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ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program

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What OIG Found

As part of the transition to value-based care, Medicare Shared Savings Program Accountable Care Organizations (ACOs) have developed a number of strategies to reduce Medicare spending and improve quality of care. This report describes the strategies that selected ACOs have found successful in reducing spending and improving quality of care. These strategies involve working to increase cost awareness in ACO physicians, engaging beneficiaries to improve their own health, and managing beneficiaries with costly or complex care needs to improve their health outcomes. Other strategies that ACOs found successful involve reducing avoidable hospitalizations, controlling costs and improving quality in skilled nursing and home healthcare, addressing behavioral health needs and social determinants of health, and using technology to increase information sharing among providers. ACOs also report challenges in each of these areas and describe the ways they overcame them.

The Centers for Medicare & Medicaid Services (CMS) recently made changes to the Shared Savings Program. As CMS carries out this and other ACO programs and develops new alternative payment models, it should support the use of these strategies and other successful strategies that emerge. These strategies can apply not only to ACOs but also to other providers committed to transforming the healthcare system toward value.

What OIG Recommends

We recommend that CMS take the following actions to support efforts to reduce unnecessary spending and improve quality of care for patients: (1) review the impact of programmatic changes on ACOs' ability to promote value-based care; (2) expand efforts to share information about strategies that reduce spending and improve quality among ACOs and more widely with the public; (3) adopt outcome-based measures and better align measures across programs; (4) assess and share information about ACOs' use of the skilled nursing facility (SNF) 3-day rule waiver and apply these results when making changes to the Shared Savings Program or other programs; (5) identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health; (6) identify and share information about strategies that encourage patients to share behavioral health data; and (7) prioritize ACO referrals of potential fraud, waste, and abuse. CMS concurred with all of our recommendations.

The full report can be found at oig.hhs.gov/oei/reports/oei-02-15-00451.asp.

Key Takeaway

ACOs report a number of successful strategies in reducing Medicare spending and improving quality of care for patients. These strategies should inform CMS's broader efforts to transform the healthcare system from fee-for-service to value-based care.

Why OIG Did This Review

Medicare spending is expected to exceed \$1.5 trillion by 2028, more than double the \$708 billion in spending in 2017. To help control Medicare spending, while promoting high-quality healthcare, CMS has been implementing alternative payment models that reward providers for the quality and value of services. This is part of the transition away from fee-for-service to value-based care.

The Medicare Shared Savings Program is part of this transition and is one of the largest alternative payment models. In this program, healthcare providers voluntarily form ACOs to coordinate patient care to reduce spending and improve quality of care. Their strategies can inform not only current and future ACOs but also other alternative payment models.

How OIG Did This Review

We based this study on a purposive sample of 20 high-performing ACOs. These ACOs had reductions in Medicare spending and provided high-quality care.

We conducted structured onsite or telephone interviews with key officials from each of these ACOs. We also analyzed supplemental documentation provided by these ACOs.

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BACKGROUND

Objective

To describe the strategies that selected Accountable Care Organizations (ACOs) have found to be successful in reducing spending and improving quality of care.

Medicare spending is expected to exceed \$1.5 trillion by 2028, more than double the \$708 billion in spending in 2017.¹ To help control Medicare spending, while promoting high-quality healthcare, the Centers for Medicare & Medicaid Services (CMS) has been seeking new ways to move away from a fee-for-service payment model to a value-based payment model that rewards providers for the quality and value of services.² In recent years, CMS has implemented a number of alternative payment models to achieve these goals.

The Medicare Shared Savings Program (Shared Savings Program) is one of CMS's largest alternative payment models that incentivizes efficient and quality care.³ In the program, healthcare providers voluntarily form ACOs and enter into a multiyear contract with Medicare. Providers in each ACO coordinate to reduce Medicare spending and improve quality of care.⁴ If an ACO is successful and meets certain Medicare requirements, it is eligible to receive a portion of the savings it generates for Medicare. In 2018, the

¹ Congressional Budget Office, *Medicare—Congressional Budget Office's April 2018 Baseline*. Accessed at <https://www.cbo.gov/sites/default/files/recurringdata/51302-2018-04-medicare.pdf> on October 3, 2018.

² CMS, *CMS's Value-Based Programs*. Accessed at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html> on October 3, 2018. See also CMS, *Feedback on New Direction Request for Information (RFI) Released, CMS Innovation Center's Market-Driven Reforms to Focus on Patient-Centered Care*, April 23, 2018. Accessed at <https://www.cms.gov/newsroom/press-releases/feedback-new-direction-request-information-rfi-released-cms-innovation-centers-market-driven-reforms>, on October 3, 2018.

³ The Shared Savings Program is a permanent program authorized under section 1899 of the Social Security Act. See also CMS, *Shared Savings Program: About the Program*. Accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html> on October 3, 2018.

⁴ Shared Savings Program ACOs are eligible for certain fraud and abuse waivers for arrangements that meet certain conditions. These waivers may allow them to implement arrangements to achieve their goals that might not otherwise be permissible under the fraud and abuse laws. See 80 Fed. Reg. 66726 (Oct. 29, 2015).

Shared Savings Program had 561 ACOs that served 10.5 million beneficiaries.⁵

In its commitment to transitioning to value-based care, CMS encourages ACOs to be innovative and to experiment with creative approaches to reduce spending and achieve high quality. It is important to look at what ACOs are doing; these strategies offer learning opportunities to other ACOs, including Medicaid and commercial ACOs as well as to participants in other alternative payment models. More broadly, these strategies support the overall goal of transforming the healthcare system away from paying for volume to paying for outcomes.

This study is a followup to an August 2017 OIG study. In that study, we found that most ACOs reduced their Medicare spending compared to their benchmarks in the first 3 years of the program.⁶ From 2013 to 2015, the net reduction in Medicare spending was nearly \$1 billion. At the same time, ACOs improved their performance on the majority of the individual quality measures. OIG also found that high-performing ACOs, in particular, maintained a high use of primary care visits, reduced the use of costly services such as emergency department visits, and lowered spending by an average of \$673 per beneficiary for key Medicare services.

The current study looks at the strategies that selected ACOs have found to be successful in reducing spending and improving quality. We grouped these strategies into seven key areas for transitioning to value-based care: (1) working with physicians, (2) engaging beneficiaries to improve their own health, (3) managing beneficiaries with costly or complex care needs, (4) reducing avoidable hospitalizations and improving hospital care, (5) controlling costs and improving quality in skilled nursing and home healthcare, (6) addressing behavioral health needs and social determinants of health, and (7) using technology to increase information sharing among providers. Another OIG review looks in more detail at the extent to which ACOs use health information technology to enhance their care coordination goals.⁷

⁵ CMS, *Medicare Shared Savings Program Fast Facts*, January 2018. Accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-2018-Fast-Facts.pdf> on October 3, 2018.

⁶ OIG, *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality*, OEI-02-15-00450, August 28, 2017.

⁷ See OIG, *Use of Health Information Technology to Support Care Coordination Through ACOs*, OEI-01-16-00180, May 2019. An additional review focuses on selected ACOs' reporting of quality measures. See the OIG work plan at <https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp>. OIG also reviewed how CMS assigns beneficiaries to Shared Savings Program ACOs. See OIG, *CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned: Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Programs*, A-09-17-03010, October 19, 2017.

ACOs

ACOs vary widely in structure. Some ACOs are made up entirely of physicians, while others include physicians and other entities, such as hospitals, nursing homes, and home health agencies (HHAs). ACOs are part of traditional Medicare, and beneficiaries assigned to an ACO may choose their own healthcare providers, even if those providers are not a part of the ACO.

Spending Reductions

ACOs must meet specific requirements to receive shared savings payments. Each ACO is accountable for the total cost of care for its assigned beneficiaries, even if the care is rendered by providers that are not a part of the ACO.⁸ For each performance year, CMS compares the ACO's spending against a benchmark. CMS calculates each ACO's benchmark by using historic spending for assigned beneficiaries. This amount is adjusted for any changes in beneficiary characteristics and projected growth in fee-for-service spending. More recently, CMS began to adjust ACOs' benchmarks based on regional spending trends.

CMS determines that an ACO generates savings if the ACO spent below its benchmark in a performance year. If the ACO spent above its benchmark, the ACO generates a loss. The degree to which an ACO shares in any savings or losses is determined by the risk arrangement it selects when entering the program. ACOs that take on only upside risk may share in the savings generated but are not responsible for any losses.⁹ ACOs that take on downside risk may receive a larger proportion of the savings compared to ACOs that have upside risk only. However, they are also responsible for sharing in any losses.¹⁰

Quality Measures

In addition to spending, ACOs are measured on quality based on a number of quality measures. These measures are divided into four domains. (See text box.)

⁸ This includes Medicare Parts A and B spending.

⁹ ACOs receive shared savings if they meet or exceed a minimum savings rate.

¹⁰ ACOs are responsible for paying a share of the losses if they meet or exceed a minimum loss rate.

ACO Quality Measure Domains

- **Patient/caregiver experience.** These measures are based on a patient survey that asks about patients' ability to access care and their interactions with their providers.
- **Care coordination/patient safety.** These measures cover hospital admissions/readmissions, use of electronic health records, and other indicators of care coordination/patient safety.
- **Preventive health.** The majority of these measures cover wellness screenings (e.g., body mass index) and screenings for certain diseases (e.g., breast cancer).
- **Clinical care for at-risk populations.** These measures cover the management of certain health conditions (e.g., diabetes, hypertension).

Using an ACO's performance on the measures, CMS assigns the ACO an overall quality score that can range from 0 to 100. An ACO's performance on the quality measures determines the portion of shared savings that it will receive and, in some cases, the portion of the shared losses for which it is responsible. Higher quality scores, such as 90 or above, mean that an ACO performed well on the majority of the individual measures, and that the ACO will receive a higher proportion of the savings.

ACO Risk Arrangements

ACOs entered the Shared Savings Program under one of three tracks that varied by risk arrangement up until 2019. Track 1 offered upside risk only; ACOs were allowed to remain in this track for up to 6 years. The other two tracks included both upside and downside risk. Specifically, Tracks 2 and 3 offered higher amounts of risk in exchange for a greater amount of shared savings.¹¹ In addition, ACOs were allowed to move from the Shared Savings Program to the Next Generation ACO Model, which is another Medicare ACO model. In this other model, ACOs have greater downside risk compared to Tracks 2 and 3.

Changes to the Shared Savings Program

CMS made several changes to the Shared Savings Program for 2019, primarily to the timeframe for when ACOs must take on risk.¹² Notably, CMS modified the contract period from 3 to 5 years and now requires most ACOs to take on downside risk by their third year if they do not choose to

¹¹ In January 2018, CMS implemented another Medicare ACO model called the Track 1+ Model, which offered lower downside risk compared to Tracks 2 and 3.

¹² 83 FR 67816.

do so earlier. CMS also established incentives for ACOs to take on downside risk earlier in the program. These incentives relax certain coverage requirements for skilled nursing facility (SNF) care and telehealth services.¹³ In addition, ACOs may develop beneficiary incentive programs that reward beneficiaries for receiving certain primary care services.

Methodology

The current study looks at the strategies that selected ACOs have found to be successful in reducing spending and improving quality. We based this study on a purposive sample of 20 high-performing ACOs. For the purposes of this report, we defined high-performing ACOs as ACOs that had both a reduction in spending relative to their benchmark and an overall quality score of 90 or above during their second, third, or fourth performance year as an ACO.¹⁴ Although all 20 ACOs started in the Shared Savings Program, 5 transitioned to the Next Generation ACO Model at the time of our review.

We conducted structured onsite or telephone interviews with key officials from each of these ACOs.¹⁵ We asked the ACOs to identify the strategies that they found successful in reducing Medicare spending and improving quality of care. We also requested and reviewed documentation to supplement their responses. We grouped the strategies from the ACOs into seven key areas. We highlighted common strategies as well as those used by individual ACOs.

See the Appendix for more detailed information about the methodology.

Limitations

This study is based on a purposive sample of 20 ACOs; therefore, the findings cannot be projected to all ACOs in the Shared Savings Program or other programs. Also, the data are self-reported; we did not independently evaluate the strategies or confirm the reported results of those strategies. Lastly, we did not evaluate ACOs based on their risk arrangement.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

¹³ ACOs with downside risk may use a SNF 3-day rule waiver to place beneficiaries into a SNF without having a prior hospital stay of 3 days or longer. These same ACOs may use the telehealth waiver to provide telehealth services to prospectively assigned beneficiaries in non-rural areas rather than only rural areas. These beneficiaries may also receive telehealth services at their home rather than solely in a location designated for telehealth services.

¹⁴ Nineteen of the ACOs met both of these criteria within a single year between 2014 and 2016. The remaining ACO reduced spending and had a quality score of 89 in 1 year. We included this ACO to ensure geographic diversity in our sample.

¹⁵ We conducted the interviews between late June and early October 2017.

FINDINGS

The selected, high-performing ACOs have implemented a number of strategies they found successful in reducing Medicare spending and improving quality of care.¹⁶ These strategies fall into seven broad categories:

- Working with physicians
- Engaging beneficiaries
- Managing beneficiaries with costly or complex care needs
- Managing hospitalizations
- Managing skilled nursing and home healthcare
- Addressing behavioral health needs and social determinants of health
- Using technology for information sharing

This report describes the challenges that ACOs faced, the ways they overcame these challenges, and the specific strategies they found successful in achieving better care at a lower cost.

WORKING WITH PHYSICIANS

ACOs are working with physicians to lower costs and improve quality

ACOs report that working with physicians in the ACOs is critical to lowering costs and improving quality. However, they note encountering a number of challenges when working with physicians. ACOs explain that physicians are often unaware of the cost of services and therefore may order more expensive services than are necessary or refer to specialists without factoring in the cost of services. In addition, physicians are often overburdened by administrative tasks, thereby reducing the time they have to care for beneficiaries. ACOs also note that they need to work with physicians to address their performance on the quality measures and to close gaps in care—particularly regarding screening beneficiaries for needed care.

¹⁶ We based this study on a purposive sample of 20 high-performing ACOs. Although all 20 ACOs started in the Shared Savings Program, 5 transitioned to the Next Generation ACO Model at the time of our review. Throughout this report, we refer to these 20 ACOs as “ACOs.”

STRATEGIES FOR Working With Physicians



- Recruiting physicians with a commitment to ACO goals
- Providing data on costs to inform physicians about their practices and their referrals to specialists
- Providing information on quality measures and gaps in care
- Redesigning office workflows
- Providing administrative and clinical support

Recruiting physicians with a commitment to ACO goals

ACOs commonly recruit physicians who have experience or a demonstrated commitment to lowering costs and improving quality. Some ACOs require that their physician practices are recognized as patient-centered medical homes—a care delivery model in which primary care physicians are responsible for coordinating beneficiaries' care with other providers. Other ACOs recruit physicians who have participated in other alternative payment models to ensure that physicians already have experience with a similar payment approach. In contrast, one ACO accepts all physicians who want to join but requires that they make a financial investment and commit to attending meetings.

In addition, several ACOs recruit physicians who have or are committed to having an electronic health record (EHR) system. Two of these ACOs require that physicians who do not have an EHR system must select one within 1 year of joining.¹⁷ EHR systems can allow providers to facilitate information sharing and improve care coordination if they are interoperable.

¹⁷ Although 86 percent of office-based physicians have adopted EHRs nationally, these ACOs established this requirement to encourage additional providers to adopt EHRs. See The Office of the National Coordinator for Health Information Technology, *Office-based Physician Electronic Health Record Adoption*. Accessed at <https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php> on April 17, 2019.

Providing data on costs to inform physicians about their practices and their referrals to specialists

Almost all ACOs provide their physicians with customized data to inform them about their practices and their referrals. This information is meant to increase physicians'

awareness of the cost of services and encourage them to consider these costs when providing care

or when making referrals to other providers. Most ACOs regularly provide spending and utilization reports to individual physicians. For example, one ACO provides data on the number of beneficiaries who visited the emergency department and asks physicians to seek opportunities to reduce the number of avoidable visits.

“Changes happen by just making [physicians] aware of the data.”

—ACO official

A number of ACOs also identify and educate physicians with unusual spending and utilization trends to help reduce costs and unnecessary services. These ACOs sometimes compare physicians' performance relative to their peers or established thresholds. For example, one ACO educated a group of dermatologists with high rates of certain surgeries about the clinical appropriateness of certain procedures; this resulted in a significant reduction in spending for the ACO. Other ACOs use claims data to identify providers outside of their ACOs who serve their beneficiaries and have unusually high spending. ACOs also have an incentive to review and report questionable billing by providers outside of their ACOs because they are accountable for their beneficiaries' health expenditures billed by those providers.

ACOs are in a unique position to identify potential fraud, waste, and abuse

In one example, an ACO analyzed the referring physicians on home health claims and identified potential fraudulent billing. It recommended a fast track for ACOs to report potential fraud, waste, and abuse.

In addition, several ACOs provide data to physicians about specialists—both within and outside of the ACO—to help them make more informed referrals that take into account cost and quality. These ACOs commonly share key information about specialists, such as the cost of their services and whether they share information and records with primary care physicians. According to one ACO, providing this information to its physicians can also influence specialists' practices. It found that when specialists know that ACO physicians are evaluating them for potential referrals, they strive to improve the quality and efficiency of their services.

Other ACOs develop lists of preferred specialists that they share with their primary care physicians. These ACOs often analyze spending and quality data to identify specialists who are aligned with the ACOs' goals. Several of

these ACOs also have specific requirements for these specialists. For example, one ACO requires preferred specialists to give timely appointments, share their notes with the relevant ACO primary care physician within 24 hours, and contact the physician before ordering any diagnostic tests.

Providing information on quality measures and gaps in care

Most ACOs provide physicians with information about their performance on the quality measures and any gaps in care. They commonly provide information about beneficiaries who are overdue for one or more preventive services (e.g., breast cancer screenings, which is one of the quality measures). They then encourage physicians to address these gaps at annual wellness visits. In addition, most ACOs evaluate physicians' practices and provide feedback to physicians about the quality of care they are providing. For example, many ACOs create report cards for physicians that evaluate their performance on each quality measure. One ACO provides each physician with a specific quality score that is compared to the ACO's overall quality score. The ACO also assigns a letter grade to each physician and provides recommendations to improve the physician's performance on specific measures. In addition, many ACOs educate physicians about the quality measures so that they know how to collect and report the appropriate data.

Despite these efforts, ACOs note several ongoing challenges with the quality measures. They report that CMS frequently changes the measures, which makes them difficult to meet.¹⁸ In addition, a few ACOs note that the lack of alignment with the measures used in Medicare Advantage and in commercial insurance plans is problematic. According to one ACO, it tracks its providers' performance on 180 quality measures used in multiple programs including the Shared Savings Program, Medicaid ACOs, and commercial insurance

ACOs report challenges meeting CMS's quality measures:

- Frequent changes to the quality measures are burdensome to providers, requiring system adjustments and physician re-education.
- Lack of alignment of the measures to other payment programs makes data collection and reporting difficult.
- Use of process-based measures rather than outcome-based measures does not always help providers focus on improving health outcomes.

¹⁸ For example, in 2017, CMS introduced four new quality measures. Note that CMS can add, modify, remove, or replace the Shared Savings Program's quality measures annually through rulemaking. CMS allows ACOs a period of transition for new quality measures before the pay for performance requirements are implemented.

plans.¹⁹ Lastly, there are concerns that a number of the quality measures are process-based as opposed to outcome-based, such as the measures that focus on the percentage of beneficiaries who are screened for certain health conditions.²⁰ One ACO notes that certain process-based measures may not be as useful because they may not necessarily improve health outcomes and can instead contribute to additional costs. This is further supported by a number of researchers.

Redesigning office workflows

Most ACOs advise physicians and their practices on office workflows (i.e., steps taken by clinicians and staff to accomplish a task) to help them address gaps in care and avoid duplicative services. One ACO provides laminated cards to office staff to remind them to check that certain screenings are completed. Another ACO provides each physician with a list of actionable items, such as recommendations about which beneficiaries to see more frequently during the year. To avoid duplication in care, one ACO has its care management teams meet every morning to discuss their patients. These meetings ensure that each patient's care is coordinated among the various providers responsible for the care. In addition, some ACOs integrate workflows into physician practices' EHR systems. For example, one ACO provides a beneficiary-level dashboard that shows which beneficiaries need certain screenings, such as an eye exam or a screening for tobacco use. At the beginning of a visit, the physician or support staff reviews the dashboard to identify which screenings to provide on that day.

Providing administrative and clinical support

Many ACOs provide administrative support to improve the efficiency of physician offices and increase the amount of time that physicians spend with beneficiaries, which can improve quality. A number of ACOs provide staff to physicians to perform functions that range from scheduling appointments to managing prescription refills. Several ACOs provide clinical support: they complete preventive health screenings and create patient summary reports before beneficiaries see their physicians. For example, one ACO—which had a large increase in screening for fall risk had nurse care coordinators administer these screenings to beneficiaries while in the waiting room.

¹⁹ ACOs are required to calculate and submit data for a number of the quality measures for the Shared Savings Program. CMS calculates the data for the remaining measures. Although ACOs are not responsible for these measures, they commonly track their providers' performance on them throughout the performance year so that they can provide feedback to providers and suggest changes in practice when needed.

²⁰ Process-based measures evaluate what a healthcare provider does to maintain or improve health, such as the percentage of beneficiaries receiving a preventive service.

ENGAGING BENEFICIARIES

ACOs are engaging beneficiaries to improve their own health

Encouraging beneficiaries to take a more active role in their health can lead to better health outcomes, quality care, and reduced healthcare costs.²¹ However, ACOs note that it is challenging to build relationships between physicians and beneficiaries, and thus encourage beneficiaries to get involved in their own health.

STRATEGIES FOR Engaging Beneficiaries

- Increasing wellness visits to engage beneficiaries
- Educating beneficiaries on healthcare topics



Increasing wellness visits to engage beneficiaries

To address these challenges, many ACOs focus on increasing beneficiaries' utilization of annual wellness visits. ACOs use annual wellness visits—which are different from annual physicals—to build relationships between beneficiaries and physicians and to engage beneficiaries in their health. Physicians conduct health risk assessments and provide personalized health advice to beneficiaries during these visits. For example, one ACO helps physicians identify beneficiaries who have not received an annual wellness visit and then helps them set up those appointments. As a result, it increased its rate of these visits from 15 percent to more than 50 percent in 2017.²² The ACO found that beneficiaries who completed annual wellness visits saw their physicians more often throughout the year to manage their conditions.

“ Small differences in lifestyle would make a big difference, but you have to teach [beneficiaries]. ”

—ACO official

²¹ Kristin L. Carman, Pam Dardess, Maureen Maurer, Shoshanna Sofaer, Karen Adams, Christine Bechtel, and Jennifer Sweeney, *Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies*, Health Affairs, February 1, 2013. Accessed at <https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1133> on October 3, 2018.

²² For comparison, CMS found that only 20 percent of Medicare beneficiaries received an annual wellness visit in 2016. See CMS, *Beneficiaries Utilizing Free Preventive Services by State*, 2016. Accessed at <https://downloads.cms.gov/files/Beneficiaries%20Utilizing%20Free%20Preventive%20Services%20by%20State%20YTD%202016.pdf> on October 3, 2018.

Educating beneficiaries on healthcare topics

ACOs also provide direct education and partner with outside entities to engage beneficiaries in their own health. Many ACOs educate beneficiaries on healthcare topics, such as end-of-life care; they also teach beneficiaries how to better manage specific conditions, such as diabetes. One ACO also trains its care coordinators to conduct motivational interviews, which is a counseling method that aims to motivate people to change their behavior.²³ Over time, this ACO observed a higher level of beneficiary satisfaction with their visits. The ACO also created a patient handbook with guidelines on what to do for certain symptoms, when to visit the emergency department, and when to contact a primary care provider. Several ACOs partner with other entities to educate their beneficiaries. For example, one ACO works with a local supermarket whose dietician educates diabetic patients on healthy food options as they shop.

One ACO partners with emergency medical technicians (EMTs) to educate beneficiaries

One ACO partners with its area's EMTs to educate beneficiaries who are high utilizers of ambulance services on when to call an ambulance and the availability of other care options. It found that beneficiaries are more receptive to this outreach due to their familiarity with the EMTs.

²³ For more information about motivational interviewing, see The Substance Abuse and Mental Health Services Administration, *Motivational Interviewing*. Accessed at <https://www.integration.samhsa.gov/clinical-practice/motivational-interviewing> on October 3, 2018.

MANAGING BENEFICIARIES WITH COSTLY OR COMPLEX CARE NEEDS

ACOs are managing beneficiaries with costly or complex care needs

Beneficiaries with costly or complex care needs account for a disproportionate amount of total healthcare spending.²⁴ These beneficiaries—as well as beneficiaries who are at future risk of needing high-cost or complex care—have a wide variety of health conditions, such as diabetes, chronic lung disease, or congestive heart failure. Without intervention, their cost of care can dramatically increase over time. These beneficiaries are also especially vulnerable to poor-quality outcomes associated with fragmented care.²⁵

STRATEGIES FOR Managing Beneficiaries With Costly or Complex Care Needs



- Using care coordinators to manage beneficiaries' health
- Providing care outside of the physician's office

Using care coordinators to manage beneficiaries' health

To help manage the care of beneficiaries with costly or complex care needs, almost all ACOs use care coordinators. ACOs typically provide care coordinators with a customized list of beneficiaries. The care coordinators monitor these beneficiaries closely and help them transition from one care setting to another. For example, care coordinators ensure that when beneficiaries leave the hospital, they have the correct medication and equipment, as well as a followup visit with their primary care provider.

Care coordinators also help beneficiaries schedule appointments and ensure that beneficiaries have care plans in place. In many ACOs, they also periodically check with beneficiaries in between physician visits to monitor changes in their health. At one ACO, care coordinators ask beneficiaries with chronic obstructive pulmonary disease, congestive heart failure, or

²⁴ Susan L. Hayes, Claudia A. Salzberg, Douglas McCarthy, David Radley, Melinda K. Abrams, Tanya Shah, Gerard Anderson, *High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?*, The Commonwealth Fund, August 29, 2016. Accessed at <https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-who-are-they-and-how-do-they-use> on October 3, 2018.

²⁵ Janice L. Clarke, Scott Bourn, Alexis Skoufalos, Eric H. Beck, Daniel J. Castillo, *An Innovative Approach to Health Care Delivery for Patients with Chronic Conditions*, Population Health Management. February 1, 2017. Accessed at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278805/> on October 3, 2018.

high-risk diabetes to call and report their health status every day. If a beneficiary reports a condition that requires followup, the care coordinator directs the beneficiary to a registered nurse who can request a pharmacy consultation to identify any medication errors, or arrange for hospital, home health services, or primary care services, if appropriate. For these beneficiaries, the ACO reported over a 43-percent reduction in emergency department visits and a 47-percent reduction in hospital readmissions by the second year of the program.

Providing care outside of the physician's office

Many ACOs also provide additional support—such as home visits, telephonic support, and monitoring devices—to beneficiaries with costly or complex care needs. These services help manage beneficiaries' conditions between physician visits.

Over half of the ACOs have care coordinators or physicians who visit beneficiaries in their homes. One ACO sends a respiratory therapist to beneficiaries with chronic obstructive pulmonary disease, while another provides high-risk beneficiaries with at-home services that range from blood draws to ultrasounds. A few ACOs provide home visits by a multidisciplinary team, including a physician, pharmacist, and care coordinator to address beneficiaries' multiple needs.

Other ACOs offer telephonic support to beneficiaries to help manage their conditions between physician visits. These ACOs provide beneficiaries 24-hour access to a care coordinator, a physician, or a nurse. For example, at one ACO, care coordinators provide their phone numbers to high-risk beneficiaries so that they can call for advice about their health condition. If a call is insufficient to address the beneficiary's concern, care coordinators triage the symptoms and coordinate with physicians as needed.

One ACO uses tablets to help manage the health of beneficiaries who have end-stage congestive heart failure

One ACO provides tablets that issue medication reminders to its beneficiaries with end-stage congestive heart failure. It also provides them with a scale that transmits information directly to the care coordinators. This allows the ACO to monitor whether a beneficiary has gained weight over a short period of time, which is often a sign of a serious medical condition in patients with congestive heart failure. The ACO reported that hospitalizations for this group declined, on average, from four times a year to once a year.

MANAGING HOSPITALIZATIONS

ACOs are reducing avoidable hospitalizations and improving hospital care

Inpatient hospital care accounts for the largest amount of Medicare fee-for-service spending, totaling over one-third of total Medicare spending in 2016.²⁶ However, ACOs note that hospitals are often difficult to engage; they also find that hospitals often lack the incentive to lower their costs partly because they are reimbursed primarily based on the volume of admissions. ACOs face challenges with reducing avoidable hospitalizations and with encouraging beneficiaries to seek alternatives to emergency room care when possible.

STRATEGIES FOR Reducing Avoidable Hospitalizations and Improving Hospital Care



- Expanding access to primary care services
- Targeting frequent users of emergency room services
- Improving care coordination within hospitals
- Improving care coordination at hospital discharge

Expanding access to primary care services

To help prevent avoidable hospital visits, most ACOs provide additional access to primary care services. Primary care providers in almost half of the ACOs have extended hours that include evenings or weekends. In addition, a few ACOs keep a number of appointment times open each day so that beneficiaries with urgent needs can be seen on the same day. A few other ACOs guarantee next-day appointments for beneficiaries who visit the emergency room but are not admitted to ensure that their concerns are addressed in a timely manner.

In addition, some ACOs make clinicians accessible during off hours so that beneficiaries do not automatically seek emergency care. At one ACO, primary care physicians are available at any time for beneficiaries to call to help determine whether visiting the emergency room is necessary and to inform them about alternatives such as urgent care clinics. Another ACO operates a 24-hour hotline for beneficiaries to call. Hotline staff triage

²⁶ This includes Medicare Parts A and B spending. See CMS, *Medicare Part A and Part B Summary: Persons With Utilization, Program Payments, and Cost Sharing for All Original Medicare Beneficiaries, by Type of Coverage and Type of Service, Calendar Years 2011–2016*. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/2016_Utilization.html on October 3, 2018.

beneficiaries based on their symptoms and advise an appropriate course of action, which may not necessarily be a visit to the emergency room.

Targeting frequent users of emergency room services

Many ACOs identify beneficiaries who frequently visit the emergency room unnecessarily so that providers can work with them. Providers in a few of these ACOs educate these beneficiaries on alternatives to the emergency room. Other ACOs collect

information on why these beneficiaries are visiting the emergency room and create customized solutions for them to address their needs, such as connecting them to social services. For

example, one ACO identified a beneficiary who had 30 emergency room visits in a year; by offering a standing weekly appointment with a primary care physician, the ACO reduced the number of emergency room visits to two the next year.

“ We tell practices to ask patients: ‘Why did you go to [the emergency room]?’ Now some of the practices changed their workflows based on [those] reasons. ”

—ACO official

Improving care coordination within hospitals

ACOs that include hospitals as participants often utilize hospitalists—physicians who work exclusively in hospitals—to coordinate and monitor their ACO beneficiaries’ care. Hospitalists closely review inpatient costs, lengths of stay, and quality of care by closely monitoring these beneficiaries. One ACO also requires its hospitalists to communicate with the beneficiaries’ primary care physicians, which does not always occur.

In contrast, ACOs that do not include hospitals as participants are limited in their ability to coordinate and monitor their beneficiaries’ hospital care. However, a few ACOs are able to embed their staff into hospitals to actively monitor beneficiaries’ care. These staff commonly participate in clinical rounds and discharge planning, as well as monitor for appropriate lengths of stay. In addition, a few ACOs immediately provide medical records to hospitals outside the ACO once they are alerted that their beneficiaries are in the emergency room or being admitted to help reduce duplicative services.

ACOs report ongoing challenges with working with hospitals that are not participants in their ACO. These challenges range from not knowing when their beneficiaries are admitted, transferred, or discharged to not having access to the hospital to monitor their beneficiaries’ care. One ACO notes that the hospitals in its area commonly arrange appointments for beneficiaries to follow up with new primary care physicians after discharge, even though these beneficiaries may already have their own primary care physicians.

Improving care coordination at hospital discharge

To help ensure smooth and safe transitions from the hospital, ACO staff commonly participate in discharge planning, assess beneficiaries' post-discharge needs, and monitor transitions of care. They often educate beneficiaries about their symptoms, arrange for transportation, secure medical equipment, and reconcile their medication to reduce errors. At one ACO, a pharmacist works with its beneficiaries to address medication adherence issues. Another ACO reconciles its beneficiaries' medication and provides 30 days of all medications to beneficiaries when they are being discharged from the hospital. This initiative is targeted toward beneficiaries who have numerous medications or who indicate they may not fill their prescriptions right away. As a result of this initiative, the ACO saw a large reduction in medication errors and a significant reduction in the hospital's readmission rate.

In addition, ACOs emphasize the importance of followup visits with beneficiaries' primary care physicians following a beneficiary's discharge from a hospital. These visits ensure that beneficiaries understand their instructions and identify any outstanding needs. Many ACOs schedule these visits for the beneficiaries shortly after discharge. One ACO created its own quality measure to ensure that primary care visits occur within 14 days after discharge. Another ACO had a 50-percent drop in readmissions for beneficiaries with chronic heart failure due to its transition of care efforts, combined with scheduling followup visits within 7 days.

MANAGING SKILLED NURSING AND HOME HEALTHCARE

ACOs are controlling costs and improving quality in skilled nursing and home healthcare

Skilled nursing and home healthcare made up 13 percent of total Medicare spending in 2016.²⁷ ACOs note that their ability to coordinate care and influence cost is limited because SNFs and HHAs are not typically included in the ACOs. ACOs note challenges forming relationships with these providers which may not share the same incentives to lower cost and improve quality.

In addition, beneficiaries must be fully-admitted to a hospital for 3 nights to qualify for SNF benefits under Medicare Part A—referred to as the “3-day rule”—which can potentially limit an ACO’s ability to arrange the most appropriate and cost-effective care.²⁸ Accordingly, concerns exist that the 3-day rule can result in unnecessary and costly hospitalizations in instances when it is safe to transfer patients directly to a SNF without hospitalization or when fewer than 3 days of hospitalization are needed.²⁹

²⁷ This includes Medicare Parts A and B spending. CMS, *Medicare Part A and Part B Summary: Persons With Utilization, Program Payments, and Cost Sharing for All Original Medicare Beneficiaries, by Type of Coverage and Type of Service, Calendar Years 2011–2016*. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2016/2016_Utilization.html on October 3, 2018.

²⁸ For additional requirements, see 42 CFR §§ 409.30(a)(1).

²⁹ See Nicole Fallon, *LeadingAge Calls for Elimination of Three-Day Stay Requirement*, August 28, 2017. Accessed at <http://leadingage.org/legislation/leadingage-calls-elimination-three-day-stay-requirement> on October 30, 2018. See also US Sibia, JJ Turcotte, JH MacDonald, and PJ King, “The Cost of Unnecessary Hospital Days for Medicare Joint Arthroplasty Patients Discharging to Skilled Nursing Facilities,” *Journal of Arthroplasty*, September 2017. Accessed at [https://www.arthroplastyjournal.org/article/S0883-5403\(17\)30295-4/fulltext](https://www.arthroplastyjournal.org/article/S0883-5403(17)30295-4/fulltext) on November 6, 2018. In addition, note that outpatient stays and time spent as an outpatient prior to inpatient admission do not count toward the 3-day requirement. See Medicare Benefit Policy Manual, ch. 8, § 10.

STRATEGIES FOR Working With SNFs and HHAs



- Designating certain SNFs and HHAs as preferred providers
- Embedding staff in SNFs to monitor beneficiaries' health
- Conducting warm handoffs to improve care transitions
- Enlisting primary care physicians to more closely scrutinize care needs
- Using the SNF 3-day rule waiver for flexibility in accessing needed care

Designating certain SNFs and HHAs as preferred providers

Many ACOs recognize certain SNFs—and less frequently, HHAs—as preferred providers. Through selective recruiting methods, ACOs enter into arrangements with providers that offer low-cost and high-quality care.³⁰ Several ACOs review SNFs' claims data to evaluate their spending and quality to identify SNFs that offer high-value services at a lower cost. A few ACOs recruit SNFs based on CMS's quality rating system, requiring that SNFs have at least a three-star rating.³¹

In addition, almost half of the ACOs impose specific requirements on SNFs or HHAs that want to be preferred providers. For example, some ACOs require that these SNFs or HHAs share data, such as notifications of admissions and discharges and information about medications and expected lengths of stay. Other requirements range from mandatory participation in meetings with ACO providers to a pledge from SNFs to accept all of an ACO's beneficiaries who choose them.

Embedding staff in SNFs to monitor beneficiaries' health

A number of ACOs embed staff in preferred SNFs. These ACO staff commonly monitor the health of the ACO's beneficiaries and contribute to their care plans. For example, one ACO has a care manager who attends

³⁰ Preferred providers benefit by receiving enhanced status on ACOs' referral lists. However, while ACOs may designate certain SNFs or HHAs as preferred providers, ACO providers must give to beneficiaries a list of available SNFs and HHAs in the geographic area and may not steer them to specific SNFs or HHAs. For more information about beneficiary choice in selecting SNFs and HHAs, see 42 CFR § 482.43(c)(7).

³¹ CMS developed the Five-Star Quality Rating System to help consumers, their families, and caregivers compare nursing homes more easily. See CMS, *Five-Star Quality Rating System*. Accessed at <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsqrs.html> on October 3, 2018.

meetings about its ACO's beneficiaries, monitors the implementation of care plans, and advocates for changes in treatment when necessary. Another ACO—which experienced a 19-percent reduction in SNF lengths of stay—provides recommendations about when to discharge beneficiaries, particularly focusing on SNFs that typically keep beneficiaries for the maximum Medicare payment period. Another ACO—which experienced a 25-percent reduction in SNF lengths of stay—embeds advanced clinical and geriatric nurses who participate in clinical rounds and monitor their beneficiaries' progress.

In contrast, ACOs have less direct staff involvement in home healthcare. One ACO holds interdisciplinary care meetings that include an HHA representative. Another ACO has staff who help to ensure that home health visits are made and that durable medical equipment is ordered and delivered.

Conducting warm handoffs to improve care transitions

Several ACOs conduct “warm handoffs”—where ACO staff are involved in an in-person transfer of a beneficiary between different care settings, such as a hospital to a SNF or HHA. These handoffs help build relationships between care coordinators, providers, beneficiaries, and their families and provide opportunities to clarify or correct information and improve care coordination.³² At one ACO, care managers establish relationships with beneficiaries prior to discharge from the hospital to facilitate a more seamless transition; they are responsible for handing off each beneficiary to a post-acute facility and for monitoring his or her care for 30 days after discharge. During this time, they help reconcile medication to prevent any errors and ensure that beneficiaries have adequate transportation to appointments and that medical equipment is delivered.

³² See also Agency for Healthcare Research and Quality, *Warm Handoffs: A Guide for Clinicians*. Accessed at <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/warm-handoff-guide-for-clinicians.pdf> on October 3, 2018.

Enlisting primary care physicians to more closely scrutinize care needs

A number of ACOs rely on primary care physicians to more closely scrutinize their beneficiaries' need for skilled nursing and home healthcare. Many ACOs request that they review their orders and care plans for skilled nursing and home healthcare and look for unnecessary services. One ACO directs physicians to look at the clinical appropriateness of the care and to consider when home health is a feasible alternative to a SNF, which is more expensive.

Another ACO educates its physicians to review home health orders and particularly focus on

physical therapy services that may not be needed. One ACO—which experienced a 21-percent reduction in SNF per capita spending—instructs its physicians to contribute to its beneficiaries' SNF care plans and discharge goals.

“ We think twice about sending a patient to a SNF—maybe there are some [patients] who can go home with home health. We think about what is necessary for the patient.”

—ACO official

Using the SNF 3-day rule waiver for flexibility in accessing needed care

Six of the 20 ACOs were eligible to use the SNF 3-day rule waiver; this waiver allows eligible beneficiaries to go directly to an approved SNF from their home, the physician's office, or the hospital when their hospital stay is shorter than the required 3 days.³³ A few of these ACOs found the waiver particularly helpful when the beneficiaries otherwise did not qualify for a SNF stay and it was unsafe for the beneficiaries to be discharged directly home. One of these ACOs also attributed a reduction in emergency department spending to the use of the waiver. The ACO cited an example of a beneficiary who had a history of frequent and inappropriate emergency department visits who was able to get needed care at a SNF by being directly admitted from his primary care office.

³³ Medicare covers a SNF stay if the beneficiary has a prior inpatient hospital stay of 3 consecutive days or more and the hospital stay occurred within 30 days of admission to the SNF. ACOs that take on downside risk are eligible to use the SNF 3-day rule waiver. See CMS, *Medicare Shared Savings Program: Skilled Nursing Facility 3-day Rule Waiver Guidance*. Accessed at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SNF-Waiver-Guidance.pdf> on October 3, 2018, and CMS, *Three-Day Inpatient Hospital Stay Requirement for Care in a Skilled Nursing Facility Admission Waiver*. Accessed at <https://innovation.cms.gov/Files/x/nextgenaco-threedaysnfwaver.pdf> on October 3, 2018.

ADDRESSING BEHAVIORAL HEALTH NEEDS AND SOCIAL DETERMINANTS OF HEALTH

ACOs are addressing behavioral health needs and social determinants of health

Research has shown a strong association between having a behavioral health condition and a high utilization of healthcare services.³⁴ These conditions—which include mental health and substance use disorders—can impact not only a person’s quality of life but also his or her health outcomes. As several ACOs note, when left untreated, behavioral health conditions often result in costly services, such as avoidable emergency room visits and longer hospital stays.

ACOs report a number of challenges with addressing beneficiaries’ behavioral needs. These most commonly include a lack of behavioral healthcare providers, limited availability of data to identify beneficiaries who have behavioral health needs, and fragmented approaches to physical and behavioral healthcare.

STRATEGIES FOR Addressing Behavioral Health Needs



- Recruiting behavioral health providers
- Using data to identify beneficiaries with behavioral health needs
- Integrating physical and behavioral healthcare into primary care settings

Recruiting behavioral health providers

To address shortages of behavioral health providers, a number of ACOs actively recruit behavioral health providers to participate in their ACOs. ACOs also encourage their primary care physicians to become more adept at recognizing, screening, and treating certain common behavioral health conditions, such as depression and anxiety. One ACO uses telemedicine, which allows behavioral health providers in a neighboring State to provide services to its beneficiaries.

³⁴ Susan L. Hayes, Douglas McCarthy, and David Radley, *The Impact of a Behavioral Health Condition on High-Need Adults*, The Commonwealth Fund, November 22, 2016. Accessed at <https://www.commonwealthfund.org/blog/2016/impact-behavioral-health-condition-high-need-adults> on July 19, 2018.

Using data to identify beneficiaries with behavioral health needs

To help identify beneficiaries who have behavioral health needs, a few ACOs use claims data to look for certain diagnoses of mental illness or patterns of medication use. However, ACOs acknowledge that their data are limited. In general, patient records on substance use disorder diagnoses and treatments, and in some States, records on mental health illnesses, may only be released to a healthcare provider by patient consent.³⁵ Several ACOs supplement their existing data with data from behavioral health screenings that their providers conduct about drugs, alcohol, and depression.

Integrating physical and behavioral healthcare into primary care settings

Several ACOs integrate behavioral healthcare services into their primary care settings to address the problems with fragmented care. For example, one ACO is developing multi-disciplinary clinics that include primary care physicians, behavioral health providers, and social workers. As several ACOs note, an integrated practice allows for better coordination of care, where the primary care physician can more easily monitor whether beneficiaries are taking their medication and keeping their appointments. A few ACOs found that an integrated care model is particularly effective in responding to the behavioral and physical healthcare needs of people with complex conditions, as a single global care plan can be developed to address the totality of the beneficiary's needs.

STRATEGIES FOR Addressing Social Determinants of Health



- Incorporating non-medical staff into practices to address unmet social needs
- Targeting resources to beneficiaries most likely to have unmet social needs

Social determinants of health, such as access to housing and food, can also affect health outcomes. Unmet social needs can potentially increase a beneficiary's risk of developing chronic conditions and increase healthcare

³⁵ The Substance Abuse and Mental Health Services Administration and The Office of the National Coordinator for Health Information Technology, *Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?*. Accessed at <https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf> on October 3, 2018.

utilization and costs.³⁶ ACOs report challenges with identifying beneficiaries with unmet social needs and with helping beneficiaries address these needs.

Incorporating non-medical staff into practices to address unmet social needs

Many ACOs incorporate non-medical staff, such as social workers and case managers, into their healthcare practices to better serve beneficiaries who have unmet social needs. These staff members often serve as liaisons to community social services and help beneficiaries address a variety of issues, such as housing, food, transportation, and medication assistance. One ACO, which embeds therapists and social workers into primary care practices, found that this arrangement is less stigmatizing and more convenient to beneficiaries.

Targeting resources to beneficiaries most likely to have unmet social needs

A few ACOs target beneficiaries who they identify as most likely in need of these services: one ACO focuses on high-risk beneficiaries with complex needs, whereas other ACOs focus on certain beneficiaries who might benefit from additional assistance, such as beneficiaries who struggle with medication adherence or beneficiaries who have patterns of avoidable visits to the emergency room. For example, at one ACO, action plans are created for beneficiaries who frequently visit the emergency room for a warm bed and a meal. Despite some progress in this area, funding for these services is difficult to find. As one ACO explained, it has difficulty finding sustainable sources of funding to support these efforts, as such services are not generally reimbursed by Medicare.

³⁶ CMS, *First-ever CMS Innovation Center pilot project to test improving patients' health by addressing their social needs*, January 5, 2016. Accessed at <http://www.nihb.org/docs/02172016/cms.pdf> on October 3, 2018.

USING TECHNOLOGY FOR INFORMATION SHARING

ACOs are using technology to increase information sharing among providers

Sharing medical information is helpful to coordinate care among different providers and across different settings. However, ACOs report that they do not always have access to beneficiaries' medical information from other providers—including ACO providers and providers outside the ACO—that are involved in their beneficiaries' care. They note challenges with the interoperability of ACO providers' systems and with using State and regional data systems to communicate with providers outside their ACOs. Despite some ACOs making progress, challenges remain with using technology to share information.³⁷

STRATEGIES FOR Using Technology to Share Information



- Using one EHR system or developing alternative systems to communicate with ACO providers
- Using State and regional data systems—health information exchanges—to communicate with providers outside their ACOs

Using one EHR system or developing alternate systems to communicate with ACO providers

Many ACOs have developed strategies to overcome challenges with interoperability. One strategy is to move toward the adoption of one system for all providers. Having a single EHR system helps ACOs ensure that data can be shared across all providers. As a result, one ACO is transitioning current providers to an EHR system that most of its providers are already using.

However, not all ACOs are able to move toward one system and many ACOs have multiple EHR systems. Some of these ACOs have developed other ways for their providers to share clinical information. Several ACOs have a secure communication system where providers can quickly message each other. As one ACO describes, embedding a secure direct messaging service into every EHR system allows its providers to easily communicate data even without interoperability. In addition, several other ACOs have their providers upload beneficiaries' medical records to a secure data warehouse so that all providers can access data in a single location.

³⁷ For more information about ACOs' use of technology, see OIG, *Use of Health Information Technology to Support Care Coordination Through ACOs*, OEI-01-16-00180, May 2019.

According to one of these ACOs, this method helps the ACO improve coordination of care among its primary care physicians and specialists.

Despite this progress, some ACOs continue to note challenges with having multiple EHR systems, mainly that it is difficult to share clinical information among providers and to aggregate data for analyses and quality reporting. A few ACOs further note that certain vendors add barriers to extracting and sharing data between EHR systems and offer solutions that can be very costly to overcome. They cite examples of potential “information blocking,” which is when an entity is likely to interfere with, prevent, or materially discourage the access, use, or exchange of electronic health information.³⁸ At an ACO with 47

Challenges with sharing information:

- Lack of EHR interoperability makes it difficult to share clinical information among providers
- Potential information blocking—interfering with or discouraging the use or exchange of information
- Not all health information exchanges (HIEs) are fully functional, comprehensive, and easy to use

different systems, the ACO notes that connecting to other EHR systems is cost prohibitive. Another ACO agrees that the cost is extremely high to connect its systems and that this problem impedes patient management. A third ACO notes that the cost to export data from its systems to other systems is immense, which limits its ability to coordinate care.

Using State and regional data systems—health information exchanges—to communicate with providers outside their ACOs

Almost half of the ACOs receive information from providers that are not in their ACO through the use of the State or regional HIEs. These exchanges, which are created through State or regional public-private partnerships, are designed to help providers share patient clinical information in a timely and coordinated manner. They generally include real-time reports on hospital admissions, discharges, and transfers. ACOs can use these data to track the services their beneficiaries receive

One ACO shares HIE information through its mobile application

One ACO developed a mobile application that pulls information from the State’s HIE and sends real-time alerts on hospital admissions, discharges, and transfers to the appropriate physicians.

³⁸ For more information, see 42 U.S.C. § 300jj-52. In March 2019, the Office of the National Coordinator for Health Information Technology issued a proposed rule implementing the information-blocking statutory provision and defining related exceptions (84 Fed. Reg. 7424 (Mar. 4, 2019)). For more information on reporting complaints, see https://www.healthit.gov/sites/default/files/information_blocking_complaints_flyer.pdf.

from providers outside the ACO and coordinate care when needed. ACOs with access to comprehensive HIEs said that they appreciate having the resource; one ACO noted that it found HIE data to be critical to its operations.

In contrast, a number of ACOs are either located in States that do not have HIEs or note drawbacks to their existing HIEs. Several of the ACOs with existing HIEs explain that their State or regional HIEs are cumbersome, not fully operational, or lacked sufficient data. For example, one ACO that borders a neighboring State found that its HIE lacks data from the hospital in the neighboring State that receives most of its beneficiaries in need of hospitalization. Another ACO found that its State HIE requires beneficiaries to opt-in, making the system less useful for its purposes. As a result, this ACO partners with area hospitals and designed its own system that provides daily notifications about its beneficiaries' hospital admissions, discharges, and transfers.

CONCLUSION AND RECOMMENDATIONS

Through the Medicare Shared Savings Program, CMS is tying shared savings payments to the quality and value of the care provided. The program rewards effective and efficient providers and moves away from fee-for-service payment.

As part of the transition to value-based care, Medicare Shared Savings Program ACOs have implemented a number of strategies they found successful in reducing spending and improving quality of care. These strategies involve working with ACO physicians so they become more aware of costs, engaging beneficiaries to improve their own health, and managing beneficiaries with costly or complex care needs. Other strategies that ACOs found successful involve reducing avoidable hospitalizations and controlling costs and improving quality in skilled nursing and home healthcare. Additional strategies involve addressing behavioral health needs and social determinants of health and using technology to increase information sharing among providers.

These strategies demonstrate important steps forward in the effort to reorient the healthcare system away from a fee-for-service model toward a model that rewards providers for greater efficiency and better quality of care. These strategies are also in line with the broader goals of making providers accountable navigators of the health system and preventing disease before it occurs or progresses.

CMS recently made changes to the Shared Savings Program. As it carries out this and other ACO programs, administers other alternate payment models, and develops new ones, it should continue to support the use of these strategies and other successful strategies that emerge. These strategies may apply not only to ACOs but also to other providers committed to transforming the healthcare system toward value. To help meet this goal, we recommend that CMS do the following:

Review the impact of programmatic changes on ACOs' ability to promote value-based care

CMS should review the impact of recent programmatic changes to ensure that ACOs can continue to be successful in their movement toward value-based care.³⁹ CMS should conduct this review to determine the extent to which ACOs are participating in the program and the extent to which ACOs are reducing spending and improving quality. In addition, it should use its

³⁹ For detailed information on the changes to the Shared Saving Program, see 83 FR 67816.

review to inform its decisions when making changes to other alternative payment models and when developing new models.

Expand efforts to share information about strategies that reduce spending and improve quality among ACOs and more widely with the public

ACOs have implemented a number of strategies to reduce spending and improve quality. These strategies have focused on key areas, such as targeting costs and quality associated with physicians, hospitals, and skilled nursing and home healthcare. CMS should expand on its ongoing information sharing about strategies and lessons learned, including sharing the information in this report.⁴⁰ It should share this information with ACOs, and more widely. To the extent possible, it should make this information public so that healthcare providers may use this information to improve the cost and quality of the healthcare they provide.

Adopt outcome-based measures and better align measures across programs

As noted in the report, the use of process-based measures, rather than outcome-based measures, does not always help providers focus on improving health outcomes. ACOs also note the need to align measures across different programs. CMS has a number of initiatives and processes in place, such as the Core Quality Measures Collaborative and Meaningful Measures initiative, to ensure that measures are outcome-based where possible and to further standardize measures across different programs and models.⁴¹ CMS should continue to ensure that these efforts result in well-aligned outcome-based measures as intended, or if needed, CMS should pursue other efforts.

Assess and share information about ACOs' use of the SNF 3-day rule waiver and apply these results when making changes to the Shared Savings Program or other programs

ACOs in performance-based risk tracks of the Shared Savings Program have been able to use the SNF 3-day rule waiver for added flexibility in accessing covered care for their beneficiaries. CMS should identify and collect information about ACOs' experiences and outcomes in using this waiver and how it has affected ACO performance. This information should include, for example, the types of patients who benefit from shorter hospital stays or

⁴⁰ CMS recently shared a number of care coordination strategies used by ACOs to ensure that beneficiaries receive both high-quality and efficient care. See CMS, "Care Coordination Toolkit," March 2019. Accessed at <https://innovation.cms.gov/Files/x/aco-carecoordination-toolkit.pdf> on April 16, 2019.

⁴¹ CMS recently reduced the number of quality measures in the Shared Savings Program from 31 to 23, with the majority being outcome-based measures. See 83 Fed. Reg. 59452, 59715 (Nov. 23, 2018).

from going directly to a SNF without prior inpatient hospitalization. It should then share this information with other ACOs, providers, and stakeholders more widely. CMS should also use these results in determining whether to make changes to the Shared Savings Program. Additionally, CMS should determine whether and how to further incorporate this waiver into other alternative payment models or programs.

Identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health

A person's health outcomes can be negatively impacted by unaddressed issues related to behavioral health and social determinants of health. ACOs report challenges with addressing these issues because they are not easily identified and resolved within a medical care setting. CMS should continue to identify and gather information from CMS initiatives that encourage behavioral health integration, as well as other strategies used by providers or organizations. CMS has taken a number of steps to encourage integration of physical and behavioral health services. For example, in Medicare, CMS recently instituted new Medicare payment codes for individual providers, Federally Qualified Health Centers, and Rural Health Clinics to encourage behavioral health integration.⁴² In Medicaid, certain States are using health homes to provide these services and are including behavioral health in their quality and performance metrics for Medicaid ACOs.

CMS should also facilitate sharing of information about various strategies and resources that ACOs utilize to address social determinants of health. For example, an ACO may partner with community organizations, such as local Area Agencies on Aging, to help clinicians identify and coordinate social services for beneficiaries who need them. CMS should facilitate information sharing—through the development of case studies, tool kits, and other methods—to encourage additional ACOs to utilize successful strategies.

Identify and share information about strategies that encourage patients to share behavioral health data

CMS should promote improved access to behavioral health data for ACOs. When physicians have access to both physical and behavioral health data, they can better meet their beneficiaries' needs and improve their health outcomes. Currently, ACO providers and others only have access to data on substance use disorder treatments when they obtain written consent from

⁴² To meet the criteria for the payment codes (HCPCS codes G0502, G0503, G0504, G0507, and G0512), providers must furnish services under a behavioral health integration care approach.

their beneficiaries.⁴³ CMS should identify and share with ACOs the various approaches physicians take to discuss the need for behavioral health data with their beneficiaries.

Prioritize ACO referrals of potential fraud, waste, and abuse

As noted in the report, ACOs have the ability to uncover potential fraud, waste, and abuse by identifying patterns of unusual billing by a wide range of providers. This includes providers that participate in the ACO and those that do not. ACOs' access to claims data for their assigned beneficiaries and their ability to analyze billing patterns gives ACOs a unique perspective that can be utilized for program integrity purposes. To that end, CMS should ensure that referrals from ACOs are provided a heightened level of attention commensurate with the quality of these referrals. This could involve changes to CMS's process for receiving or reviewing referrals from ACOs or assigning these referrals a higher level of priority within its existing reporting process.⁴⁴ Additionally, when CMS suspects fraud, whether reported by ACOs or by individual providers, it should continue to refer those cases to OIG.

⁴³ HHS currently seeks public input on ways to promote information sharing for treatment and care coordination through modifications to the Health Insurance Portability and Accountability Act rules. It is considering rulemaking that would allow covered entities to share patient information on substance use or serious mental illness with family members, caregivers, and others who are in a position to avert threats of harm to health and safety. See 83 FR 64302.

⁴⁴ CMS stated that it would create a fast-track process for value-based model providers, such as ACOs, to report potential fraud. See video at <https://www.congress.gov/committees/video/house-ways-and-means/hswm00/3VJAHBWYOZQ>. Accessed on March 7, 2019.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with all of our recommendations.

In response to our first recommendation, CMS stated that it uses the performance results of the ACOs for program operations and policy planning and that it regularly reviews changes in ACO and clinician participation to help inform policy and operational changes to the program and to inform model development to promote value and reduce burden.

In response to our second recommendation, CMS stated that it will continue to update and expand the information it makes available to ACOs through its peer-to-peer learning forum. In addition, it will continue to make information about strategies publicly available as it had with its recently released ACO Care Coordination Toolkit and case studies.

In response to our third recommendation, CMS stated that as part of its annual process for measure selection, it is transitioning toward more outcome-based measures while balancing the need for important process-based measures.

In response to our fourth recommendation, CMS stated that it reviews program requirements as part of the annual reconciliation process for the program and considers whether changes should be proposed through annual rulemaking. It also provides ACOs with individual quarterly reports that include details on the use of waivers by ACOs. It also noted that it has shared information about strategies for using the SNF 3-day rule waiver as part of the ACO Care Coordination Toolkit.

In response to our fifth and sixth recommendations, CMS stated that it will continue to update and expand the information it makes available to ACOs through its peer-to-peer learning forum. CMS also noted that its recently released ACO Care Coordination Toolkit provides information about how ACOs address social determinants of health and the behavioral healthcare needs of their beneficiaries.

In response to our seventh recommendation, CMS stated that it will ensure that referrals from ACOs are provided a heightened level of attention commensurate with the quality of these referrals. It will also continue to ensure that ACO referrals are reviewed to determine whether they are actionable, and that cases of suspected fraud are referred to OIG.

We appreciate CMS's current efforts relating to the different areas covered in the recommendations. At the same time, we encourage CMS to take additional steps beyond its current efforts to address the recommendations in this report.

For the full text of CMS's comments, see Appendix B.

APPENDIX A: Detailed Methodology

We based this study on an analysis of interview data and supplemental documentation from a purposive sample of 20 high-performing ACOs. We analyzed the strategies they reported to reduce spending and improve quality.

Selection of ACOs

We selected a purposive sample of 20 high-performing ACOs. We selected ACOs that were in operation for the first 3 years of the Shared Savings Program and were still active at the time of our review. For the purposes of this report, we defined high-performing ACOs as ACOs that had both a reduction in spending relative to their benchmark and an overall quality score of 90 or above in their second, third, or fourth performance year as an ACO.⁴⁵ Although all 20 ACOs started in the Shared Savings Program, 5 transitioned to the Next Generation ACO Model at the time of our review.⁴⁶ The 20 ACOs varied by size, geographic coverage, provider composition, and risk arrangement.⁴⁷

Structured Interviews with ACO Officials

We conducted structured onsite and telephone interviews with officials from the 20 selected ACOs. The officials typically included senior-level executives, operations officers, medical directors, quality assurance officers, compliance officers, population health officers, and data analysts. We asked ACO officials about the strategies that they found successful in reducing spending and improving quality. We grouped these strategies into seven key areas. We highlighted common strategies as well as those used by individual ACOs. We conducted the interviews between late June and early October 2017.

⁴⁵ Nineteen of the ACOs met both of these criteria within a single year between 2014 and 2016. The remaining ACO reduced spending and had a quality score of 89 in 1 year. We included this ACO to ensure geographic diversity in our sample.

⁴⁶ The 20 represent ACOs in the three tracks in the Shared Savings Program that were in operation during our sampling timeframe—Track 1, Track 2, and Track 3. In addition, five of the ACOs started in the Shared Savings Program and then moved to the Next Generation ACO Model.

⁴⁷ We determined the size of the ACO based on beneficiary population, which we defined as the unique number of final-assigned beneficiaries served by each ACO in 2015. ACOs varied in the following way: ACOs ranged in size from 5,700 assigned beneficiaries to almost 150,000 assigned beneficiaries; 8 ACOs comprised only physicians; 7 ACOs had downside risk; the ACOs were regionally distributed across the country; and 2 ACOs served rural communities.

Review of Supplemental Documentation

We requested and reviewed supplemental documentation from the selected ACOs about their strategies. Examples of this documentation included articles authored by the ACO leadership and training material disseminated to physicians. We reviewed this documentation to further understand their initiatives.

APPENDIX B: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

Date: JUN 20 2019

To: Joanne Chiedi
Acting Inspector General
Office of Inspector General

From: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

A handwritten signature in blue ink that reads "Seema Verma".

Subject: Office of Inspector General Draft Report: "ACOs' Strategies for Transitioning to Value-Based Care: Lessons for the Medicare Shared Savings Program" (OEI-02-15-00451)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report on strategies that the Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) use to reduce the growth in Medicare spending and improve quality of care for patients.

The Shared Savings Program was established by Congress in order to promote accountability for patient populations, coordinate items and services under Medicare Part A and B, and encourage investment in infrastructure and redesign care processes for high quality and efficient service delivery. Currently, Shared Savings Program ACOs serve more than 10.5 million Medicare fee-for-service beneficiaries. ACOs are an important tool for moving CMS's payment systems away from paying for volume and towards paying for value and outcomes, as ACOs are held accountable for the total cost of care and quality outcomes for the assigned beneficiary patient population they serve. ACOs receive a share of any savings they generate if they meet quality performance and program participation requirements, and ACOs participating in a two-sided model must also pay CMS shared losses if spending exceeds the benchmark.

In 2018 CMS finalized "Pathways to Success," an overhaul of the Shared Savings Program. "Pathways to Success" strengthens the Shared Savings Program by promoting accountability and competition, beneficiary engagement, high-quality care, and program integrity. Having more ACOs take on real risk, while offering them the incentives and flexibility they need to coordinate care and innovate, is an important step forward in how Medicare pays for value.

Building on lessons learned from initiatives involving the Shared Savings Program and the Next Generation ACO model, and leveraging innovative approaches from Medicare Advantage and private sector risk-sharing arrangements, the Innovation Center recently announced the testing of the Direct Contracting model. This model creates opportunities for a broad range of organizations to participate with CMS in testing the next evolution of risk-sharing arrangements to produce value and high quality health care.

CMS has supported ACOs in their efforts to improve the delivery of care for their patient populations through learning systems available to ACOs. These learning systems provide ACOs with a forum in which they can collaborate and learn from one another. For example, through the learning systems, CMS hosts approximately 70 virtual events and 18 in-person events each year on topics tailored to meet the needs and interests of current ACOs.

Recognizing that each ACO has a different approach to successfully providing value-based care, CMS is developing a series of toolkits that explore different aspects of ACO operations. Through these toolkits, CMS aims to educate the general public about strategies used by ACOs to provide value-based care while also providing actionable ideas to current and prospective ACOs helping them improve or begin operations, particularly as they consider a shift to a two-sided risk model. The first in the series of planned toolkits was released in March 2019.¹ CMS concurrently released seven case studies to describe innovative initiatives from ACOs on a variety of topics including engaging beneficiaries, coordinating care in rural settings, and promoting health literacy. Each case study includes detailed results and lessons learned.²

CMS remains diligent in its efforts to enhance quality of care, improve patient outcomes and safeguard Medicare funds and will continue to work with OIG as we make improvements to our ACO initiatives.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

CMS should review the impact of programmatic changes on ACOs' ability to promote value-based care.

CMS Response

CMS concurs with this recommendation. CMS reviews program requirements as part of the annual reconciliation process for the Shared Savings Program and considers whether changes should be implemented through rulemaking. CMS reconciles ACOs' financial and quality performance annually to determine shared savings and shared losses. The process provides insight into how ACOs are performing with regard to financial and quality results. The results are released to ACOs individually and publically available on the data.cms.gov website. ACOs are required to publicly report their results as well. The results are used internally for program operations and policy planning as well as externally by researchers and other industry stakeholders. CMS also regularly reviews changes in ACO and clinician participation to help inform policy and operational changes to the Shared Savings Program and inform Innovation Center model development to promote value and reduce burden.

OIG Recommendation

CMS should expand efforts to share information about strategies that reduce spending and improve quality among ACOs and more widely with the public.

¹ <https://innovation.cms.gov/Files/x/aco-carecoordination-toolkit.pdf>

² <https://innovation.cms.gov/initiatives/ACO/>

CMS Response

CMS concurs with this recommendation. CMS will continue to update and expand information in the ACO learning systems, which provide ACOs with a peer-to-peer learning forum in which they can collaborate with and learn from one another. In addition, CMS will continue to make information about strategies used by ACOs publicly available, including those that have reduced growth in spending and improved quality, as CMS has done already through releasing the ACO Care Coordination Toolkit and case studies.

OIG Recommendation

CMS should adopt outcome-based measures and better align measures across programs.

CMS Response

CMS concurs with this recommendation. As OIG noted, CMS has a number of initiatives and processes in place, such as the Core Quality Measures Collaborative and the Meaningful Measures Initiative, to ensure that measures are outcome-based where possible and to further standardize measures across different programs and payers. In determining the focus of future measure development, and as part of its annual process for measure selection, CMS is transitioning toward more outcome-based measures while balancing the need for important process based measures focused on improving patient care and quality, such as preventive screening measures for cancer screening and immunizations. Recently, CMS reduced the Shared Savings Program ACO quality measure set by eight measures in an effort to streamline the measure set, encourage better outcomes, and further promote interoperability.

OIG Recommendation

CMS should assess and share information about ACOs' use of the 3-day waiver and apply these results when making changes to the Shared Savings Program or other programs.

CMS Response

CMS concurs with this recommendation. CMS reviews program requirements as part of the annual reconciliation process for the Shared Savings Program and considers whether changes should be proposed through annual rulemaking. In recent rulemaking, CMS overhauled the Shared Savings Program, including extending the availability of the Skilled Nursing Facility 3-day rule waiver to additional ACOs participating in two-sided risk tracks by allowing ACOs with either prospective assignment or preliminary prospective assignment with retrospective reconciliation to access waivers. CMS provides Shared Savings Program ACOs with individual quarterly reports that provide utilization and expenditure data including details on the use of waivers by ACOs. CMS also educates Shared Savings Program ACOs on the use of quarterly program data in predicting their financial performance. Separately, the Innovation Center conducts regular evaluations of the ACO models that are tested under its authority and applies lessons learned in these models when developing new ACO models and refining the financial methodology of existing models. CMS has also shared information about strategies for using Skilled Nursing Facility 3-day waivers as part of the ACO Care Coordination Toolkit.

OIG Recommendation

CMS should identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health.

CMS Response

CMS concurs with this recommendation. CMS will continue to update and expand information in the ACO learning systems, which provide ACOs with a peer-to-peer learning forum in which they can collaborate with and learn from one another. In addition, CMS will continue to make information about strategies used by ACOs publicly available, including those that have reduced growth in spending and improved quality, as CMS has done already through releasing the ACO Care Coordination Toolkit and case studies. The Toolkit specifically explains how ACOs support and coordinate care for beneficiaries who have conditions affected by social determinants of health, among other areas.

OIG Recommendation

CMS should identify and share information about strategies that encourage patients to share behavioral health data.

CMS Response

CMS concurs with this recommendation. CMS will continue to update and expand information in the ACO learning systems, which provide ACOs with a peer-to-peer learning forum in which they can collaborate with and learn from one another. In addition, CMS will continue to make information about strategies used by ACOs publicly available including those that have reduced growth in spending and improve quality, as CMS has done already through releasing the ACO Care Coordination Toolkit and case studies. This information includes strategies related to behavioral health care.

OIG Recommendation

CMS should prioritize ACO referrals of potential fraud, waste, and abuse.

CMS Response

CMS concurs with this recommendation. CMS is committed to ensuring program integrity through expeditious review and prioritization of referrals of potential fraud, waste, and abuse from all sources, including ACOs. CMS will ensure that referrals from ACOs are provided a heightened level of attention commensurate with the quality of these referrals. Criteria for review will continue to include factors such as the degree for potential fraud and potential harm to beneficiaries. When an ACO, ACO participant, or ACO provider/supplier identifies and reports aberrant billing patterns or suspected fraud, the Shared Savings Program staff refers such activity to CMS's Center for Program Integrity (CPI). CMS will continue to ensure that ACO referrals of suspected fraud, waste, and abuse, like all referrals, are reviewed to determine whether the referral is actionable. In addition, CMS will continue to refer cases of suspected fraud to OIG.

ACKNOWLEDGMENTS

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This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, Nancy Harrison, Deputy Regional Inspector General, and Meridith Seife, Deputy Regional Inspector General.

For more information about this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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