Five Important Health Care Trends that Consumers Should Track

written by Theresa Hush | July 29, 2021

In the world of health care, change is never-ending. Politics,

government regulation, scientific advancement, technology, and the economics and financing of health care foster shifts to reshape how care is delivered and how much it costs. Many of these shifts are completely invisible to us as health care consumers. But they also drive what is happening to and around us, determining availability and affordability of physicians or other services.

This came home to me last month when we had friends over for dinner, and the conversation turned to our work. I mentioned Accountable Care Organizations and got blank stares. The Affordable Care Act of 2010—yes, the one that created Obamacare—also authorized new methods to save money. One of those methods is Accountable Care Organizations, or ACOs, which began in 2012. There are several in and around our city of Chicago. Over ten years later, many consumers are completely unaware of their existence, and most importantly, how ACOs may affect their own health care.

Does it really matter if you, as a health care consumer, are unaware of major trends and changes in the business of health care? I think it does. Otherwise, as these changes are implemented, you respond to new systems without understanding the implications or knowing how to influence your own situation.

It’s time for that to change. Understanding these five major health care movements will get you started:

1. Value-Based Health Care and ACOs are part of a broad movement to improve affordability and quality of health care.

The underlying concept of Value-Based Care is simple: The investment in payments for health care services should produce the best value. Value-Based Care promotes systems to measure quality of services delivered to patients, to reward health care providers (physicians and facilities) for better performance, and to provide incentives for eliminating unnecessary costs.

To understand the trends, get familiar with the terms of Value-Based Care through this previous article, which also will give you more information about the scope of initiatives. The most significant Value-Based Care model is called Accountable Care organizations, or "ACOs" comprising physician practices, either independent or associated with hospitals that work together to identify high quality care and achieve savings.

You may be in an ACO and not realize it, because you haven't changed physicians and are continuing previous care. But if your physician joined an ACO or the health system formed an ACO, that ACO automatically incorporates the patients attributed to its participating physicians. Your membership in a Medicare ACO is based on your past visits to an ACO-participating physician for the majority of your primary care, or if you have no primary physicians or specialists who are participating in the ACO.

Your ACO doesn't reduce your Medicare benefits or change your ability to get care elsewhere. But your ACO could influence

your decisions by their referral arrangements or through coordinating services. You can opt out of sharing your data with your ACO, but the only way you can leave it is to change physicians.

If you are in a private insurer ACO plan, your ACO may be aligned with a narrow network coverage under which you might pay more for a non-ACO physician or hospital. That differs by each health plan as well as your employer-based coverage.

As part of helping you navigate your care, your ACO may welcome you to the ACO, to coordinate care, to invite you to ACO programs or education, conduct surveys, or to follow up after admissions or emergency services.

Why should you care about Value-Based Care and ACOs? Because ACOs are actively working to influence how you navigate the system and to optimize your services. If you have frequent encounters with physicians or facilities, they will try to engage you in activities to reduce your health risks. If you are aware of the ACO, you can both benefit from ACO improvements as well as affect the ACO’s mission and its initiatives through consumer input.

2. Cost transparency is on the way, but consumers must currently insist on information.

Many consumers are frustrated by not understanding how much planned health care services will cost, or by trying to decipher price information you’ve been given by providers. Medicare has mandated that hospitals produce accurate pricing information to consumers, but this is new and still at an early stage. You can and should ask for price information before

proceeding with “elective” services, including diagnostics, prescription drugs, and therapies.

Health care pricing is extremely complex. What consumers need to know is that most prices are negotiated between the physician group and/or hospital and the individual health plan, or mandated by Medicare/Medicaid. The “charge” is rarely the same as the cost, unless you are paying for the services yourself. Now is the time to take advantage of the trend and ask for the information you need to make decisions.

Consumers should remember also that “coverage” and “cost” are not the same. The difference is huge. If a service is not covered by your insurance, or covered after a steep deductible, you will have to pay most of the cost. If a service is covered but there is still a big cost, you should still know what that is to determine the value of that service. Why? Because you are paying for it either through premiums or in after-insurance costs. Our advice is this: Ask both whether certain services are covered, as well as the total cost and the cost to yourself. And keep asking questions until you are convinced that you have the most complete information.

3. The Informed Patient movement is growing, and along with it the need for consumers to become educated and health-literate.

Health care payers and consumer advocates have long fought for transparency and information for consumers to make better decisions. The Informed Patient movement is similar to cost transparency, only it is focused on the clinical effectiveness or value of services for improving patient outcomes, including

longevity and quality of life. There are various initiatives in this movement to create more awareness of how to navigate better health care, ranging from the federal Agency for Healthcare Research and Quality (AHRQ), which releases various reviews of research on effectiveness of clinical therapies, to the non-profit Informed Patient Institute, and many individual payer and consumer initiatives, including Medicare.

While it's difficult to access evidence-based information on therapies presented in scientific terms or locked behind medical journal paywalls, you can ask physicians to provide information about the effectiveness of various approaches. You should expect to be able to compare the benefits and risks of doing nothing versus doing one or another therapy.

Consumers should also be aware that between 10 to 20 percent of health care services have been identified as "low value," meaning that there are few if any proven clinical benefits. There are many movements to eliminate payment for these services, but also to educate consumers. The American Board of Internal Medicine (ABIM) has done good spadework in educating consumers and physicians about these services through its Choosing Wisely program.

4. Patient health data is growing exponentially, creating benefits and risks to consumers.

The volume and integration of health data is rapidly expanding. Coming from clinical record and imaging systems, insurance claims, scheduling, operating systems, patient wearables and medical devices, and genetics data, health data is fueling

artificial intelligence (AI)-driven scientific knowledge advancement.

At the same time, this is the Wild West of data expansion and problem-solving. Patient-originated data is being deployed on a large scale to answer questions that are both clinical and social, but there remain many questions about the validity of the underlying data and their assumptions. Data is never flawless.

So, too, are there issues with data privacy, access to information that could be used, for example, to attach a cost to a consumer's personal decisions that affect health risks. Will your Apple Watch or Fitbit only be used to help you, or will the data connect to your employer and/or insurer? There are cases where the latter is happening now.

Consumers need to know where their health data is being captured, and how to access and control it. Technology is moving towards patient-owned and controlled data, but currently the "owners" of patient data are health care providers, insurers, and private business.

5. Recognition of health inequities is generating opportunities for change—with continued strong advocacy.

COVID-19 illuminated the disparities in health care for people of color, rural communities, and indigenous Americans. While the medical literature has abounded with data showing these disparities for many years, the pandemic highlighted the severe toll that these inequities create. Likewise, but less

emphasized at present, are health care issues faced by women, regardless of origin.

There are fledgling new initiatives with funding to close the gaps in access and coverage. The Medicare program has announced that it is seeking to better measure equity as part of Value-Based Care. But how does any of this matter to you, if you aren't in one of the groups that may be specifically helped?

Health care is financed on a sliding payment scale; people who have coverage pay more. People who can't get coverage or treatment aren't exactly "free" to the system. Instead, their costs may be tallied in a slightly different way. For example, they could end up much sicker and using more costly, higher end resources in the Intensive Care Unit. The cost of that "free" care is shifted onto insurance premiums for people with private insurance. There is no such thing as free—we are all paying for the inefficiencies of health care. So we all have a stake in making it more equitable and effective.

Strong advocacy will be essential to sustain initiatives that address health care disparities. As a social issue, it is a target for political disputes. In the past, there have been many studies of disparities that produced treatises and recommendations but lacked long-lasting solutions.

Being more informed about health care helps health care work better for consumers. It's complex, mostly because it has been hidden from consumers—and not by subterfuge. Patients are invisible because they purchase health care through a intermediary insurer, and that insurer has been calling the shots. But as a consumer, you don't need to be either invisible

or silent.

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Image: Thomas Bormans

The 2022 CMS PFS and QPP Proposed Rule: 7 Things to Know

written by Dave Halpert | July 29, 2021

After the 2020 election, we predicted seven trends to expect in Value-Based Care. Our forecasts were right on track. Last week the Biden Administration released its first Physician Fee Schedule and Quality Payment Program Proposed Rule, a 1,747-page document that promotes restructured value-based care initiatives. As we predicted, it recognizes both a significant health equity gap and a lack of useful data available to healthcare consumers as major challenges to overcome.

We're highlighting the seven biggest takeaways from the newly proposed Rule. Here's the short version: The bar is higher, with substantial MIPS scoring changes ahead, and providers and organizations will have to prepare for a massive update to quality measurement and reimbursement in 2023, while at the same time keeping afloat in 2022 as cost score increases kick in.

Here's what you need to know:

1. ACOs have an extension on Quality Reporting for Medicare-only patients, but just long enough to implement the transition.

Although CMS's decision to sunset its Web Interface for ACO Quality reporting this year was finalized in the 2021 Rule, CMS bowed to pressure and postponed the timeframe to do so. ACOs maintained that reporting for the totality of the patient population (rather than a sample of Medicare patients) was not feasible.

They argued that, even if all practices did have Certified EHR Technology (CEHRT)—they do not, and are not required to—adding the results across practices would not produce accurate results, as the measures are intended to look at unique patients, rather than encounters. We've reviewed ACO data challenges and quality reporting over the past several months, and addressed hypothetical and real concerns for ACO data aggregation efforts. While some ACOs will need time to work with practices and manage implementation, all ACOs cannot continue with insufficient data long-term. Whether regulated or demanded by competition, ACOs will need to aggregate data to survive.

CMS has proposed an extra year of transition for ACOs. In 2022, they will have the choice of reporting all-payer clinical quality measures (CQMs) or continuing to report a sample of Medicare patients through the CMS Web Interface. In 2023, ACOs will still have the option to use the Web Interface, but they will be required to report one all-payer measure. This is

significant, as even one all-payer measure requires the infrastructure to collect and aggregate data from disparate sources.

2. MVPs are delayed, but better defined.

CMS has filled in a lot of the blanks that surrounded MIPS Value Pathways (MVPs). While the concept was simple (a coordinated, rather than siloed quality effort), there was little definition beyond the five guiding principles. Nevertheless, there is more to be specified, and MVPs will be delayed until 2023. Upon rollout, CMS will start with seven possible MVPs:

- Rheumatology
- Stroke Care and Prevention
- Heart Disease
- Chronic Disease Management
- Emergency Medicine
- Lower Extremity Joint Repair
- Anesthesia

For each MVP, groups will need to choose a population health measure (e.g. Hospital-Wide, 30-day, All-Cause Unplanned Readmission Rate), report on a set of pre-determined quality measures (one of which needs to be an outcome measure), and complete Improvement Activities and Promoting Interoperability measures. CMS will score cost based on the MVP's pre-determined cost measures.

One of the biggest questions was how MVPs could be applied to a multispecialty group. CMS addresses that with the concept of "subgroup" reporting. This will start as an option, but will

become mandatory in 2025, and may lead to the sunsetting of "Traditional" (not part of a MIPS APM or MVP) MIPS after the 2027 performance year. Qualified Registries will be able to support MVPs.

With mandatory MVPs and MVP Subgroup reporting on the horizon, practices should begin preparing as early as possible in order to ascertain and address the inevitable operational and workflow challenges.

3. Traditional MIPS Quality reporting gets tough.

CMS has often stated their goal of getting providers out of "Traditional" MIPS and into MVPs or APMs, and this year's proposals will certainly drive some organizations that way. Proposed changes to Traditional MIPS—from the minimum performance threshold down to individual quality measure scoring—will make the program much more challenging.

By statute, the minimum performance threshold (the lowest score that can be achieved before penalties kick in) for the 2024 payment year (2022 performance year) must be either the mean or median of the final scores from the prior period. As MIPS performance has been historically high, this rule would lead to a jump from the prior thresholds. For the 2022 performance year, CMS has proposed using the mean from the 2017 performance year, which is interesting, given that this was the initial "transition" year of MIPS, but providers should breathe a sigh of relief, as this yields the lowest possible threshold. The mean for the 2017 performance year was 75, so providers and groups will need a score of at least 75 to avoid a penalty. The exceptional performance bonus will be 89, and 2022 will be the

last year before it expires.

Unfortunately for MIPS participants, not only is the performance threshold increasing, but earning high marks in Quality will be more challenging. Several proposed scoring changes will make it harder to earn high scores, even if an entity is consistently performing as well as they have in prior years, and even if they are reporting on the same measures.

First, CMS has proposed that, if a measure either does not have a benchmark or the minimum denominator (20 cases), the measure will not earn any points in 2022. In 2021, these measures were worth 3 points. This doesn’t sound like much, but along with this, CMS is proposing significant changes to 84 existing measures, meaning that they will no longer have benchmarks. In other words, just because providers earned 10 points for each of their measures in 2021, there is no guarantee that the same performance across the same measures could earn a single point in 2022.

CMS has also proposed removing the 3-point floor for measures that have been benchmarked. Previously, even though measures are graded in terms of performance deciles, they were scored between 3 and 10 points. In 2022 and beyond, CMS is proposing that these measures could begin earning from 1 to 10 points. Once again, it doesn’t sound like much, but with topped-out measures and measures with benchmarks in transition, small cuts add up.

The exception will be new measures, as they cannot be benchmarked. These will have a 5-point floor for the measure’s first two years in the program. If the measure can be

benchmarked after the first year, it will be worth between 5 and 10 points. If it cannot be benchmarked, it will be worth 5 for one more year.

Finally, and as if you didn't need another reason for concern, CMS is also getting rid of bonus points for end-to-end reporting and for reporting additional high-priority measures.

The payment adjustment range remains the same: a maximum penalty of 9 percent, with a sliding scale for incentive payments based on the size of the penalty pool (the program must remain budget-neutral). With the increased complexity and decrease in available point-earning measures, organizations will need a trusted and knowledgeable partner to avoid falling into a MIPS Quality Reporting trap.

4. Cost will be subject to increased focus.

By law, 2022 is the year that Quality and Cost must shoulder an equal portion of the total MIPS score. Therefore, in 2022, each will be weighted at 30 percent of the MIPS final score; so, just as much effort should be directed to Cost as to Quality.

In addition to the two global measures (the 12-month Total Per Capita Cost measure and the episode-based Medicare Spending Per Beneficiary measure), CMS is retaining its 18 existing specific episode measures, and adding five additional episodes:

- Melanoma Resection (procedural)
- Colon and Rectal Resection (procedural)
- Sepsis (acute condition)
- Diabetes (chronic condition)
- Asthma/COPD (chronic condition)

The chronic condition measures would be attributed according to a new methodology, beginning with two claims billed in a short timeframe by clinicians in the same group, where that condition is diagnosed. The first visit must be an evaluation and management (E/M) visit and the second must be either an E/M for primary care services or a procedure code related to the management of the specific condition. To get to the provider level, CMS looks at the volume of qualifying services billed by each clinician in the practice. CMS confirms that the clinician is still active and practicing by looking for recent E/M visits with condition-focused service and whether the clinician wrote condition-related prescriptions for multiple patients.

The challenge for 2022 performance is that, since CMS re-weighted the cost component in 2020, they will not be releasing detailed cost information with the 2020 feedback reports at the beginning of August. That means that practices will not have any meaningful information from CMS about their costs until the 2021 Cost scores are released in late summer 2022. In short, Cost will be more important in 2022 than any prior year, and physician groups will be flying blind unless they significantly invest in cost data analysis and episodes of care. In order to succeed in this setting, organizations will need to understand how they compare to others, identify pain points, and take steps to improve.

5. CMS will push for improved data exchange and patient-reported outcomes using Digital Quality Measures.

The 2022 Proposed Rule upholds CMS's desire to enhance quality measurement through the development and deployment of Digital

Quality Measures. This Proposal includes an RFI for transitioning to quality measurement using Fast Healthcare Interoperability Resources (FHIR) by 2025. What makes this interesting is that a Digital Quality Measure (dQM) is NOT the same as an Electronic Clinical Quality Measure (eCQM).

Given the emphasis on eCQMs in the legacy Meaningful Use program, the gradual abandonment of eCQMs may be surprising. However, this move is in keeping with CMS's stated objective of bringing more patient-reported outcomes and patient-generated health data (like wearables) into the quality measurement fold. For organizations who have gotten used to saying "my EHR takes care of the quality reporting," take note—that process is on its way out. The focus on data exchange will be through Application Programming Interfaces, or "APIs," meaning that patients, clinicians, and other entities can share data more easily, but while preserving privacy. The goal, using these APIs, is to collect data from a variety of sources, including patients, payers, providers, and registries, and to produce results.

6. The effects of the pandemic will be felt in program rules for years to come.

COVID-19 turned the health care delivery system (and everything else) on its head. With patients sheltering in place, the demand for telehealth exploded. As clinics continue to expand personal visits, the question of continued reimbursement for telehealth services has been left open. For the time being, CMS is allowing dozens of telehealth services to remain "in play" through the end of 2023. It is anticipated that many will no longer be covered at that point, but there is still

uncertainty, and this solution at least offers an opportunity for a smoother transition.

Of particular note is the focus on improved access for mental health services through telehealth. This proposal allows for reimbursement even if the visit is audio-only. Furthermore, several geographic restrictions for telehealth mental health services have been lifted, which should remove a serious barrier to care.

We also see updates to individual components within quality programs that come directly from the effects of the pandemic. For example, CMS proposes that the Promoting Interoperability component of MIPS requires immunization registry reporting and electronic case reporting (where groups report certain diagnoses in order to track outbreaks), and Improvement Activities and Quality measures related to COVID-19 immunizations.

7. CMS needs your help to define health equity strategies.

As we have described, a gap in health equity leads to a vast discrepancy in healthcare outcomes. We noted that hospitalizations and deaths related to COVID-19 highlighted this, but only represent a fraction of the problem.

The theme of health equity runs through the Proposed Rule. It can be seen in the desire to push ACOs to demonstrate quality care for all patients, and in the request for comment on ways to encourage providers who treat vulnerable populations to participate in Alternate Payment Models.

With these concerns in mind, CMS has issued a Request for Information (RFI) on how to close the health equity gap. The RFI is centered around stratification of quality measures by race and ethnicity, and the improvement of patient demographic data collection, with evidence showing that outcomes are worse for those who live near or below the poverty level, those who belong to a racial or ethnic minority, are part of the LGBTQ+ community, or who live in rural areas.

To comment on this RFI, or any other portion of the Proposed Rule, you can do so prior to September 13, 2021 at 5:00 p.m. Eastern time by visiting http://www.regulations.gov and following the "Submit a Comment" instructions, referring to file code CMS-1751-P.

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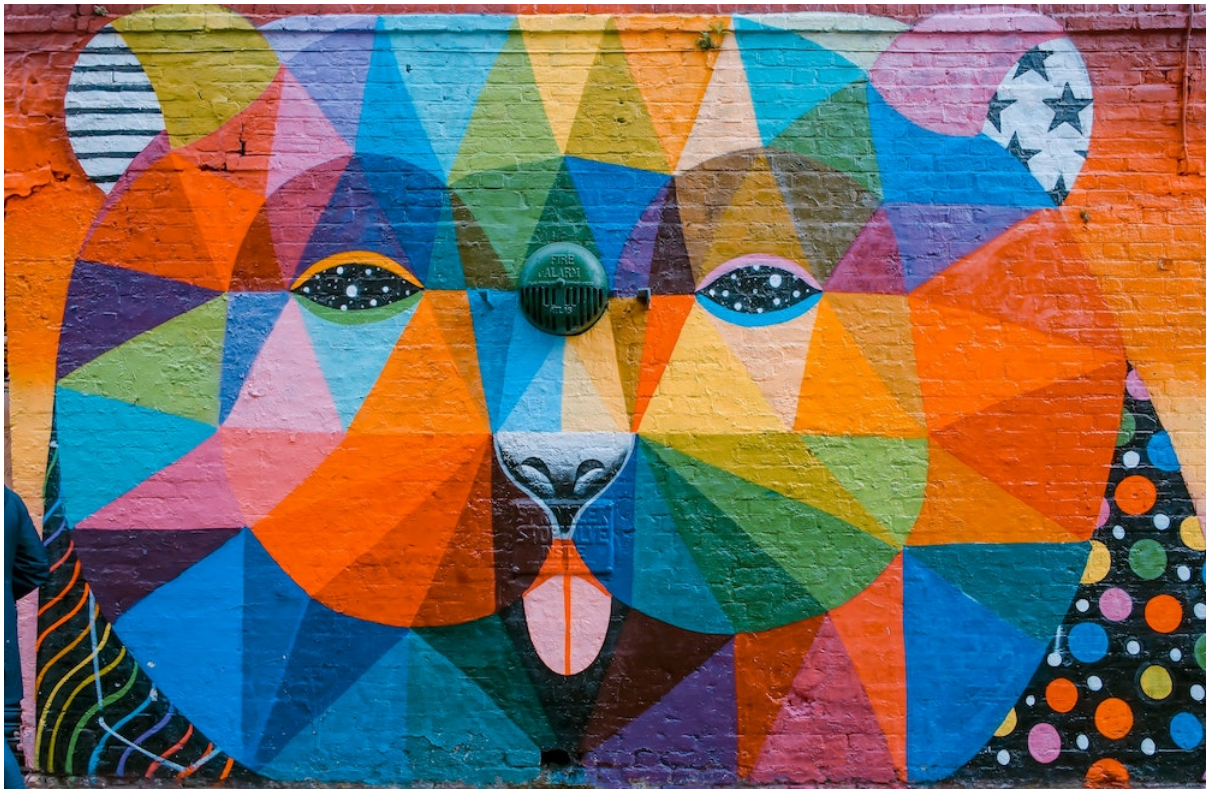
Image: Suzanne D. Williams

ACOs: Scale Up Data to Achieve APM Success

written by Theresa Hush | July 29, 2021



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More data is required for ACOs, now that Alternative Payment Models have moved to high gear. In this article we'll take the mystery out of how to realistically gauge your data needs and scale up data, so that your ACO can be successful. We'll show

you how to identify the links between what you want to accomplish as an ACO or medical group in value-based payment models and those data requirements, and help you target your data efforts. Data will drive your analytics, and analytics will fuel your interventions to produce better outcomes and cost performance.

Data Must Scale Up with Need to Manage Risk

When providers were focused on meeting patient volume targets, operations systems like billing and scheduling provided an adequate basis for tracking volume and revenues. But the shift to APMs demands accountability for outcomes, health equity and costs, which means that you need more relevant data. Your participation in payment models should not be opportunistic. Instead, it should be predicated on an understanding of the vulnerabilities and strengths of your patient populations and issues that could derail your budget. The right data gives you the insight you need to avoid cost overruns and plan your Value-Based Care (VBC) strategies.

It’s no secret, however, that ACOs, physician organizations, and small to moderate medical groups are often the most data poor. Less well understood is the fact that calculations defined in VBC demand different data and novel approaches to organizing that data for analysis. The following three approaches, used separately or progressively, will move you from data poor to sufficient and enable you to meet the competition.

Your Approach to Data Sufficiency Must Address Quality, Equity, Costs

The new CMS pathways for ACOs have raised the bar for ACO cost and quality activities. The increased Risk carried by ACOs under the ACO Pathways to Success means that a focus on costs must be laser-like. And the APM Performance Pathway, your gateway to qualifying for shared savings, requires a major change in quality reporting by expanding the denominator to all patients regardless of coverage. Although the program won't begin until performance year 2024, for some ACOs with low tech practices, it may take two years to implement.

Your simplest path to achieving initial data sufficiency *just to remain an ACO* is to aggregate the data needed to complete quality reporting tasks and implement interventions and improvements that generate savings. In short, this approach is task-oriented to keep you in compliance. But it will also help you grow, because these data are also valuable for participating in Risk with private health plans.

> Quality reporting. The new APM Performance Pathway requires ACOs to report a small number of quality measures on all patients, regardless of insurance coverage, beginning in 2024. This puts ACOs on the same footing as medical groups in quality performance measurement. But because some ACOs have many independent medical groups, new APP rules will dramatically increase ACO data needs for this segment, requiring data aggregation from provider systems. Practice data aggregation will be a must for quality reporting, to capture the full denominator of patients in measures.
> Cost tracking and high cost areas. Increasing levels of

provider risk raise a critical need to identify cost drivers. Examination of costs for all patients, specialty services, and practice variations requires all-patient data. The data that must be collected for APP reporting will be essential for filling in the missing details of claims data, but it requires much more manipulation to provide more than basic information on cost categories. However, starting with basics is possible through aggregating and organizing data to identify key cost territories.

What Data is Rich Enough

There is no getting out of covering the basic ACO requirements, but the basics won't be enough to sustain you against competitive medical groups or payment models that want to lure away your physicians and patients. If your goal is to secure your network of physicians, that goal must include data and infrastructure to support physicians to achieve their financial and clinical goals, and to keep their patients.

Aggregation of provider all-patient data and claims gives you a significant foundation for getting to the next step: identifying your highest potential improvements and Interventions. This is the time to use that data not just to meet external requirements, but also to achieve more for your providers and patients. Start with helping practices transform care for patients, reversing the trajectory of costs for progressive chronic disease, improving patient risks, and rationalizing specialty services.

All-patient data must be rich enough in clinical information to be effective. Practices cannot realistically apply interventions to one payer group; all-patient data permits a

broader strategy of improvements and interventions. But this data is a starting point to capturing additional data based on those interventions.

You should be able to pick out three care areas where your data highlights clinical and/or administrative initiatives that are core to your mission, have a substantial effect on your patient care spending, and where there is a payoff to you and your patients. Focusing on clearly defined clinical areas creates a foundation of interventions to fortify savings that are long-term, rather than one-time. It also builds an internal energy source that fires growth for your organization. Based on your own patient populations and clinician involvement, you could choose from among these strategies to facilitate programmed approaches to care that can be adopted broadly:

- Diabetes prevention in patients with a variety of progressive risk factors;
- Improving control in patients with poor control in diabetes and hypertension;
- Behavioral health collaboration with community providers to avoid emergency and admissions through better screening and referrals;
- Falls programs to improve balance, gait, and strength of vulnerable patients;
- Reduction of obesity with medication, nutrition, and coaching.

Many physicians and patients alike are frustrated by ineffective or repeated efforts to reduce patient risk. But those efforts have largely depended solely on patient visit interactions to effect changes in patient behavior, which is

unrealistic. Or, they have called in resources for care coordination, which, without real data, produce moderate results, at best.

Old approaches do little to ensure that physicians themselves have the sustained support necessary for targeting new pharmaceutical therapies, nutritional or behavioral health services, or motivating patients between appointments. Data analysis and sharing among clinicians, coupled with population health, can create more effective and consistent programs of outreach and patient participation in risk efforts. But to help physicians really deliver state-of-the-art care, it must make sense both clinically and organizationally.

Engage Providers and Patients in Growth with Data-Based Tools

Equipped with foundational data and initial interventions, growth is typically the next goal for ACOs and medical groups engaging in Risk. Getting there requires a bit more data and infrastructure for transforming care and for identifying and preventing specific areas of cost escalation. The latter include the use of low value services, poor patient selection for therapies, and patients with poor control or disease progression on continued ineffective therapies.

Illuminating patterns of patient behavior and clinical practices that are driving costs and outcomes requires two additional data developments. First, there must be a reorganization of data you have already collected from practices and claims into comparable units for analysis. Patient episodes of care, which can be condition- or procedure/treatment-based, eliminate unnecessary noise from the

data—visits for incidental care, for example. Episodes enable comparison of patients as well as practices, therapies and their outcomes, and costs.

Mature ACOs and medical groups will need episodes as a lens to clarify outcomes and costs. Let’s say you want to see how your patient population with diabetes is faring. The diabetes episode reveals patients with persistent poor control, their risk factors, other clinical and service events, and what pharmaceutical agents are currently being prescribed. You will see patients with circulatory problems and chronic kidney disease, and those with dramatic events like hypoglycemia admissions. By viewing patients in populations through this approach, you’ll find that the available clinical opportunities are remarkably clear, as are the inconsistencies in patient results.

Second, ACOs should seek additional sources of data and integrate them into existing databases, such as values from patient devices, patient-reported outcomes, and self-care surveys. Claims for filled prescriptions and patient activity levels through health apps could also be of value for certain interventions.

Transformative data approaches deploy technology and data to engage patients and physicians in an ongoing dialogue with results. Programs involving continuous glucose monitoring, for example, are having positive results because they provide continual feedback.

Episode data helps physicians see how the critical decision points of treatment turn into costs and outcomes across their

patients and help create future approaches for improvement. The data clearly reveal both extremes—unpreventable high-cost, complicated episodes where no actions would have changed the results, and episodes where intervention is possible and could have significantly reduced costs.

Data Sufficiency Is Iterative and Achievable

Some ACOs start out with the assumption—based on experience—that they can economize data and technology. In our competitive, increasingly venture-backed practice environment, this is a path to extinction.

The initial costs of data aggregation are high for low-financed ACOs, but they are more feasible if those costs are either spread across practices or supported by a growth strategy that helps physicians adopt common technology with shared cost. ACOs will need to build data aggregation strategies like any business dependent on data for fuel—because they can no longer afford not to have it.

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Image: Toa Heftiba

New ACO Playbook: How ACOs Can Transform Clinical Care for Diabetes

written by Theresa Hush | July 29, 2021

An illuminating article about ACOs, featuring current and former MedPAC chairs' perspectives, argues that savings have been constrained because too much is beyond ACOs' purview to manage. Examples include both external restrictions (the exclusion of prescription drugs and provider fee payments from ACO control) and internal cultural or economic barriers (conflicts of interest that make it difficult to reduce hospitalization revenues).

ACOs Are Caught Between Roles as Provider and Payer

The current ACO model is, indeed, challenging. Blending both provider and payer functions is fraught with conflict. But the provider-directed model was supposed to function closer to the actual delivery of care, and thereby be more capable of generating change. Instead, ACOs have deployed health plan strategies that were implemented decades ago, which failed to

stem rising costs: care coordination, management of referrals, restriction of unnecessary (post-acute) services. Why? For one, many ACOs are separate or subordinate partners to the clinical organization, making it harder to establish change. Or so you might think.

ACO groups are continuing to press Medicare for favorable protections to try and achieve slower savings over time. But if you are an ACO, you are better served by reassessing how to deal with the new competitive environment and how to involve clinicians in efforts to achieve better outcomes and lower costs. How realistic is the idea of a major drop in spending from ACO activities—or an overall improvement in patient health—if the clinical care delivered to patients remains the same?

The idea that an ACO can only perform administrative cost-cutting is weak. During the formation of ACOs, officials lauded provider prototypes like the Mayo Clinic, Kaiser Permanente, and Cleveland Clinic for their exemplary clinical leadership and clinical care. Those organizations are amassing data, artificial intelligence technology, and innovative ventures to tweak clinical processes and improve outcomes. Can your ACO do the same with clinical leadership, even if it takes time? The answer is yes, and here’s why that challenge is worthwhile.

ACO Competition Is Playing by a Different Set of Cost and Care Strategies

As we laid out in our introduction to the New ACO Playbook, ACOs now have a lot of competition. This includes large medical groups that are expanding their territories nationally or regionally, MSO- and equity-backed physician practices

organized to take advantage of value-based contracts, and regional academic or large multi-specialty networks with growth aspirations. These ambitious, consolidated providers with broader regional and national reach are raising expectations for equivalent value from ACOs.

Let’s examine strategies to determine how your ACO can adapt, grow, and realize your vision for your own providers and patients. Chronic illness, particularly metabolic diseases, provide the clearest examples to lay out the possibilities or tweaks needed for ACO models. To illustrate, we’ll take a closer look at clinical interventions for diabetes.

Can Creative Clinical Interventions Improve Lives and Reduce Costs of Diabetes?

The epidemic of diabetes in the U.S. continues to grow. An estimated 8.2 percent of the total population have been diagnosed with diabetes, and at least one-third of Americans are in the queue with pre-diabetes. About one-fifth of people with diabetes are unaware that they have it. The age of diagnosis is younger, and the disease is increasing significantly among children.

Of people with diabetes, 38.6 percent have chronic kidney disease. Diabetes is the leading cause of chronic kidneys disease and also associated with major cardiovascular and ischemic heart disease, stroke, amputations, and diabetic crisis events. Diabetes generates total direct and indirect costs of an estimated $327 billion (2017), which is increasing as health costs rise.

Changing outcomes among people with diabetes would have a

substantial impact. According to one study, lowering the main diabetes marker, Hemoglobin A1c (HgbA1c), by one percentage point or more, lowered total health care costs by an estimated $685 to $950 per year per patient in the improved cohort compared to others. Another study associated a 1 percent increase in A1C with a 7 percent increase in patients' health care costs over the next three years.

ACOs' Current Diabetes Efforts Favor Population Health Triggered by Costs and Events

ACO results in diabetes management vary greatly, with mixed and variable quality results. While one study shows failure to improve medication use and adherence, another shows improvement in the aggregate performance level of the key Hemoglobin A1C (HgbA1c), although this widely varies among ACOs and has no clear causes.

Perhaps your ACO has many clinical interventions aimed at diabetes. In general, however, ACO programs to affect diabetes control or prevention appear sparse, at best, especially given the significant costs associated with the metabolic disease. There are two good reasons:

> Dependence on HgbA1c as the primary diabetic datapoint provides information on glucose levels over the prior two-to-three months, but not the continuous glucose readings necessary for patient feedback, for managing diet and other lifestyle factors, or for ongoing monitoring to prevent adverse events like hypoglycemia. For the greater volume of patients with pre-diabetes, there is similarly no ability to prevent diabetes onset. One encouraging development, Continuous Glucose Monitoring (CGM), is non-invasive

wearable technology that could provide continuous glucose readings for both groups. Yet, insurance and Medicare coverage usually limits CGM coverage to patients already on insulin, and there is slow adoption by physicians, even when CGMs are covered by insurance.

Data is insufficient for clinical management by ACOs, because few ACOs are integrating provider clinical data with claims data, and even those who do, don't have the technology to create a comprehensive view of patient condition episodes, like diabetes. Even HgbA1c levels have only been available to some ACOs, because the previous method of quality measurement only used a small patient sample, so many ACOs are not universally collecting provider data. If you have that problem, you will be hard pressed to meet APP quality reporting requirements in 2022 without immediate action.

ACO Adoption of CGM and Other Wearables Could Be a Game-Changer

Making CGMs available for people with diabetes, as well as for some pre-diabetic patients who are at high risk, could significantly help to slow or halt disease progression, as well as reduce cost overruns. For ACOs, the opportunity to use cheaper, newly available technology to promote clinical integration could have far-reaching effects.

Even on a small scale, ACOs could partner with companies to offer devices to patients either prior to appointments or over a longer time span. CGMs would collect data and provide feedback on diet and lifestyle to patients. This information could be deployed to help implement diabetes education efforts

or nutritional interventions. CGM use could also substantially boost patient self-management through education. Currently less than 5 percent of patients receive their Diabetes Self-Management Education and Support benefits; the CGM would link the patient's own data to knowledge and then improvement.

Engagement in CGM data could also help to advance physician understanding and involvement in patient care improvements, raise awareness of the value of diabetes education for patients, and increase the rate of pre-diabetes screening. Physician involvement is essential, given current low rates of pre-diabetes screening and limited awareness of CDC-sponsored diabetes programs.

Finally, CGM and other wearable technology would enhance ACO efforts to capture clinical data for analysis and development of other interventions.

Use of Continuous Glucose Monitoring and other wearable technologies (soon to include blood pressure) is but one example of how you can simultaneously support clinical interventions to reduce costs, while improving patient outcomes and engagement, along with physician engagement. While financing CGMs could be challenging in the short term, there may be ways to mitigate this through planning, rotating the reusable devices, or seeking partnerships with vendors for benefit of research.

Your ACO has the power today to involve your constituents in real innovation—the best way to meet your goals as well as the competition.

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: Ashley Winkler

The Real Registry Advantage for ACOs Reporting Via APP: 5 Myths Debunked

written by Dave Halpert | July 29, 2021

The clock is winding down on the CMS Web Interface, and the reality of mandatory quality reporting via the Alternate Payment Model Performance Pathway (APP) for ACOs in 2022 is setting in. In order for ACOs to develop and execute their APP quality reporting plan in time to avoid catastrophe, it's imperative to begin evaluating options now.

ACOs, however, have staged a push-back to the APP based on a number of assumptions about their impact on ACO economics, success in reporting, and elements of reporting. A lot of these are simply untrue, based on faulty assumptions about reporting through the APP. For many ACOs without a single EHR (and even some that do), there are misconceptions about registry reporting. These include cost, ease of reporting, accuracy, data currency, and reporting differences.

It’s time to debunk the myths and lay out the reality of reporting via the APP, as well as differentiate between registry and EHR reporting.

Myth #1: Reporting under APP Is Prohibitively Expensive for ACOs

Many ACOs believe that reporting under APP would be extraordinarily expensive because of required data gathering, as well as the level of effort to achieve performance.

The Reality: Not true. An advanced registry can deploy different data collection methodologies by practice or data source in a manner that is both comprehensive and economical.

The word “interface” hits resource-strapped ACOs and practice IT departments like a shockwave, sparking fears that department budgets will take a massive hit from vendors’ support and development teams, while timelines on existing projects will be set back.

But that assumption is based on data aggregation practices that many advanced registries don’t use. While there are certain minimum data sets required to successfully report quality measures, there are also many ways to package that information and securely transmit it from Point A to Point B. If the required data elements are already included in an existing output file, an advanced registry need only establish the secure connection with you, taking the effort out of creating a new file. If a required data element (or elements) are missing, an advanced registry will help you to determine what is missing and the most cost-effective method to compile and send it (a “flat” file, an established standard like FHIR, or a

combination of several data types).

This flexible approach also mitigates burdens associated with measuring and improving performance. Following training and validation, timely uploads of data files combined with rapid processing ability make it easy to track ongoing performance. If there are gaps, an advanced registry can work with you to determine whether these are gaps in data or gaps in care. If the former, an advanced registry will work with you to determine where the data in your system(s) resides and to establish a process for integrating it. If the latter, that advanced registry can develop strategies with you to improve and to measure the ongoing effects of your efforts.

Myth #2: ACOs Can Report Quality More Successfully Through EHRs

The Reality: Not true. You will actually do worse reporting eCQMs through your EHR(s) than MIPS CQM through a registry. Why? Because this myth has two flaws: it assumes that EHR data is always complete, and that reporting is a solely technical process. Let’s address these two separately.

The “complete data” fallacy can be seen both globally and locally.

Just because your ACO is able to report on at least 70 percent of an eligible measure denominator, CMS expects 100 percent of that denominator in your file submission. In other words, even if you report on 100 percent of what is likely 90 percent of your population, you may have mathematically covered the 70 percent data completion threshold, but you have not actually fulfilled the CMS reporting requirements.

Furthermore, Quality Data Reporting Architecture (QRDA) files may be sufficient for individual systems and practice Tax Identification Numbers, but adding scores together, even if each practice has been able to do so, yields inaccurate and unacceptable results. APP measures are designed to be reported at the ACO level and are to be reported once per year per patient (See Myth #4). If a patient sees multiple practices, adding files together from each practice duplicates numerators and denominators, and invalidates measure calculations.

In addition, customized EHR templates and interfaces create data gaps in pre-programmed eCQM templates. In the real-world EHR balancing act, if care isn't documented, it didn't happen; but if it can't be documented easily, it won't be documented at all. To deal with providers' EHR documentation fatigue, many organizations have created different workflows for providers, varying by factors including clinic location, patient population, provider specialty, and dozens of others. Further complicating an automated data collection and export process are all the variations in how users are trained on these templates, and how they're actually used by each individual. Simply put, data reported from the "predicted" data pool may not be complete.

This brings us to the notion that reporting is just a technical process. Unlike EHRs, where quality reporting is a technical add-on to their basic value, the main business of advanced registries is measuring and reporting Value-Based Care. For example, when reporting on an outcome measure like MIPS CQM 001 (Diabetes: Hemoglobin A1c Poor Control) or MIPS CQM 236 (Controlling High Blood Pressure), a missing result in an eCQM is a performance failure. With an advanced registry, however,

it’s the starting point to understanding where the data resides and finding the values in your data to increase your performance, by giving you an ongoing view of measure completion and performance that highlights these missing elements, and helping you to identify next steps. Ideally, you’ll move to the point where eCQM reporting is less of a risk. An advanced registry that is ONC-certified to report on eCQMs can pivot with you.

Myth #3: Registries Only Require a Sample of Patients

Some ACOs confuse the data completion threshold with permission to use only a sample of patient data.

The Reality: Not true. The “data completion threshold” is 70 percent of the eligible denominator, but in registry reporting, CMS *prohibits* sampling and/or “cherry picking” of patients in a practice.

In the APP, quality reporting via the MIPS CQM method means that CMS will score the measure in the same manner it does for MIPS. Briefly stated, the measure denominator is defined according to which patients met the denominator criteria in the measure specification. These criteria are specific to the measure, and may include age, gender, a certain diagnosis and/or procedure code, etc. Once the denominator is established, all applicable responses are assigned to the numerator.

For example, a patient between 18 and 75 was seen in the office and received a diagnosis of diabetes, putting that patient into the denominator. The patient’s most recent A1c value is the

numerator and is designated as either “performance met” or “performance not met.”

CMS refers to the total numerator divided by the denominator as the “Data Completion Rate,” and mandates that at least 70 percent of eligible patients are reported in order to assign a performance score to the measure (measures with less than 70 percent data completion earn zero points). Performance is calculated by looking at the number of “performance met” responses divided by the total number of responses (after subtracting the number of denominator exceptions, if applicable).

Some (less scrupulous) registries once advertised that they would improve their clients’ performance scores by excluding the “performance not met” measure responses for MIPS scoring, artificially inflating performance. Not surprisingly, CMS established rules to eradicate using a “cherry picking” methodology to report. But most advanced registries are looking for more accountability in quality and cost, so that they can help their ACO clients achieve higher goals.

Myth #4: Registry Reporting for MIPS CQMs Will Show Outdated Results

Because registries must collect data from EHRs, ACOs often assume that this takes time and creates delays in information available to ACOs and their practices.

The Reality: Not true. Most advanced registries collect on a frequent schedule, even daily, to provide timely and actionable feedback to practices or ACOs.

The purpose of a registry is to help its clients measure and improve patient health outcomes over time; apply insights, support and technology to effect change; and to measure the results. Measuring outcomes over time, costs associated with episodes and conditions, and even measure results are long-term endeavors, and a real-time data interface, while feasible, is not the best use of a registry's clients' resources.

In contrast, the purpose of an EHR is to ensure that providers have all of the necessary clinical information to make informed and educated decisions with patients regarding treatment (and to ensure proper reimbursement). Quality reporting is an add-on. Real-time data for reporting looks great on paper but adds little benefit to successfully reporting on the three APP quality measures.

That does NOT mean that quality reporting through a registry will preclude you from proactive efforts throughout the year. Our clients send data in intervals from monthly to daily, depending on their own needs and resources, and results are updated as data is received. What's more, as issues are encountered, a registry can help you dig into the reason for the issue, and work with you to resolve it.

Myth #5: Reporting APP Through Registries Limits Measure Quality Results

Some ACOs believe that registries only use claims or direct entry to populate measures.

The Reality: Not true. This myth assumes that registries do not collect provider data. In fact, advanced registries have collected provider data for years, capturing discrete clinical

data from EHRs and incorporating all relevant patient services data. At Roji, for example, we have been collecting clinical, demographic, and billing data from provider systems since 2003.

Registries also integrate data from disparate EHRs and other data repositories, providing more accurate measurement to fuel reporting and ACO population health. Advanced registries with sophisticated technology and experience can track a single patient across the continuum of care, even when there is not a shared Medical Record Number between systems (and most times, there is not!). From a quality measure perspective, this means that an ACO can correctly define a measure's denominator and apply the appropriate measure numerator, even when those two elements do not come from the same system. This makes it easier to meet quality completion and performance.

For example, if a patient with diabetes is seen by a podiatrist in the office, that patient will fall into the denominator for MIPS CQM 001 (Diabetes: Hemoglobin A1c Poor Control). Because the patient also saw the ACO's attributed primary care provider (PCP) and had a recent Hemoglobin A1c test performed (along recorded result), the registry also captured that data. The registry will identify that (a) the patient is eligible for the measure one time, rather than two, and (b) use the actual clinical value (e.g. 6.5 percent) to fulfill the measure in accordance with the CMS measure specification. The enhanced data will help improve ACO coordination of care services and ensure more accurate quality performance.

In summary, each ACO will be faced with unique challenges as CMS transitions from its Web Interface to APP reporting. In the short-term, the most important thing that you can do is to plan

ahead for the APP in its inaugural year. To ensure that your efforts empower your ACO in ways beyond simple reporting, develop a longer-term strategy that determines how you'll use this additional data. Measure responses need not be swept into an administrative process for meeting requirements, but rather, used as key performance indicators for disease progression and condition management.

Finding a partner who will work with you on a flexible and adaptable strategy will set you on the right path and put you in the best position to improve in future years.

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: Vlad Zaytsev

New ACO Playbook: To Show Standout Performance, ACOs Must Rethink Quality

written by Theresa Hush | July 29, 2021

The health care media are full of articles asserting that ACOs have proven their mettle in delivering health care of highest quality. Citing ACO quality reporting results, CMS and advocates point to the majority of ACOs passing CMS quality standards, and that ACOs are improving their results on quality measures over time. The vast majority of ACOs meet quality measures, with 92 percent passing the qualification for shared savings in 2019.

But is quality performance a distinguishing feature that ACOs can use competitively—and sustain the payment model's long-term prospects? To earn permanency and competitive advantage, ACOs must show that the payment model galvanizes participating providers to perform better than non-ACO groups—specifically, direct contracting entities, Primary Care First groups, and equity-backed practice organizations. While difficult to measure, however, there is some evidence that there is little

distinction in quality between regular physician groups and ACOs. We have also questioned whether savings levels have sufficiently advantaged ACOs to be able to argue for continuation of the payment model.

Without a distinction for better outcomes, ACOs miss an excellent opportunity to guarantee survival. With a good public relations strategy of indisputable quality metrics, ACOs could rally patients and physicians alike to their cause. Unfortunately, ACO quality performance, while meeting the standard set for the program, doesn't actually help ACOs stand out as the path to highest quality health care. Why? Both *what* is measured and *for whom* does not go far enough to achieve that goal.

Let's examine current quality performance systems and how ACOs could redesign their own efforts to improve their positioning—while delivering improved results for patients.

How ACO Quality Works, and Where It's Headed

Requirements for ACO quality have changed over time, but have always included patient surveys, CMS-calculated measures, and ACO-reported patient quality measure results. The ACO quality framework was once distinct from other CMS quality programs, but this is changing. The late 2020 introduction of the APM Performance Pathway (APP) applicable to MIPS ACOs (ACOs in the beginning stages of downside Risk adoption, with practitioners subject to MIPS) puts ACO Quality more in line with MIPS, beginning in Performance Year 2021.

The APP has a single score, like MIPS, and includes the same four components: Quality, Promoting Interoperability,

Improvement Activities, and Cost. These components can be reported and/or calculated differently for ACOs. As in the past, the Quality component involves surveys of patient health care experience processes performed by a certified CAPHS vendor, CMS-calculated quality measures based on beneficiary claims, and ACO-reported quality measure results.

But the APP is different for one major reason: the quality measurement includes *all* patients in ACO participating practices, not just Medicare or attributed patients. Until the 2021 Performance Year, ACOs used the CMS Web Interface to report quality for a small sample of 248 ACO patients that were loaded by CMS into each ACO's Web Interface app. The ACO staff then worked with ACO participating practices to gather the measure results for those patients. This sample and pre-populating with claims data made it easier to meet quality requirements.

The quality reporting burden on ACOs was reduced by the APP in number of measures, from a high in 2013 of 22 ACO-reported measures, to the 2021 levels of 3 using the new APP reporting method. But it vastly increased the volume of patients for whom quality must be reported under the three measures.

After pressure from ACOs, CMS then allowed continuation of the Web Interface reporting method as an option for 2021 only, with reporting of the 10 previous measures. The National Association of ACOs (NAACOS), joined by other medical associations and lobbying groups, is continuing to object to the APP rule for 2022, however. If successful, this will hurt the ACOs in the long run. Here's why:

ACO Quality Measurement Harms ACOs by Curtailing Data to Improve Care.

ACOs may feel validated by the good press on ACO quality. But even—and, perhaps, especially—if they succeed in sustaining the prior method of ACO-reported measures through a sample of patients, they will soon find themselves unable to demonstrate their Value compared to medical group models that have pursued a different payment model, or to Medicare Advantage. They simply won't have the data to do it.

The need to have data collection from all practices is the very essence of what ACO advocates are fighting in their quest to change the APP method of reporting. They perceive it as expensive and burdensome to do. And they have acknowledged that they do not collect that data now.

Yet, collecting outcome and transaction data for the practice population is essential to improving patient outcomes and important for Risk payment model success. It allows the ACO to create metrics of quality and outcomes beyond APP measures, which are at best simplistic measures of an ACO practitioner's quality profile. Take this hypothetical scenario, using one of the three APP measures:

> Would you be satisfied to know that your physician met quality requirements for diabetes care based on one HgbA1C value every year? And that your physician group passed quality if more patients had values under control?

One might consider a HgbA1c value to be a minimum bar for assessing the status of diabetic patients. We might also attribute collective lower ranges of levels to indicate quality

success. Without more data, however, we actually don’t know anything about the quality of care. Does the measure result reflect a lower risk practice, or a more successful practice? And if the measure results in practices with higher values, does that reflect a problem in quality, or a higher-risk patient load? Static quality snapshots tell us little about quality performance, and they can’t help to determine a plan to improve outcomes.

The common flaw of CMS measures under both MIPS and ACOs is that they have failed to evolve into outcomes based on better data. But that data is available, and for ACOs it should be put to use in advancing better care.

ACO Quality Measurement That Is Out of Sync Across CMS Programs Puts Physicians at a Disadvantage

Remember the days of pre-pandemic travel, when flight attendants recognized their airline competitors and thanked passengers for choosing them? ACOs would be wise to understand that they are in competition for their physicians, unless those physicians are under salary. Those physician groups are often in competition for patients, and patients are increasingly guided by data. Many physician groups are participating in Risk agreements that require them to improve outcomes to reduce costs.

If the MIPS-reporting physician groups can report quality metrics based on all their patients, yet ACOs do not, over time this will prove a competitive disadvantage. The different payment models and changes in medical group ownership guarantee

it.

Separate reporting rules make comparisons between non-ACOs and ACO results even more difficult and cumbersome. They also negate the ability for ACOs to compare themselves with competitors like Medicare Advantage Plans.

Three Ways That ACOs Should Rethink Quality

To make a name in quality, think of how Cleveland Clinic is "doing" heart. They collect all their patient encounter and clinical data and organize specific clinical episodes. Then they evaluate the episodes to identify clinical or administrative triggers that cause outcomes or costs to go the wrong way. They tailor interventions in their processes, and continue to evaluate data in a feedback loop to improvement. And then they develop a content marketing strategy and broadcast their quality—not in Cleveland and in its suburbs, but in other markets like Chicago.

This is what competition looks like, and it is the future. How do ACOs need to rethink their quality programs to meet those challenges? Try some of these basic strategies:

1. Create a vision for quality that is separate from regulatory quality reporting.

Regardless of regulatory requirements, ACOs must chart a path that focuses on where they can excel and how to attract physicians and patients. For ACOs based in primary care, that focus may be on prediabetes and metabolic diseases and their complications. For multi-specialty ACOs, it may also involve other areas of clinical excellence like orthopedics or

neurology, high volume services that attract patients. ACOs that develop a quality agenda beyond measure-based reporting can involve physicians in envisioning better outcomes and be aspirational. Aspiration creates leadership, which, in turn, energizes the ACO to make that vision reality. Anyone who has started a business will tell you that aspiration and energy are keys to growth.

2. Get the data for quality measurement and do much more with it.

Patient data should never be single purpose. Look at your patients not by condition, but by 50 different metrics on how they found you and what they are getting from you (or elsewhere), and what services they received, before they disappeared. Also examine outcomes by individual conditions, by episodes that package all services, by cohorts that examine core conditions with disease progressions, by conditions with various treatment regimens. See which providers are treating patients and look at patients whose treatment regimens aren’t improving their outcomes. In these data are the revelations that will define many paths to improvement that will both improve patient outcomes and save money.

3. Involve your physician in data.

Don’t start with scoring; it will inevitably spark push back. But give physicians insight into the ACO patients and ACO costs, and how they figure into it. Start small with patient cases, but share feedback on how they compare, and how their costs and outcomes compare with similar specialists. Find mechanisms that are effective for physician discussion and participation, as a learning process. Ask for their

contributions to improvements.

If ACOs intend to be known as leaders for quality and efficiency in health care, they have to do more than achieve regulatory compliance. They need to break through the competition. ACOs can demonstrate improved outcomes and better quality services because they can organize and inspire their providers to make it so, while payers cannot. Now is the time to start using their best hand, rather than playing “safe.”

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Image: Uriel Soberanes

New ACO Playbook: Three Touchstones for ACO Viability

written by Theresa Hush | July 29, 2021

Some believe that an ACO's leadership structure predicts its success. They point to differing savings results for physician-led versus hospital-led ACO shared savings models (MSSPs) to

make their case. In particular, they make the argument that future Value-Based Care (VBC) policies should benefit the growth of successful physician-led ACOs, protecting them from policies that force them into Risk.

There are significant flaws to tying ACO structure to the viability or value of the model, however, or in discrediting ACOs which don't yet produce those savings but may have other important characteristics for the long term. In a more competitive health care environment, the value of ACOs is not only the amount of savings generated, but the model's ability to grow and expand Value-Based Care. That ability is not just a function of structure, but also of the ACO's assets. In most hospital-led ACOs, Fee-for-Service incentives certainly continue to reward volume, and hospitals will promote internal referrals to specialty and ancillary services; but these referrals may also result in better coordination of care, clinical decision-making, and more choices for patients. The methodology to determine ACO savings captures none of these nuances.

If we tie ACO structure to viability of the Medicare ACO program itself, we must ask this question: Are smaller, lower revenue, physician-led ACOs capable of leveraging sustained support for ACOs as a Value-Based Care model? This is unlikely. Physician-led ACOs have left the program in greater numbers because of discomfort with increasing levels of Risk. But a more important takeaway is that physician practices themselves are choosing other VBC models—against Medicare ACO participation and for other programs.

To generalize from successes by ACO structure is misleading and

distracting. There are hospital-led ACOs with significant physician leadership, ACOs with blends of hospital and physician ownership, and the pure physician-led ACO consisting of one small group or a federated group of primary care practices. ACO models exist along a spectrum that includes both the owner/leaders of the organization and leverage through market penetration.

ACOs Are Losing Status as the Most Prominent Provider-Led VBC Model

ACOs no longer stand alone as the most prominent Value-Based Care model for providers. In its first year of operation, Primary Care First (PCF) attracted 827 participating practices, compared to a current volume of 477 Medicare ACOs. Dropping numbers of ACOs and competitive health care participation models should signal a reassessment of the criteria by which we—and providers—are assessing ACO viability.

Value-Based Care has moved forward in both private and governmental insurance markets. As the private market developed its own ACO-like agreements with providers, it opened opportunities for providers to build strategies for growth and community connections in concert with Value-Based Care. The pandemic launched additional expectations of needed changes in health care and highlighted health care equity as a priority. Investment opportunities prompted expansion of investment-backed physician organizations that are eager to participate in Risk.

To Be Viable, ACOs Must Achieve Business Success

Achieving formula-based savings targets won't guarantee success for future VBC models. The Medicare ACO shared savings plans were generated by law and regulation to stimulate provider activities to improve health care. The market matured. Now we must examine the viability criteria for ACOs under a changed and newly competitive environment. Even if the ACO models continue, they must be able to retain both participating physicians and patients.

In 2019, McKinsey & Company outlined seven characteristics of successful alternative payment models. Focused on policymakers as well as ACOs, it's worth a review. But being "successful" first requires a viable, cohesive plan for staying in business amidst competition. ACOs that meet these three essential criteria will compete more successfully in Value-Based Care:

1. Growth Orientation

A small ACO can produce high savings from historical spending, and this will sustain the model for a while. But it is not compelling enough. Organizations that are on a path to growth as well as savings will have greater impact. The growth must include both higher volume of business for providers within the ACO, by contracting with commercial payers, Medicare, and Medicaid, as well as higher growth of new patients. A larger patient base provides the potential for greater engagement and collaboration among physicians, depth of clinical services, and more efficient clinical pathways.

Growth protects the ACO in a risk environment, especially if

the ACO can draw younger and healthier patients into services. Expansion makes the ACO not only more important to participating physicians, but also gives it leverage with specialties and facilities, and creates the basis for more ACO investment.

Some ACOs are limited geographically or by participation, and cannot grow. These organizations are, indeed, more vulnerable under financial risk and susceptible to patient leakage.

From a Medicare VBC perspective, programmatic growth is essential to vibrancy and savings success of the ACO initiative. Otherwise, even five percent or more in savings for a small number of ACOs is not worth the cost of the initiative, and the program will begin to deteriorate or be replaced.

2. Data and Technology

Some ACOs lack the resources and infrastructure to go beyond the basics of coordinating care. Data and technology are required to understand what is driving costs and how to create interventions at the physician and patient level.

Current efforts to delay changes in Medicare ACO quality reporting only serve to hamper the tools that ACOs have to compete, to establish clinically-driven programs to improve outcomes and reduce costs, and to involve physicians in their results.

Every viable business measures its success through analytics, no matter how small. The more at stake, the more data is required. EMRs have come a long way, and larger ACOs with one EMR have an advantage in data analytics. But the core EMR

purpose is point-of-care improvements; thus the ACO may require additional technology arrangements to help with cost analysis and condition-based bundles, specialty payments, and revealing cost variation by procedures and conditions.

3. Consumer- and Patient-focused Strategies that Can Fortify ACO Leadership and Change Efforts

These include:

- Building community connections and capacity for services not provided within the ACO, such as behavioral health services;
- Adoption of remote clinical monitoring like devices and patches to improve understanding of patient status;
- Efforts to improve collection of patient social and economic risk data;
- Promotion of cost transparency by ACO providers;
- Support to practices for informed decision-making initiatives.

ACOs have often been perceived as entities that can operate in the back office on behalf of their participants. Those administrative functions are essential. But as new payment models and programs emerge from payers and providers, we need more energy and value from ACOs. That’s the formula for viability as well as success.

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Image: Markus Spiske

New ACO Playbook: Can Coordination of Care Save Enough Money to Save ACOs?

written by Theresa Hush | July 29, 2021

Central to the controversy about ACOs' potential for Value-Based Care is whether they actually save enough money and reduce costs fast enough. Researchers and advocates have produced various independent studies of ACO savings, the most generous estimating $1.8 billion in cumulative savings over the first three years of the program, almost double CMS estimates. Many others, however, dismiss the small proportion of savings—at a few percentage points—relative to total Medicare spending.

The previous CMS administration was clearly dubious about the shared savings model. It favored payment models that put providers at financial risk to increase cost reduction incentives, even though that resulted in declining ACO numbers. ACOs are now on a "glide path" that leads to increasing levels of risk over time, changing the "win-win" approach that was the hallmark of initial ACO development. CMS also introduced

payment models like Primary Care First (PCF) and Direct Contracting (DC) to fix payment levels for Medicare through capitation, which competed with ACOs for patients and providers.

Provider Actions to Control Costs Are at Center of Dispute

For policymakers, coordination of care has been a hallmark concept associated with ACO benefits. Here's how the current CMS Innovation Center website expresses the values of the original ACO concept: providers voluntarily come together "to give coordinated high quality care . . . [that] helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors." Well-coordinated, high-quality care produces savings, according to CMS.

But can ACOs can really control traffic between every chronically ill patient and the ACO health network, helping them to get appropriate care and improving clinical decision-making in the process? There are a number of reasons why many ACOs find this problematic:

- The ACO is often separate from the chain of command in practices and health systems, thus not always in a position to command resources, staffing, and even cooperation from practices;
- Financial incentives still favor volume over efficiency in patient care;
- ACOs with independent practice participation don't usually have interoperabile systems between those practices, and

many also don’t collect timely provider data, making it difficult to identify patients’ current status or services; Technology investment has been historically very low among ACOs, leading to lack of information to coordinate care for many patients.

Current ACO Coordination of Care Efforts Are Basic and Inconsistent

Most ACOs would agree that they have not yet achieved the future in well-connected care. According to one study, the first years after ACO formation are consumed by primary care transformation, implementation of care management, and reduction of emergency room use. Few ACOs address specialty services costs and specialty network development, clinical standards of care, and acute care during that time.

As to high risk or high cost patients, where we might expect ACOs to have been able to make real progress, one recent evaluation of ACOs’ programs for seriously ill patients reveals that while most can identify seriously ill patients, only 8-21 percent of ACOs had major initiatives to affect their care. Notably, the small number of ACOs that successfully carried out these initiatives did achieve substantial reductions in per-beneficiary costs, emergency department use, hospital admissions, and other indicators.

Many ACOs have developed successful coordination of care efforts that are specifically targeted to patient populations and health care problems. Most ACOs perform some patient outreach and population health activity to reach out to patients. But to characterize these coordination of care activities as “well-connected care” per CMS is an overreach,

especially for ACOs that are strapped for resources and lack data.

The status of care coordination raises questions about how ACOs can meet goals and be successful Value-Based Care models, and how to prioritize their strategies:

> How can ACOs speed up the process of enabling more connected, informed health care among their providers and patients, or “advanced” coordination of care?
> What tools are necessary for ACOs to generate effective coordination of care activities?

Three Strategies for Faster, More Significant Coordination of Care Activities

Savings is the metric that policymakers associate with ACO success. The political process is rarely sensitive to the need for time to effect cultural change, or the difficulty of overcoming obstacles; rather, the pressure is always on finding the next thing that might work. In that environment, the rise of competitive payment models suggests that ACOs may have a shorter time frame to gain ground.

Here are three very targeted but comprehensive strategies to make coordination of care more effective:

1. Organize data to identify the most significant and high cost patient risks, especially chronic metabolic and systemic disorders, and behavioral health.

Coordination of care should include clinical planning and

organization of care, not just administrative patient outreach. Creating episodes of care for patients with diabetes, heart disease, and related metabolic disorders is the starting point for analyzing associated risk factors and outcomes, and then creating smaller patient cohorts for specific interventions.

Patients with diabetes or other conditions comprise too large a group to be considered for interventions; the variable needs between patients is too big, and patients have outcomes across the spectrum. To effectively target patients for coordination, start with outcomes and disease progressions, because these are the strongest indicators of present and future costs. It is also essential to evaluate various points of patient crises in connection with these episodes, such as emergencies or admissions, and create further subsets of patients needing treatment review, community services, and changes in care teams.

What tools are necessary to perform these tasks? Claims data is essential, of course, to identify historical patient issues. But provider data is richer in clinical information and can provide more current data about outcomes and most recent patient crises. Integration of these two data sources is essential for true coordination of care. Creation of episodes is beyond the capability of most ACOs and even health systems; use of outside analytics and technology companies will be required.

2. Build specialty arrangements to allow data sharing and collaboration on care plans between primaries and specialists.

Sharing of episode data is essential for bonding primary care and specialty physicians in coordinated and patient-focused care in cases involving multiple outcomes and complex treatments. ACOs building specialty referral arrangements in urban markets may have an advantage because of the competition for these patients among specialty groups. But even in rural environments, specialists would appreciate and gain from data sharing.

As financial payment models progress, ACOs should look for opportunities to negotiate mutually beneficial arrangements with specialty groups that will benefit both parties and the patient.

Where specialists are difficult to find—like behavioral health, for example—using episodes to analyze patient success will clarify the areas where it is necessary for ACOs to reach out to community resources.

3. Create care plans and care teams in concert with patient cohorts that reflect common issues, including social determinants, historical utilization, and outcomes.

This technique can be used to effectively standardize care plans on a spectrum of patient status/risks. This promotes treatment regimens and care teams, which have been shown to be more effective in improving outcomes care in diabetes and heart disease.

To be comprehensive, episodes must be able to identify all the professionals providing relevant care to the patient with the episode condition(s). Again, use of a vendor to create episodes that are clinically and financially cohesive is an essential tool for this intervention.

For ACOs limited to coordination activities that are administratively focused on patient outreach and appointments, using these clinically-focused strategies sounds daunting. But capture of provider data will be necessary for ACOs to even complete quality reporting beginning in 2022, so these ACOs and their providers should already be thinking of ways of to overcome this historical obstacle. Here's the plain truth: without taking more assertive action on patient costs, typical ACO efforts have significant limitations. ACOs will need to arm themselves with the tools of larger systems, competitive equity-backed practices, and Medicare Advantage plans, all of which are building data to perform more advanced coordination of care.

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Image: Randy Fath

Why ACOs Need a New Playbook

written by Theresa Hush | July 29, 2021

A lot has happened in health care since 2012, when final rules permitted provider-organized ACOs to be the driving force of Value-Based Care under the 2010 Affordable Care Act (ACA). As we pass the ACA's eleventh anniversary, a dwindling number of Medicare Shared Savings Program (MSSP) ACOs are entering a new phase marked by higher expectations and more difficult economics.

To succeed in this challenging environment, ACOs will need different tools going forward than first contemplated, because

of competition, both from providers under new value-based payment models and from Medicare Advantage plans. They also face more skepticism. Although rule changes now require ACOs to adopt downside risk, too many decision makers still distrust savings calculations for ACOs. The Medicare Payment Assessment Commission (MedPAC) that once promoted ACOs became more uncertain of savings potential from the MSSP formulas. In short, both MSSP and Next Generation model ACOs will confront challenges as to whether the models can do what they—and the stakeholders in Value-Based Care—had hoped.

Upcoming Roji Series of Articles: The New ACO Playbook

In "The New ACO Playbook," Roji does a deep dive into how ACOs can move forward from the present and ensure their future as Value-Based Care models with demonstrable savings and better outcomes. We will focus, in particular, on MSSPs and how they can navigate the Value-Based Care territory to succeed. We explore these questions:

- Will ACO savings be competitive with other payment models like capitation?
- Is coordination of care enough to generate long term savings?
- How should ACOs grow?
- How can ACOs help patients overcome barriers to improved outcomes?
- What can ACOs do to improve equity and access among its patients?
- How can ACOs help participating and specialty clinicians improve outcomes and cost performance?

- What infrastructure is essential for ACOs, and what spending is cost-effective?
- How can ACO-primary care relationships be more collaboratively engaged?
- What does demonstrating quality success mean in the future?
- How can ACOs create data sufficiency to meet the demands of performance improvement?
- What does the successful future ACO look like in a competitive Value-Based Care environment?

The Competitive Environment for ACOs: The Past Does Not Predict Future Results

As financial analysts frequently tell us, past financial success does not predict future results. And most of us believe that holds true (about others). But the tremendous effort required to conceive and continue our own organizations makes us fighters and can obscure our vision of the future.

Even before the COVID-19 pandemic exposed health care's frailties, the Value-Based Care landscape was shaken up. CMS broadcasted risk payment models long before the agency actually released Primary Care First (PCF) and Direct Contracting (DC) payment models. Subsequently during lockdown, practices with capitation under Medicare Advantage or commercial health contracts realized the financial advantage when patients could not come in for services. Just like that, the benefit of capitated payments as a predictable revenue source became clear. In all, 827 sites are participating in PCF. Significantly, the list of sites spans the spectrum of nationally known large organizations, as well as local groups—a clear signal about what providers are choosing to do.

Simultaneously, private equity practices began moving into primary care, payer-linked companies like Optum purchased independent practices, and physician MSOs re-emerged. Their collective goal is to be the vehicles for successful Value-Based Care arrangements in both the public and commercial arena, primarily via capitation.

These investments aren’t side adventures; they vest practices in organizations and commit infrastructure, data, and support to their operations. They do what ACOs planned to do, but separately and under their own banner. Perhaps equally important, in a market-oriented culture they are visible champions of their own brand, which means that their visibility can also help growth.

Limited Resources Will Constrict Future Value-Based Models

The addition of value-based payment models and expansion of interest should not alarm ACOs. But the involvement of more players should signify to ACOs that some deep changes may be needed in order to compete successfully.

Why should these models be competitive? Over time, CMS and other payers will not invest resources in models that they don’t believe are effective—or whose current success is static. Those models will simply lapse.

The first sign of this could be on the horizon. CMS, which has extended the termination date of Next Generation ACO models for a year, will determine whether this model of ACOs will be permanent. Will Next Generation ACO savings—previously questioned by CMS—and higher risk structures be continued, or

will CMS decide that 37 participants are not enough to support and that Direct Contracting is indeed the next natural step?

While MSSPs have time to address how they should meet the market now developing and still be successful, now is the time to garner their resources. As we explore the questions facing ACOs, we will be asking you to participate in short surveys to provide feedback on merits or experience with the concepts. Stay tuned!

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Image: Emilio Garcia

5 Value-Based Behavioral Health Strategies for ACOs and Medical Group Models

written by Theresa Hush | July 29, 2021

For ACOs and Direct Contracting Medical Groups adopting value-based payment models, behavioral health is often overlooked. But your patients' unmet behavioral health issues are a big cost driver for emergency care and inpatient admissions, and they compound risk factors in disease. They also influence your patients' adherence to treatment plans. You may believe this is a problem you can't resolve because behavioral health is beyond the boundaries of your participating network. Even so, you need to be aware of a significant emerging trend: integrating behavioral health in primary care.

The difference between physical medicine's approach to disease versus behavioral health is striking. For major diseases causing death and morbidity, the health care industry focuses intensely on creating better screening tools and reaching more people, making early diagnoses, and perfecting treatments. We turn to risk factor prevention and vaccinations to stop

incidence or progression of disease. For cancer care, cardiovascular conditions, diabetes, and COVID-19, our combined capacity to tackle the biggest health threats is profound when we believe that costs of delay and nontreatment are too high to ignore.

By contrast, behavioral health has all too often remained a secondary or unfamiliar consideration. Some health systems have begun to recognize the need to focus more attention on behavioral health and its ramifications for costs and outcomes. Is behavioral health part of your Value-Based Care strategies? If not, your inability to address these patient needs will have consequences. These include both direct outcomes for the patient and family—hospitalizations and suicides—as well as indirect outcomes for the patients' other conditions.

Continuing to ignore this aspect of total health has a huge societal cost, as well. Behavioral health underlies violence against others, financial crises, and homelessness. The plague of mass shootings in the U.S. is tied to behavioral health issues, too; although the vast majority of people with mental health issues are not violent, at least 40 percent of shooters have had previously identified mental health disorders, and many have histories of past personal trauma or unaddressed sociopathy and anger.

Payment models must support the integration of behavioral health in primary care. The Bipartisan Policy Center's March 2021 task force report on behavioral health integration outlines essentials for integrating behavioral health into the medical system; it's an excellent resource for ACOs to build integration models, to ensure a common core of standards, and

to collectively support payment reform. The report addresses the lack of available, licensed behavioral health providers in some regions, and the unwillingness of existing BH providers to accept insurance. To broaden the pool of professionals and expand their networks, ACOs and Medical Groups have an important, collective opportunity to solve this problem by advocating for changes in the payment system to encourage behavioral health services, as well as to permit alternative payment arrangements within the ACO, such as capitation and sub-capitated payments for specialists.

Five Strategies for Creating Behavioral Health Initiatives

Your ACO or Medical Group can develop strategies to address behavioral health and lower your potential risk under value-based payment models. The basic process is no different than for any serious medical condition, although larger in scale and involving a more diverse population. Here are five basic strategies to get you on the path:

1. Create models for behavioral health integration in primary care that the ACO/Medical Group can support with resources and data.

Integration of behavioral health care into primary care is essential for expanding patient services, but there are many models, ranging from behavioral health providers' inclusion in primary care practices, to separate practices that share management of patient care. Recent reevaluation by the Millbank Foundation highlights the emergence of a Coordinated Care Model using trained case managers to arrange joint management of

patients by behavioral health and primary care providers.

Which models work best in your organization will depend on your practices' varying resources, locations, and patient populations, so different models may be adopted by practices within ACOs having independent primary care practices. Pre-assessments of BH capacities, current attitudes, and expertise are vital to constructing an effective approach to selecting models. The ACO's role is not to dictate to practices the terms of integration models, but, rather, to define the standards for overall behavioral health integration and to encourage models that the ACO can support with services and technology.

Despite many efforts to reduce negative feelings about behavioral or mental health problems, research shows that these conditions remain a stigma for providers and patients alike. As a result, physicians are reluctant to assess and diagnose early, and patients do not speak freely; but failure to identify core BH issues can delay or eliminate the possibility of comprehensive and effective patient care. No matter where you start in your current culture, meeting your goals will depend on helping practices develop a high level of comfort with identifying patient needs during patient discussions, and then meeting their needs in conjunction with behavioral health professionals.

2. Adopt ACO/Medical Group technology, with data collection standards, to support BH Integration.

A flexible approach to BH integration in practice settings facilitates and requires a shared system that supports

practices with BH patient registries and population health tools. Collecting practice data in addition to claims—and expanding that dataset to include BH patient assessment data—is critical to evaluating and comparing costs, outcomes, and results of initiatives undertaken by practices. The technology should allow for practices to share comparative data on key performance metrics.

In many cases, this is a huge leap for ACOs, which have relied, at best, on claims data to fuel their initiatives. But that must change for ACOs to be able to evaluate outcomes and succeed in Risk by pursuing initiatives that go beyond administrative cost control.

A rich data foundation enables behavioral health episodes of care as well as integrated chronic disease/behavioral health episodes. Using episodes creates the capacity to compare patients in cohorts against each other and to make comparisons by provider, to reveal cost variation and to identify issues in patient care. By involving clinicians and direct patient care staff in shared data results on costs, outcomes, and measures of patient service, ACOs and Medical Groups can create common ground for improvement initiatives.

3. Implement ACO/Medical Group Behavioral Health assessments and reach consensus on pathways to treatments and referrals.

One of the most important functions your ACO can fulfill is the creation of common assessment tools and processes, with the help of BH clinicians and expertise. The primary benefit to your organization is facilitating standardized patient clinical

information and a stated standard of care. A shared approach also alleviates the burden—and disparities—associated with practices developing their own assessments or questions that could include biases that may dissuade patient honesty.

You can then proceed to foster more coordinated pathways for treatments and protocols for referrals among practices, incorporating tweaks informed by data from BH and chronic care episodes.

4. Implement training curricula across all practices, including cross-training strategies between behavioral health and primary care clinicians.

Some of the most innovative strategies to integrate BH into primary care involve shared training and exchanging expertise to fulfill needs in either BH or primary care. These can be as basic as involving behavioral health specialists in patient engagement, such as motivational patient interviews. Likewise, primary care clinicians can provide direction for complex medical situations involving behavioral health patients.

How cross-training materializes is largely dependent on the practice's chosen behavioral health integration model. The more distance between the parties, the less cross-functionality, requiring more coordinated planning.

Practices that have fully integrated behavioral health enrich patient care, providing patients a seamless and accepting environment to engage in both primary care and behavioral health management.

5. Establish outside BH referral sources for patients that require specialized expertise or facilities, or care that cannot be provided inside the practices through behavioral health integration.

To close the loop on behavioral health care, your ACO or Medical Group must formulate a referral network for patients who need specialized services. One important consideration is whether the partnering referral organization is willing to contribute data to your pool of patient data. While claims data from such referrals is available, it lacks evaluation and clinical information, including medications, that are part of the patient's treatment plan. This prohibits the ACO or Medical Group from including these details in patient episodes, leaving knowledge gaps that disable improvement strategies.

External BH referrals beyond the ACO's BH-integrated primary care practices include substance abuse treatment, treatment for severe psychoses and psychiatric disorders, and support for patients who fail to progress in treatment despite efforts. Creating this clinical behavioral health safety net is essential to providing good patient care; in some communities, however, it is very difficult due to lack of available resources, as well as limits on insurance acceptance or coverage issues.

This may sound like a heavy lift. It is also a major opportunity to be an agent for essential change. Your ACO may be in a prime position to catalyze better behavioral health care. ACOs and Medical Groups collectively can play a significant role as advocates for changes in payment models and

coverage to ensure that patients have access to these critical services.

It’s also good business. Taking on this set of strategies will improve your chances of success under Risk and ensure that your behavioral health programs improve patients’ outcomes and lower costs. Your organization will fulfill the promise of whole patient care that was envisioned, but never achieved, by other models, such as prior Medical Home and Medical Neighborhood initiatives. In sum, behavioral health integration’s triple play strengthens your ACO’s sustainability, supports your participating providers, and benefits your patients.

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