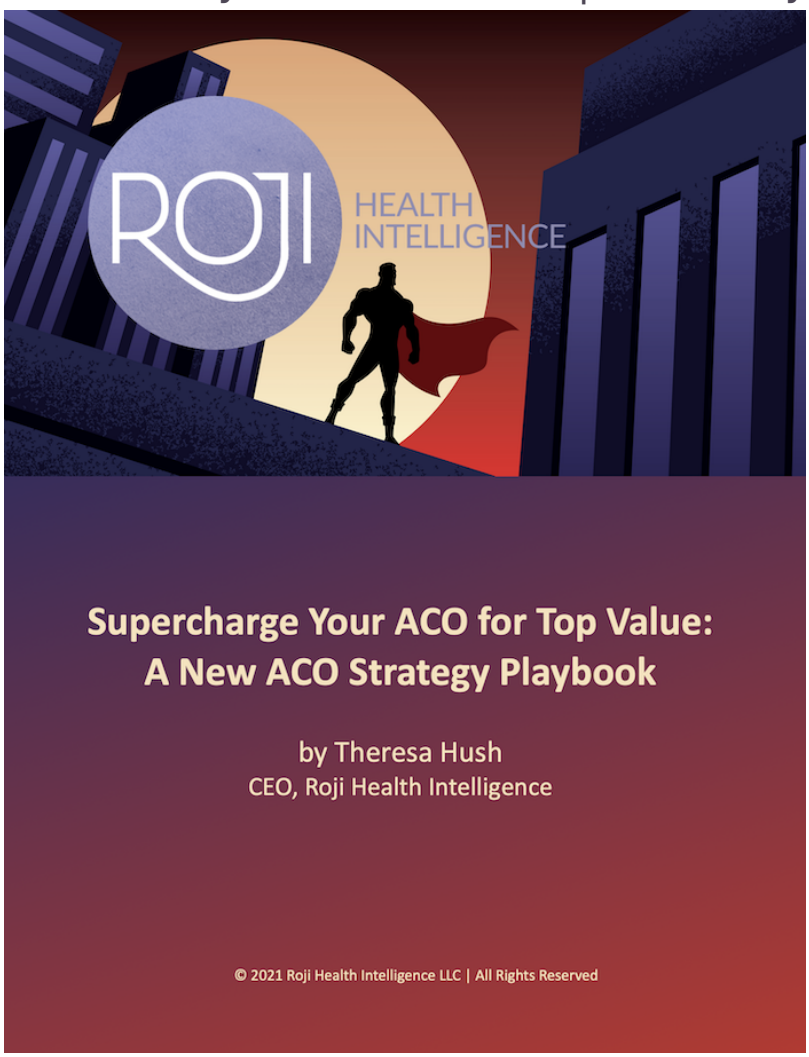
Image: Florian Roost

Supercharge Your Way to Value-Based Care

written by Theresa Hush | February 10, 2022



Whether you are an ACO, a health system considering value-based payment, or a medical

group weighing your options for Value-Based Care, Roji's new eBook, *Supercharge your ACO for Top Value*, has the strategies you need to reduce the cost of care and get clinician backing for innovation.

The health care market's reconfigured landscape puts ACOs—and health care organizations still in a Fee-for-Service contracting circuit—in danger of losing their ability to capture the savings from more effective and efficient health care driven by data, strong physician buy-in, and direct-to-consumer marketing. Medicare Advantage and equity-backed medical groups are competing with traditional providers and ACOs in a fierce contest for physicians and patients.

Stay relevant by building your strategies to supercharge your Value-Based Care plan by downloading this free eBook today.

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The 2022 CMS PFS and QPP Final Rule: A Warning Shot to Provider Holdouts of Value-Based APMs

written by Dave Halpert | February 10, 2022

CMS has released the 2022 Physician Fee Schedule and Quality Payment Program (QPP) Final Rule, and the message of these 2,414 pages is clear: CMS wants to push providers into value-based care arrangements.

That intent was foreshadowed by the Proposed Rule released over the summer, which confirmed our predictions of trends under the Biden administration. Specifically, we saw a push to move providers into value-based care arrangements with an emphasis on closing the health equity gap, and a shift toward measuring progress through enhanced quality reporting requirements within a value-based care arrangement.

To that end, in the Final Rule CMS doubles down on its commitment to push providers out of “Traditional MIPS” and into APMs or MVPs. Here are their four key strategies:

1. Move MVPs from Theory to Practice

CMS has acknowledged that flexibility within Traditional MIPS creates an environment in which the four components under measurement (Quality, Improvement Activities, Promoting Interoperability, and Cost) can be fulfilled independently. The result is the same fragmentation they had sought to avoid when consolidating legacy programs like PQRS, Meaningful Use, and the Value-Based Payment Modifier. Their solution, MIPS Value Pathways (MVPs), is intended to weave these four components into a comprehensive quality initiative.

CMS has been pushing the concept of MVPs for several years, but the logistics were undefined—until now. This rule outlines the nuts and bolts of how MVPs will be developed and reported, starting with seven MVPs available in 2023:

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Support of Positive Experiences with Anesthesia

To successfully complete the MVP reporting requirements, participants must submit data on the same three MIPS components as they do today: Quality, Improvement Activities (IA), and Promoting Interoperability (PI). The difference is that, in an MVP, the Quality, IA, and Cost components are identified in advance, ensuring that the MVP topic is the driver of

measurement.

For Quality, participants report on a set of four pre-determined quality measures, and at least one of those must be a relevant outcome measure—and each provider in the MVP must have a clinically appropriate outcome measure within the set. The Improvement Activities category is fulfilled by attesting two medium-weighted or one high-weighted IA that is relevant to the MVP topic. Promoting Interoperability is specialty-agnostic; while it must be completed, the MVP topic is unrelated to PI measures. Likewise, a required Population Health measure (either Hospital-Wide, 30-day, All-Cause Unplanned Readmission Rate, or Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions), calculated by CMS, is required. This Population Health measure is separate from the Cost component, which is also calculated by CMS, and based on the cost measures associated with the MVP.

Beginning with 2024 performance, MVP results will be publicly posted. For groups for which an appropriate APM is not available, but that wish to demonstrate clinical excellence in a specific area, MVPs may be the most advantageous option, but only if you have the tools to measure and improve performance on an ongoing basis. Furthermore, since each MVP is required to have at least one outcome measure (plus three more that are relevant to the MVP), those who rely on their EHRs to report are limiting their measure selection in a manner that may make it more challenging to succeed—specifically, because the electronic measure library is substantially smaller than the library of MIPS measures. Fortunately, CMS has granted Third-Party Intermediaries (like Qualified Registries) the ability to

support MVPs.

2. Put Increased Responsibility on Individual Clinicians through “Subgroup” Reporting

The biggest question surrounding MVPs was related to multi-specialty groups and how they would be expected to participate. In Traditional MIPS, these groups could pick from the entire library of measures, even if those measures applied to a small minority of the group’s clinicians. To ensure that MVPs are reliable mechanisms for measurement, CMS has introduced the concept of “Subgroup Reporting.” This means that groups must divide into smaller groups for reporting so that each clinician is reporting on a topic that is relevant to their field of practice. As each MVP is concentrated on a specific area, Subgroup reporting is CMS’s way of ensuring that clinicians are not able to succeed in an MVP without demonstrating that they played a role.

MVP reporting will be substantially more formalized than the existing group reporting process. Group Reporting in Traditional MIPS automatically applies to clinicians who bill under that group’s Tax ID Number (TIN), which further obscures an individual clinician’s contribution to the overall score. This will not be the case with MVPs. To ensure that CMS knows which clinicians are being scored under which MVP, CMS has established a registration process for MVP participants, which is defined in this rule.

The registration process bears a striking resemblance to that of an Alternate Payment Model, and most importantly, requires participating providers to be identified at the individual NPI level, whether reporting as a group, APM entity, or a subgroup.

The informal “everyone billing under our TIN” method will be off limits; organizations will need to effectively communicate with their clinicians to ensure an understanding of how each individual will be evaluated. There may be multiple MVP subgroups, Traditional MIPS participants, and APM Qualified Participants.

The registration period occurs between April 1 and November 30 of the performance year. Once it closes, *no changes may be made* to the MVP selection, the measures within the MVP, or the participant list. Subgroups will be identified by a unique ID, similar to an APM site.

An organization without dynamic tools to organize participants and programs is putting itself at risk, as those clinicians who slip through the cracks will be subject to financial penalties.

3. Enhance the Challenges of Traditional MIPS

From the above summary, it’s clear that implementing an MVP and demonstrating superior performance will require organizations to overcome challenges on administrative, IT, and clinical fronts. Since MVPs are not mandatory, the natural temptation for Traditional MIPS participants is to maintain the status quo.

But if you’re nodding in agreement, beware! The Rule outlines several changes to Traditional MIPS, and these will make it challenging to avoid financial penalties in 2022 and beyond.

By statute, 2022 is the first year that Quality and Cost will carry the same weight toward your total MIPS score—each component is worth 30 percent. To understand why that’s so

important, consider the history of MIPS. At the outset, Quality was worth a whopping 60 percent of the MIPS score, while Cost was for informational purposes only, having no bearing on the total. The Promoting Interoperability category (then called Advancing Care Information) was focused on reporting, rather than performance. Since then, the Promoting Interoperability category has become more performance-oriented and requires 2015 EHR Certification. Although many MIPS participants felt the sting from Promoting Interoperability, they were able to make up for suboptimal PI scores with excellent Quality scores. Now, however, with Quality and PI weighted at 30 percent and 25 percent, respectively, organizations must recognize that excellent quality reporting cannot effectively correct for poor PI performance.

The other side of this story is Cost, which has gone from an FYI to nearly a third of MIPS performance. The challenge here is that CMS did not release any Cost feedback in 2020. In response to the pandemic, CMS reweighted the Cost component for the 2020 performance year, and since the category carried no weight towards the total MIPS score, providers and organizations received no information. That means, going into 2022, the soonest anyone will learn where their baseline performance resides (their 2021 score) on the 18 existing episodes and two global measures will be in the late summer/early fall of 2022.

In other words, the year will be more than half over before anyone knows where they stand, with less than half a year to make the improvements needed to separate themselves from the pack (or catch up with it!). Furthermore, the five cost measures that were proposed (Asthma/COPD, Colon and Rectal

Resection, Diabetes, Melanoma Resection, Sepsis) have all been finalized. With so much more of the total score at stake, the Cost component puts Traditional MIPS participants in a tenuous position, at best.

Additional changes compound the challenges for Traditional MIPS participants. Even if the category weights remained unchanged, it would still be harder to succeed in 2022 using the same strategy employed in 2021. The minimum performance threshold—the break-even point between bonuses and penalties—is being raised by 15 points, from 60 to 75. Given the category weighting updates, this creates a very real possibility that participants could submit full sets of data for all categories, yet still incur a financial penalty for failing to meet the minimum threshold.

Smaller changes to quality measure scoring add insult to injury. Beginning in 2022, there will no longer be bonus points awarded for reporting additional outcome or high priority measures. The End-To-End bonus points for reporting on fully electronic measures without manual intervention is also on the chopping block. Many have counted on these bonuses to recoup ground that was lost to performance on outcome measures, or measures that could not earn full marks due to topped-out status, low volume, or lack of an established performance benchmark. CMS provides some relief by putting a floor on the points that may be earned by new measures, but this is tempered by their removal of the 3-point floor for established measures. In 2023, the 3-point floor will also be removed for established measures without benchmarks and for measures with low volume—for those who are not in small practices (15 or fewer clinicians), these will no longer be worth any points.

With penalties remaining high (up to a 9 percent penalty), those who have “gotten by” in prior years are making a risky bet that the same strategy will clear the newly-raised bar. In 2023, it will be even harder.

4. Reward Existing APM Participants with Lenient Transition Timelines

In recent years, we’ve seen a common theme in CMS rules: substantial changes are proposed for ACOs, but walked back to varying degrees in the Final Rule. Eventually, the change takes effect, but on a longer timeline than proposed. This year is no different.

In 2020 CMS proposed retiring the Web Interface as a reporting option for everyone, including ACOs, at the end of that year. The 2021 Final Rule, released in the fall of 2020, granted a one-year reprieve, allowing ACOs one more year to report on a sample of patients through the Web Interface, rather than on all patients through the Alternate Payment Model Performance Pathway (APP).

The 2022 Proposed Rule indicated that ACOs would be able to report via the Web Interface for one more year, but would have to report at least one all-patient eCQM or MIPS CQM in 2023. The 2022 Final Rule gives ACOs the ability to continue reporting via the Web Interface through the 2024 performance year, with no requirement for an all-payer measure in the interim. The 2025 deadline coincides with CMS’s deadline for converting to Digital Quality Measures (dQMs).

Despite the delay, it will be more challenging for APMs to demonstrate quality care in the very near future; CMS has

postponed its requirement for reporting measures on all patients via the APP, but has not axed the proposal. Taken in the context of CMS's desire to improve equity across its programs, the concept of reporting quality metrics on all patients has a deeper meaning than a CMS desire to sunset their Web Interface, and all-patient reporting cannot be credibly delayed much longer.

Coinciding with the delayed retirement of the CMS Web Interface, CMS has adjusted the timeline for ACOs to meet enhanced quality performance standards, but with a subtle push for ACOs to move to the APP.

Consider this: For 2022 and 2023, in order to meet performance standards, ACOs must earn a quality performance score that meets or exceeds the 30th percentile across MIPS performance category scores if reporting via the Web Interface. On the other hand, if the ACO reports three eCQMs/MIPS CQMs via the APP and achieves a score equivalent to the 10th percentile of the performance benchmark for at least one of the four outcome measures in the APP set and meets the 30th percentile on at least one of the five other measures, the ACO would meet quality performance standards. In short, those who do report via the APP do not need to perform as well.

For these reasons, along with others we've previously described, forward-thinking ACOs should consider a tandem approach and simultaneously report through both the APP and the Web Interface. As we've outlined, this is the safest, long-term way to fulfill performance standards and offers one other incentive: CMS will assign the highest of the two scores to the ACO.

In order to succeed, be it in APMs, MVPs, or Traditional MIPS, providers and groups must establish a strategy now that gives them insights into their care and costs—with the ability to see the big picture, and the flexibility to trace the effects of their overall strategy down to the individual patient level.

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: Erik Mclean

New ACO Playbook: How to Supercharge Your ACO

written by Theresa Hush | February 10, 2022

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

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

Success in Your ACO Business Is Driven by Vision and Execution

Like every business trying to achieve goals and make money, your ACO is driven to success by *internal energy and vision*, combined with *good execution of strategies*. Without both of

those, you can’t reach any of these touchstones for success:

- Higher savings
- More patient volume
- Better health care outcomes and health care experience for patients

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

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

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

Supercharge Your ACO with Tools for Success

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

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

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

- Is clinical leadership included in the governance of your ACO?
- Does your ACO communicate with physicians routinely on ACO initiatives and recruit physicians to participate in crafting improvements?
- Are you working with practice ownership and management to provide physician incentives and time to participate in data review, clinician review of patients queued up for possible intervention, and participation with improvement programs?
- Are your improvement activities only focused on administrative activities, or do you have specific outcome improvement activities that involve clinicians?

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

Whether you build or buy your technical infrastructure (or use

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

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

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

Your ACO should be collecting patient-identified clinical data, social determinants, and prescribed drug data from provider systems. Integrated with claims data, this provides you with both comprehensive and detailed data for macro-analytics on costs, and microanalyses of patient episodes based on

procedures and conditions. Ask these questions to determine if you have enough information to create significant population health interventions:

- Can you identify patients that have persistently poor control of their chronic conditions, based on risk indicators and outcomes over time?
- Are you able to track any episodes of care, either chronic conditions or procedures?

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

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

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

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

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

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

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

How? Measuring your providers' patient population on an ongoing basis enables you to identify patients with needs during the course of the year. These patients can be queued up for clinician review or for visits based on measure results, so that you are both improving quality and preventing deterioration of the patient's condition. End-of-year quality reporting deprives you of initiative. Progression of disease,

continuation of low-value treatments, and disabling risk factors affect your total patient care cost. Ask these questions to examine whether you are prioritizing quality efforts for your ACO:

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

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

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

Supporting physicians in meeting ACO benchmarks means facilitating practices with the ability to easily review and schedule patients who need services, aided by data-driven patient populations built on episodes that identify patients with risk. Ask these questions to evaluate your opportunity for engaging your ACO clinicians and staff:

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

You *Can* Supercharge your ACO!

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

their part, understand the future, and that they will need support to participate in risk models.

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

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

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

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

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

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Image: Yale Cohen

New ACO Playbook: Seven Keys to Expanding ACO Savings—and Market Share

written by Theresa Hush | February 10, 2022

At the beginning of this series, we laid out a basic tenet: As shared savings plan ACOs, you need to do as well or better at lowering costs than competing value-based payment models. Otherwise, your resources and support will dwindle in favor of more promising avenues to control Medicare spending, and competition will stifle your growth.

We've examined the competition and what they offer physicians to succeed in Risk and to attract patients. The bar is high. Medicare Advantage Plans, equity-backed practices, and Management-model ACOs like Aledade have changed the playing field for physician participation and growth.

ACOs Have Lost Ground to the Competition

Medicare Advantage plans, alone, cover 26 million people, or 42 percent of the total Medicare population, gaining five points over the past five years. Most of that growth is going to for-profit health care plans, like United Healthcare and Humana.

Traditional Medicare, as a result, is declining as a share of total enrollment. The ACO slice of that pie is 12.1 million, or 19 percent, of the Traditional Medicare enrollees. Of those 12 million, a growing number represent enrollees under managed ACOs and equity-backed practices, with 10 percent in Aledade practices alone.

ACO Savings Continue to Build, But Remain Small

New 2020 figures released by CMS in late August total $2.3 billion in ACO savings, relatively flat from the $2.6 billion in 2019. These savings figures are often disparaged by industry analysts because they are calculated according to artificial benchmarks based on historical and regional spending. But let's take them at face value to make comparisons. About 67 percent of ACOs were successful in achieving savings in 2020; the most successful were ACOs accepting more Risk—by a large margin of 85 percent among two-sided-risk ACOs—versus 55 percent among one-sided ACOs achieving savings only.

For your ACO to have the best chance at growth and savings in a competitive market, being slow to adapt is not an advantage. There is noisy public criticism of ACOs for small savings compared to the total Medicare budget. While not a fair benchmark (ACO spending is a small portion of the total budget), the critique makes an important point: .02 percent

savings against the total Medicare budget indicates that ACOs are not a huge driving force in Value-Based Care. If you want to ensure your options for a provider-driven payment model, you must show that you can achieve savings equivalent to a health plan. The political timeline for that accomplishment is short.

7 Key Strategies to Higher Savings and Growth

In previous articles, we have examined actions to lower costs by (1) using data-driven analytics to compare and identify cost drivers, and (2) applying interventions or improvements to address these cost issues. You may think this is simplistic and obvious, but that is far from the truth. If your strategies are based on ideas that are promoted by others, or tactics to create physician compliance with financial benchmarks alone, your approach is solely intuitive. If you lack the data needed to examine costs in enough detail to distinguish the reasons for cost variation or opportunities for savings, it is likewise an intuitive approach. You may guess at costs based on categories of dollars and knowledge of health care. But cost categories cannot show you reasons for cost variation. An intuitive approach limits your strategies entirely to non-clinical interventions and the most basic population health tools involving patient outreach.

Without data and detailed analytics, you have a more difficult time engaging clinicians in improvements, redesigning care for the chronically ill, and supporting them in the ACO. Intuitive approaches suppress your savings and undercut your physician network strategy by keeping them in the dark.

By contrast, these seven strategies are geared to deploying interventions that specifically respond to cost variation and

drivers based on data. Most importantly, they also target your interventions to the most salient opportunities to improve conjoined patient outcomes and costs—first, by understanding the problem and second, by applying interventions in a more effective and resource-conserving manner.

Analytics Strategies

These analytics strategies give you the foundation for launching all your cost initiatives:

1. Deploy patient episode analytics to reveal cost variations and cost drivers for patients with major chronic conditions. Annualized patient episodes create a comparable unit for analysis by patient, condition, and provider. Your top priority includes high-volume metabolic diseases such as diabetes and coronary artery disease, and other chronic diseases that trigger high cost events or disease progression. By identifying patients with poor control over time and emergencies and hospitalizations, you can create a more targeted patient population for potential interventions. Collecting social determinants of health data will help you also to focus on additional risks, such as behavioral health, food and housing insecurity, and domestic abuse.

2. Use episode analytics to help support physicians in achieving better treatment plans. Patient episodes enable the evaluation of patients with poor control in the context of clinical treatment data, such as medications and use of ancillary and specialty services. For example, patients with poor control of diabetes but who are only on insulin can be queued for physician review of medications, either as a group or at their next visits. This process may reveal medication

affordability issues that should be reviewed and discussed with the practice and, if needed, referred to ACO staff for arranging subsidies or referrals to community financial assistance programs. Providing physicians with patient episode analytics that lead to specific evidence-based interventions benefits clinical treatment. It also creates engagement in costs in a positive way. If physicians participate in efforts to improve outcomes for patients with chronic diseases by a series of interventions—medications, nutritional services, referral to subspecialists—it's a win for both physicians and their patients.

3. Examine specialty services for the highest volume conditions and procedures, and seek out groups participating in specialty care models. Also using patient procedural and condition episodes, your ACO can more systematically examine both physician-referred and patient-referred specialty services. Claims data facilitates the creation of comprehensive specialty episodes based on procedure, with filters for factors that drive higher marginal costs. Examination of specialty-managed conditions and procedures can help your ACO work with specialists to lower costs and also determine optimal referral policies. Since between 40 and 60 percent of costs is driven by specialists, a specialty cost management initiative should be a significant part of your savings activities. You may find collaborative opportunities if there are specialty groups in your region that are participating in Cancer or Kidney Care Models, or that have participated in Medicare or private Bundled Procedures initiatives, as they have self-selected Risk.

Interventions and Initiatives

Data is most valuable if it is intended to immediately drive initiatives aimed at patients and their clinicians. These can be specific patient health interventions, or they can be broader initiatives to connect your ACO to a broader network of care and community resources.

4. Implement interventions both at point of care (managed by clinicians or medical staff) and population health, depending on the nature of the intervention. You will need to make data available at the point of care for clinicians. Or, your ACO may decide to manage certain interventions across a group of patients, such as a patient group nutritional services program. If your ACO is currently using population health only as patient follow-up, you can create more information and a better targeted population by deploying episodes.

5. Explore the use of technology, wearables, and monitoring devices to obtain and track patient outcomes. Identifying patients for continuous glucose monitoring has proven to be of great value for patients. Fostering use of telemedicine and other technology-assisted visits and outreach can help bridge the gap between visits, especially in behavioral health. Nurse phone lines have been used as a standard practice among payers to avoid emergency visits. These interventions, which also can be targeted based on status of the patient and condition, can benefit patients, reduce services out-of-network, and avoid hospitalizations. Like other interventions, these can be queued for clinical approval and patient outreach by episode-filtered populations so that they are best targeted.

6. Integrate behavioral health services into your ACO

initiatives. Behavioral health services are increasingly recognized as critically important components of care that influence outcomes and costs, including a large proportion of hospital admissions. Yet behavioral health is often missing and undervalued in primary care, in part because it's very challenging to fully address behavioral health issues in the primary care office. For one, the time allotted for most ambulatory encounters is too brief to manage much more than an acute symptom or problem. Additionally, it's often difficult for primary care clinicians or their patients to access mental health services due to poor insurance coverage and a shortage of available providers.

New integration models of behavioral health and primary care practices show positive results for patients and both physicians and behavioral clinicians. Your ACO can develop the initiative to foster integrative techniques to identify patients with needs and create early interventions. ACOs that have experimented with identification and referral of patients have seen substantial reductions in admissions.

7. Invest in growth by reaching out to patients and consumers regularly with educational and promotional information. Negotiate ACO agreements with private insurers. Invite patients into interventions and initiatives. Your value to your physician base or health system hinges on more than Medicare. Your ACO must bring them an increased volume of patients from other insurance plans and direct patient choice to command the resources you need to be successful. But these initiatives are not self-serving. They create energy and enthusiasm on the part of the enterprise and your patients and a potential dialogue that can lead to more and even better strategies and

interventions.

This short list of strategies cuts through the complex processes that are involved in improving costs and outcomes for patients, but it is by no means simplistic. That your ACO needs infrastructure and processes to undertake these strategies is clear, but the elements of that infrastructure will be described in our next article. What's the most important takeaway? A shortlist based on data can help you corral significant costs and cement partnership and confidence from your physicians. You can, with precision, address high cost areas that stymie your success.

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Image: Vivian Arcidiacono

New ACO Playbook: 3 Strategies to Tackle Hidden Costs of Specialty Care

written by Theresa Hush | February 10, 2022

Your ACO's most significant costs may seem obvious. CMS and most ACOs have put an enormous emphasis on reducing utilization of hospital facilities and nursing home care to control costs. But your real key to cost reduction is knowing what drives avoidable admissions and stays in the first place. And with 50-60 percent of costs attributed to specialty physicians, that is where you need to start.

Specialists are—and should be—involved in your most complex patients' care. Those specialists will benefit from a collaborative involvement in cost data. And both your ACO and your patients will benefit from better and more coordinated care as your organization works with specialists to reduce variation in costs of treatments, including procedures.

Why Look at Specialty Care?

Specialty services generate higher cost for several reasons:

patients with more serious illness, high use of medical technology, higher use of hospital outpatient or inpatient facilities, and the involvement of other specialists (e.g., imaging, anesthesia). These individual elements of the package of services that a patient receives comprise a patient episode. Comparing similar patient episodes by procedure and diagnosis will illuminate variations in costs and the packages of services used per-patient, as well as reveal opportunities.

Different practice patterns in both primary and specialty care generate cost variations. These should be examined by physicians using clear visual analytics to create an optimal clinical pathway. Episodes can also be used to identify low value procedures or clinical appropriateness issues prior to the patient undergoing treatment.

Your ACO Can Make a Difference Just by Sharing Cost Data with Specialists

Both you and your referring specialists should be aware of cost variation. The advantage you bring to specialists is the ability to bundle essential data points together into patient episodes (yes, this will require a vendor to organize the data and analytics for you). Because you have claims data, you and your specialists can see a comprehensive view of costs as well as possible interventions. They cannot see the costs without your help.

When patient episodes of the same procedures are displayed in analytics, episodes with higher costs stand out from the average. Drilling down into episode details will reveal reasons why higher or lower costs resulted; each cost differential, in turn, represents a preference or a clinical decision made by

the performing physician or associates. There could be variation in physician approaches, such as laparoscopic or open surgical incisions, or variation in imaging and choice of procedures, venues, and pharmaceuticals. Each will generate an episode cost that can be compared and investigated.

Specialists who see cost data can investigate these differences either individually or in practice settings, with the objective of identifying and reducing cost and care variation. Your ACO can likewise compare specialists and their costs for the same condition or procedure and generate discussion about the contributing factors to higher or lower costs.

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

1. Negotiate the collection and use of specialty practice data to support episodes of care.

Your options include a process that collects data entirely under specialty practice control, whereby the practice would send to your ACO their analytics and cost variation data but maintain control over the patient data itself. Most specialty practices would not have the expertise to do this without external help. Or you could use an intermediary vendor to collect the data and create the analytics for the episode, since you will need to have the latter performed anyway. Under either option, specialists could be admitted to your referral network if they participated in the data sharing.

Specialists would need data privacy assurances and would most likely be unwilling to give up financial information. However,

that is not an impediment, since using a Medicare fee schedule could substitute for real charge or collections information and would create a standard for comparison.

2. Agree on episodes for your highest-cost areas of care, and on criteria for patients to be referred to specialists.

You will not need episodes to cover all specialty areas, but only your higher cost specialty areas. Procedural episodes will typically include orthopedics, including joint replacements and spine surgery; cardiology/cardiac surgery; and some gastrointestinal services. You may also adopt episodes that are part of CMS programs, similar to cancer and kidney disease payment models.

It will be beneficial for medical specialists if you also include them in episodes related to diabetes, COPD, asthma, hypertension, heart failure, and cardiovascular conditions. This gives them a quid pro quo involvement for patients whose outcomes are not improving, and where specialty referrals could be considered.

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

3. Create mechanisms for primary and specialty involvement in selected cases, involving review of outcomes and cost episode data.

Here the objective is for physicians to develop interventions that could be rolled out on a larger scale for populations with similar issues. Communication on episodes can facilitate greater understanding and collaboration, leading to more optimal specialty care.

Roji Health Intelligence has targeted seven analytics as fundamental to episode analytics that provide a guide to what both ACOs and physicians need to see. Extending the value of episodes from cost analytics into improvements in medical decision-making will help physicians and patients realize the potential of primary care-specialty collaboration on patient care. Even in ACOs with independent specialist physicians, data-driven strategies to examine cost and outcomes can lead to benefits for cost performance and outcomes improvement.

It is virtually impossible for ACOs or specialty groups to independently achieve improvement of costs without common data between them. Collaboration and data sharing will help specialists become more competitive, have access to health plan contracts that reach more patients, and, possibly, open the field for employer-based agreements. For ACOs, engaging specialists in cost control strategies can determine whether you are successful in Risk and can compete with Medicare Advantage and other payment models.

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systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Pierre Bamin

Cost Savings Aren't the Only Objective for ACOs: Growth Matters, Too

written by Theresa Hush | February 10, 2022

Keeping within expenditure limits is a top priority for most ACOs for Medicare. That makes sense. Savings are the main distinguishing feature of an ACO arrangement, as opposed to straight Fee-for-Service reimbursement. ACOs that accept downside risk can’t afford to exceed the expenditure target. It’s in their best interest to create initiatives to cut costs and control expenses—especially for services outside the ACO, such as post-acute care.

But a cost strategy only focused on trimming expenses will likely fail the ACO in the long run. Why? Medicare ACOs face an annually decreasing expenditure limit that mandates them to lower costs with actions that are more aggressive each year. Not only are aggressive measures harder to achieve, but also they will not be enough, alone, to fulfill what the ACO needs.

ACO’s Future Depends on a Continual Influx of Younger, Healthy Patients

Most providers developed ACOs because they saw a time-limited opportunity to ensure patient market share and to practice Value-Based Health Care while it was relatively painless. But to accomplish a goal of market share, the ACO strategy must optimize the fundamental stratum for ACO success: a steady stream of healthy, loyal patients that will balance the costs of very sick patients and allow the ACO to be solvent. That’s also the actuarial formula of health plans—the sphere in which ACOs now operate.

The Medicare Shared Savings Program (MSSP) attributes a patient population to providers based on the recent experience of those patients and asks that providers manage services for those patients within a budgeted limit. Even if those patients are healthy, the cohort will age and develop significant illnesses over time. If the group is higher risk, older or poorer already, the ACO has a financial challenge from Day One.

Even with the best first-year savings and a stellar array of cost initiatives, the ACO must attract additional and healthy patients into the organization for the future of the enterprise, while also improving the costs of current patients. A general rule of business solvency is to keep current customers while attracting new ones. Up until now, health care providers did not worry much about appealing to consumers, by virtue of insurance-directed coverage. But the management of financial risk, coupled with patients’ free choice of provider, compels re-thinking.

Allowing patients to choose their providers affects the growth

and sustainability of an ACO in an elemental way. If patients go elsewhere for services, the physicians will also leave to practice where they can maintain professional growth and personal economics. The ACO—even more than its participating groups and institutions—must be accountable for patient growth by understanding and responding to consumer health care issues. Here are three action steps to help ensure a sound growth strategy for ACOs:

Step One: Make Loyalty and Retention for Current ACO Patients a Top Priority

If your current patients are already getting services outside the system, your first action plan must be to determine the weaknesses in your existing network and patient operations. You won't be able to attract new patients if your ship is leaking. If you haven't been conducting regular queries of patients using the providers that give you more detail than CAPHS, now is a good time to start.

The examination should include an analysis of your data for patterns in network use, in order to identify gaps in services or quality issues—perceived or real—that cause patients to seek services elsewhere. In addition, review cases where patients incur services and claims outside your network after seeing your primary care physicians or specialists; this is a key indicator of obstacles in your operations that could be turning customers away because of scheduling problems, communication issues or lack of confidence.

If you are a health-system-based ACO with participating specialty providers, examine your attribution of ACO patients to ensure that every patient has a primary care home in your

ACO, as well. Adverse cost for your ACO comes from patients who are attributed to your ACO for expensive specialty services and who then attach to other ACOs' primary care physicians, once they are well. You will likely lose such patients permanently, regardless of the specialty care, because of other ACO referral practices.

Your clinical efforts to improve existing patients' health status will drive the costs of that cohort now and in years to come, if they remain with your ACO. To enable healthy, loyal patients, your cost strategy must, of course, include efforts aimed at reducing the costs of patients with high risk or intensive conditions. Your data and technology to reduce costs will require more than the claims data you get from CMS, so your actions must entail creating data sufficiency by integrating provider data with clinical detail to support cost interventions.

Step Two: Understand Characteristics of Your Existing Population and What's Next

In your Medicare population, the patients using most services are probably older and require more intensive care. Don't make the mistake of attributing the needs and preferences of these patients to those on your growth agenda. Generational differences are stark not only between large, decades-determined cohorts, such as Baby Boomers and the Silent Generation but also between the generations that comprise each cohort. For example, research on the younger Boomers shows they are less willing to accept authority, more technology-savvy, and consumer-oriented. These preferences should steer ACO growth strategies.

That means your retention and growth plans must be two-pronged:

- Make loyalists of current patients by meeting their clinical needs and improving their health outcomes (which will also reduce costs), and
- Appeal to the preferences of younger consumers by understanding that they may still be working or caring for their own parents and need responsiveness to time constraints, on top of clinical excellence.

Historically, providers have focused on bricks-and-mortar and clinical excellence programs to appeal to patients. Why isn't this the most fruitful direction under risk? First of all, bricks and mortar are expensive and stationary, while patients are looking for convenience and access. That's why they are going to pharmacy-based services in greater numbers, and demanding Telehealth to avoid the inconvenience and time of visits.

Second, while clinical excellence is, of course, extremely important, constructing an ACO marketing plan on high-cost services may attract patients needing them, but not necessarily the others who seek a good medical home with convenience, good access, communication and better control over their medical decisions.

In other words, if you want to be a specialty player, perhaps you should not be an ACO; rather, concentrate your efforts on episodic bundles that can be marketed to an ACO. But if your path is to an ACO, then appeal to patients who are well, as well as sick.

Step 3: Promote ACO Growth through Voluntary Commitments by Patients/Consumers

In the past decade, health care providers have consolidated into large, vertical administrative conglomerates, in the name of efficiency. Nonetheless, there is significant evidence of higher costs and reduced competition in health care. What enabled this consolidation strategy? The belief by providers that market share could help them negotiate better rates with health plans, improve their ability to develop ACOs, and fend off competitors.

ACOs formed by consolidated health care providers claim their market share by annexation, designating patients into the ACO through Medicare's attribution policy. While smaller and non-consolidated ACOs also claim a patient population in the same way, the basis of those arrangements tends to be on physician relationships, rather than corporate use. Even so, it's unlikely that patients consider this ACO assignment an actual choice, and they demonstrate that fact by using non-ACO services. To be sure, however, most patients are not even aware that they have been attributed to a provider organization, in the first place.

The point is that ACOs must develop voluntary commitments from consumers to replace or secure their partnerships with patients, despite the lack of an official ACO or provider lock-in arrangement by Medicare. These voluntary commitments must come from both existing patients and new ones.

How can ACOs engineer such voluntary commitments from consumers? They can build responsiveness and touch into their operations, appealing to the next generations who will use

their services to help design those very services. That will require that ACOs adopt more consumer-oriented technology for appointment scheduling and dialogue with providers, along with ease of navigating services and cost transparency.

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 Credit: Andrew Preble

New ACO Playbook: Three Ultimate ACO Strategies to Keep Physician Practices Onboard

written by Theresa Hush | February 10, 2022

ACOs have zealously protected their favored status under Medicare Value-Based payment models, ensuring enough time for organizations to feel comfortable with financial risk and make investments in infrastructure. But if your own ACO is losing physicians to new equity-financed networks or to hospitals consolidating practices, more time does not help you. Primary care physicians are being picked off by your competition, and their patients go with them.

Private equity firms and venture capital-funded groups have gained significant ground in acquiring physician practices, with mergers and acquisitions hitting record highs in 2019 and 2020, and accelerating in 2021. Equity firms and health insurers now own almost one-third of physician practices, and 70 percent of physicians are employed by hospital systems and corporate entities including private equity firms and insurance companies.

Consolidation of practices through hospital and private company acquisitions is decreasing the number of small practices and increasing larger practices and networks, conferring market power and better negotiating leverage for new owners with payers and employers. It is also driving increased costs in the industry. The Biden administration recently announced intentions to enforce anti-trust laws to avoid the cost escalation associated with monopolistic providers while Fee-for-Service still dominates.

How Does Physician Acquisition and Competition Affect ACOs?

Depending on your seat at the ACO table, consolidation can hurt your competitive position, unless you are the purchaser. Practice consolidation and ACO penetration are related, with consolidation fueling growth of market share through larger physician groups.

If yours is an independent, physician-led ACO, your pool of participating physicians is shrinking. You face the potential of being edged out of your local market by consolidated groups with more marketing, attractive benefits for physicians, and consumer-friendly options for patients. Equity-backed and venture-backed medical groups often develop their own ACOs to take on risk and/or to participate in Medicare Advantage.

If your hospital-based ACO seems secure in a broad primary care physician base, keep in mind two important realities. First, as value-based payment models take hold, it will affect the economics of your operations, making hospital expenses a greater liability and stagnating physician compensation. Second, once most independent groups are picked off, well-

capitalized networks have only one source for recruiting physicians—you.

Why Are Physicians Choosing Acquisition and Employment with Equity and Venture Capital-Backed Practices?

Physicians are not pawns in the acquisition process. They are voting with their feet, influenced by benefits that private equity and venture-capital funded organizations are offering. As relatively new acquirers that are more active than other categories, private equity and venture capital-backed practices provide an excellent perspective that has been attractive to established groups desiring to maintain clinical independence. Some health system and hospital-led ACOs have also provided these benefits, especially the first two:

- Financial stability and growth. Access to financial administration and payer contracts (including risk-based reimbursement) through venture capital-backed MSOs provides an avenue for revenue stabilization and growth. Practices which suffered financially during the pandemic may be particularly focused on gaining more access to new patients, supported by investments in telecommunications.
- Data, analytics, and technology. Most private companies have a strong technology orientation, coupled with a desire to share results data with physicians that has been less common in hospital-based practices and unavailable when practices are small and self-funded.
- Support. Investment in extenders, as well as support staff, frees physicians to perform clinical functions.
- Autonomy in clinical decision-making. Equity and venture

capital-based acquisitions are perceived to offer physicians more autonomy than hospital-based practices.

Three Broad Jump-Start Strategies for Your ACO to Keep Physicians

To stem the erosion of your physician base, your ACO will need to ensure physicians that you will provide security for fundamentals of their finances, administrative efficiencies, and data to weather the effects of value-based reimbursement. These three essential strategies will help them to move onto more solid ground:

1. Implement data technology for providing physicians with the feedback and resources they need.

There are two basic options: you can use a vendor to collect and process data from practices' existing clinical and transactional systems or purchase a common system for everyone to use. The former is faster and cheaper than adopting a common system, which is often a multi-year planning and implementation process. As your capacity for analytics grows, however, you may eventually want to consider a common system so that you can integrate changes faster between various technologies.

Collecting data is just one part of this strategy. Just on the data front, you will want analytics that dive into costs and outcomes, the ability to examine total cost of care and condition-specific costs and outcomes together through episodes, and population health technology that can implement both patient outreach and physician collaboration projects. To get a handle on your downstream specialty costs and evaluate

your referrals, you will also need treatment and procedure episodes that give you comparable cost and outcome data.

Your investments should also extend to other technologies—a common telehealth system, wearable device reporting (e.g. continuous glucose monitoring), and patient-reported outcomes.

Here's why time is not on your side: the competition already has these tools, which take time to implement. You should start now. Too many ACOs are currently dependent solely on claims data and have been caught short by trying to avoid the need (and by resistance from practices) to change their practice technologies.

Delay has already made it impossible to meet new ACO Performance Pathways (APP) reporting. Waiting will only cause you to fall further behind in helping physician practices cope with the growing demands of interoperability, transparency, data, and demands for better and more equitable health care.

2. Involve physicians in data and change.

Physicians universally report that cost data is not shared with them, and they don't know how to address costs with patients. That has to change. Physicians need to be fully aware of how episode costs are calculated and be involved in creating optimal clinical pathways for improvement. They, more than administrative staff, are aware of what their patients need to change their own risks, and these physicians must be more involved in crafting solutions for their patients. Administrators who process complaints from physicians about their workload too often misinterpret the message from physicians. They aren't asking to be removed from patient care,

they are asking for either the time to do what they need, or someone to catch the ball and carry through the whole intervention.

Your programs to help physicians are best if they are physician-directed and formulated, and implemented by trusted staff. To begin this process, involve physicians in comparative analytics of their own patients and all referred services through patient episodes that are clinically defined—only possible once the data supports both claims and providers' own data.

3. Advance toward value-based reimbursement with linked rewards for physicians.

If you and your practices are still rewarding only volume of services and have not yet established a mechanism to reward value, you can't fully realize the potential of your steps toward change. It doesn't matter whether your reimbursement is still on Fee-for-Service or not; you can still construct a pool of money to align with your cost goals. Unless physician compensation is financially aligned with your goals, it will be more difficult to get attention from practices and physicians.

To do this, you obviously need to create the necessary pool of money. If you have or purchase an MSO to manage ACO claims, you can take percentages of revenues out of claims before paying providers. Otherwise, you will need to require up-front annual investments from physicians, which is much harder and may not be sufficient. As your ACO proceeds down the basic tracks of ACO Pathways, you will need a risk structure, in any case, to accommodate the ACO when value-based reimbursement becomes the norm, to protect yourself from overruns. PHOs and IPAs have

performed this function for years, but some ACOs have not.

ACOs were conceptualized as the leaders of a movement to Value-Based Care. But they are losing ground as the movement pushes forward, and risk-takers and entrepreneurs see the possibilities.

The idea that providers themselves can still be on the forefront of controlling costs is a compelling vision. But to realize that vision, you need the tools for success. Our New ACO Playbook addresses various areas of strengths and weaknesses of ACOs for competitive models, but clinicians represent the focus of these strategies, because their actions determine patient outcomes and costs. Without physician volume and leadership, your ACO cannot survive. And your physicians need much more support to stay afloat.

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Image: Ricky Kharawala