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GUIDE:

ACO & DCE BUILDING

Key Considerations on your Journey to Value-Based Care

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Introduction

The deadline to apply for the 2023 CMS Direct Contracting Program is drawing near. For those still deciding if they want to create an ACO or DCE, there are a plethora of factors to consider. Luckily, you have an opportunity to learn from those who have come before you. Trella Health, the leader in provider performance insights and analytics, recently interviewed nearly 50 ACO leaders to find out what matters to them.

This guide contains a brief overview of what we discovered for ACOs, DCEs, and other models and a glimpse at the future of value-based payment models and the post-acute care industry.

Who is this guide for?

This guide is for anyone considering building a value-based care or risk-sharing payment group like Accountable Care Organizations (ACOs) or Direct Contracting Entities (DCEs). As Medicare aims to move away from fee-for-service (FFS) payment models, value-based organizations will have opportunities for greater reimbursements. However, it's imperative that you ensure better patient outcomes with lower total costs to take advantage of these opportunities and avoid financial penalties.

With the right data, you will be able to determine your organization's strengths and where you might have room for improvement. Tracking certain market metrics can be essential to success in value-based care, as payment is dependent on performance. Organizations that make improvements will be rewarded, while organizations that fall behind will be penalized. Understanding the metrics and benchmarks is the only way to ensure your success in any value-based care model.

ACO Market Research Findings

From interviews with nearly 50 ACO leaders, we found that, across the board, value-based care organizations were unsurprisingly focused on network performance and maturation. Most ACOs tend to put more emphasis on recruiting primary care physicians (PCPs) to join their networks. While PCPs are the cornerstone of high-performing risk-sharing entities, they only make up one part of the care continuum. In fact, understanding the impact of post-acute care (PAC) on patient outcomes and costs lays the groundwork for effectively managing your network. Identifying and partnering with the best SNFs, home health agencies, and hospice providers for your population(s) can position your organization to thrive under current and emerging value-based payment models.

The point of value-based care is to reduce cost and improve outcomes by providing patients with the right care at the right time in the right setting. Until recently, a lot of organizations participating in risk-sharing models took a quantity-over-quality approach to this problem, partnering with every provider they could within their area.

As they've matured, though, organizations have discovered that they need a more curated network of strong, aligned partner providers. For hospitals and health systems, that means the need for access to key metrics for post-acute care partners. What are your partners' readmission rates? Which populations do they serve? How do their patient outcomes compare with other providers in your area?

Top Priorities

Among other key metrics to consider when analyzing their own performance or partnering with post-acute care providers, these stood out as top priorities for the ACO leaders we interviewed:

- Controlling total cost of care
- Managing provider performance and quality
- Monitoring ACO targets and contractual requirements
- Developing a preferred provider network
- Improving patient outcomes
- Recruiting high-value physicians

Of these metrics, **70%** of respondents rated controlling total cost of care among their top three priorities, and **70%** listed managing PCP performance and quality as well.

Only 30% listed improving patient outcomes in their top three, and only 10% listed recruiting high-value physicians.

However, we found that these numbers don't reflect a lack of importance. Rather, they reflect where ACOs are in their network maturation and a natural order of focus for newer risk-bearing entities. While developing a preferred provider network is important, it may come later in the network-building process than managing provider performance and quality.

Other key metrics listed as top priorities for ACO leaders included:

- Risk adjustment and high-risk coding
- Patient engagement
- Clinical team education
- Chronic care management
- Post-acute care
- SNF utilization
- Adequately using analytics tools.

Understanding the Metrics

So, what are these top-priority metrics, and what does their measurement mean for your organization? How can you determine what success looks like under value-based care, and how can you identify patterns that indicate good outcomes or poor performance?

A successful value-based care contract is only as strong as the network that delivers the care. Aligning yourself with the profile of providers that best meets your business strategy is critical to the success – or failure – of your ACO or DCE. But don't forget that not all risk-bearing entities find success from the same strategies – your network should be just as unique as the patients you treat.

Three key metrics to evaluate when building out your network's roster are:

Cost

Risk Score

Outcomes

Cost

Cost is, of course, one of the most significant metrics for any risk-sharing entity. From our findings, though, it's important for ACOs to not only understand their own cost metrics but also those of their competitors. Can you look across the entire market and see where ACOs differ, and where the benchmarks are for cost reduction?

With risk-sharing models, CMS measures ACOs based on their ability to meet their agreed-upon benchmarks and their historical performance. Success may look different from year to year, and models may vary. They all have one thing in common, though. Under any value-based or risk-sharing payment model, you will always need access to the latest, most accurate analyses of cost and other metrics.

Risk Score

A patient's risk score is a measurement of their disease severity or acuity. The higher the index score, the more likely the patient will cost more to treat – thus making them a higher risk to take on. Risk scores can be calculated for patient populations and used to identify patients that will more likely need to utilize health care services. For example, you might use the HCC score to identify the level of risk perspective PCPs have in their population and use that to measure the impact of adding them to your contracted network of providers.

Understanding your patient population's risk score for providers you are working with or considering adding to your network can help steer you toward partnerships that will improve outcomes – such as partnerships with SNFs, home health agencies, and hospices for patients in need of ongoing care or palliative care.

Outcomes

As an umbrella metric, patient outcomes can feel daunting. How do you measure outcomes for patients with chronic diseases or patients in hospice care? Delivering high-value outcomes is a combination of the right services, at the right time, in the right setting, at the right cost. It's a difficult balance to strike, which is why it's crucial to track your outcomes to effectively drive your business toward your goals.

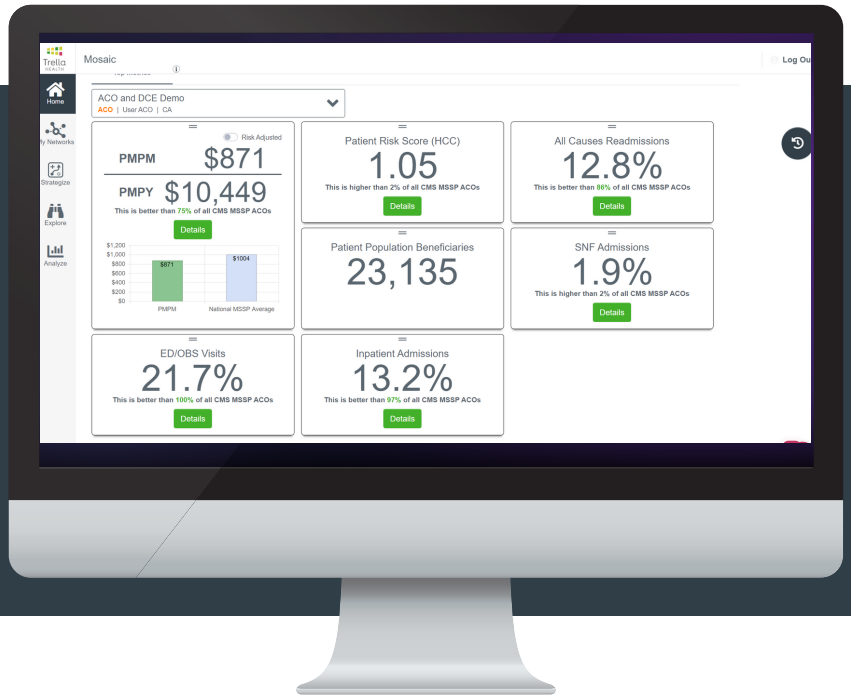
For your overall patient outcomes, ask yourself these questions:

- Did they get the right care at the right time?
  - Early intervention can reduce avoidable readmissions or hospitalizations – both of which increase overall costs.
- Was the PAC provider successful in treating the patient?
  - Did they coordinate a treatment plan that helped the patient meet necessary milestones in a way that lead to shorter treatment periods or fewer relapses?
- Did overall costs remain reasonable for the care that was provided?
  - Comparing PAC providers' total cost of care to averages in their state or market can give a good indication of the level of care they provide – and if they'd make a good addition to your roster.

The more data points you have, and the more accurately you can track patient outcomes and outcomes for entire patient populations, the more you can drill down on where your organization excels and where you may need to strengthen your network.

Putting it all Together

To improve these metrics, organizations must control costs, limit leakage, and build strong partnerships. And, while we can measure these metrics separately, they all work together. Prescribing generic medications could help control costs, but so can coordinating a patient's care from hospital discharge to skilled nursing and home health services. Determining what care a patient needs at what time and where they should receive that care is critical. And, if you build a network of skilled nursing, home health, and hospice providers, you'll have the ability to plan for patients' care and make the referrals that will keep patients in your network, drive down their healthcare costs, and improve their outcomes.



Want to see these insights in action? **Request your personalized demo of Mosaic** from Trella Health - made specifically for ACOs, DCEs, and health systems looking to build, analyze, and optimize their value-based care networks.

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Tools for Building a High-Performing Network

Now that we've explored what metrics other ACOs are focused on as they build out their networks, how do you build a tech stack that helps you start off on the right foot?

There are a variety of tools available for success under value-based care and risk-sharing payment models – but which ones are right for you?

Along with these tools, others included:

- **84.6% of organizations use some form of data analytics solution**
- **82.1% use a population health platform**
- **61.5% use an information exchange**
- **59% use a care coordination solution**
- **56.4% use a claims clearinghouse**

ACOs are using these tools and platforms to measure a range of metrics. Some overlap one another, and many don't work well together, creating gaps and redundant workflows. We asked respondents which of the following sources they would like to be integrated into an analytics tool:

- **CCLF data from CMS – 100%**
- **Medicare Part C – 90%**
- **All CMS provider data (part A and Part B)– 80%**
- **Medicare Part D – 80%**
- **SNF Minimum Data Set – 60%**
- **Medicaid – 40%**
- **Home Health OASIS data – 30%**

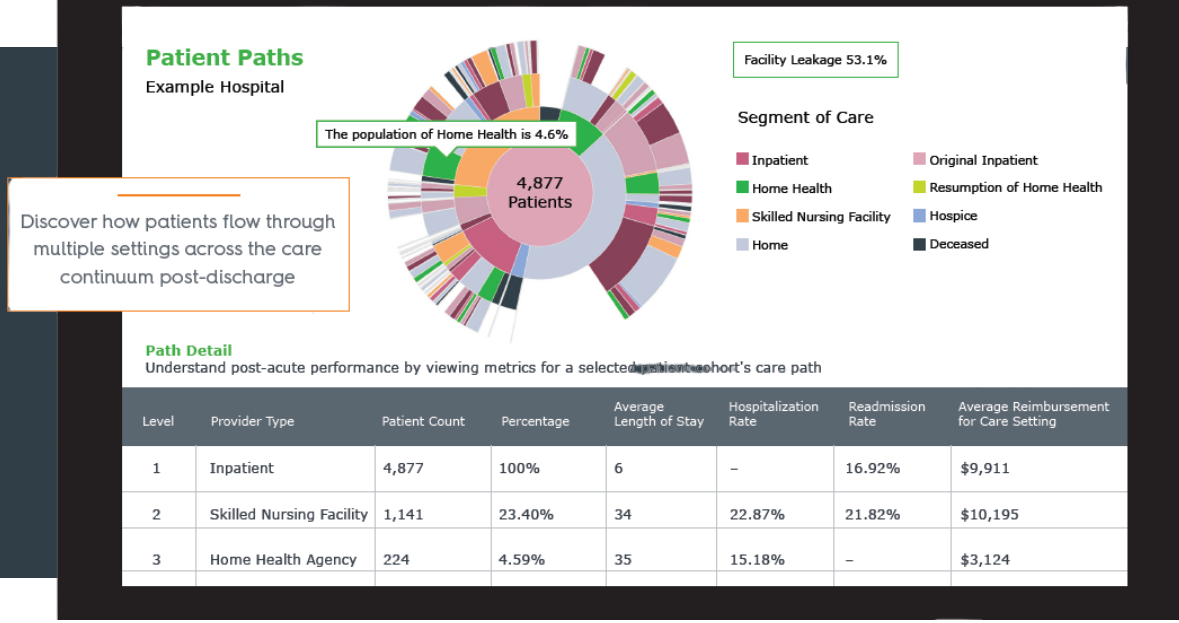
Access to multiple sets of data across the entire acute and post-acute care market has become critical to success. This is especially true of health systems and organizations serving multiple, varied populations. As they gain success in one population, they need the tools and analytics to duplicate that success with their other populations – whether we're talking about post-acute care patients, skilled nursing facility residents, Medicare FFS beneficiaries, or any number of other populations and payer mixes across a health system or organization.

Access the Data You Need - Mosaic from Trella Health

Trella Health offers a clear view of the data and insights you need to ensure that your organization is performing to the standards you need to succeed. Not only that, but with access to key metrics from all of Medicare Parts A, B, and C (Medicare Advantage), you can benchmark your performance against competitors, and you can vet potential partner organizations to build a stronger network.

All risk-sharing and value-based care programs have one thing in common: They depend on the ability to track and measure key performance metrics. With Trella, you have the tools you need to build strong partnerships and make informed decisions for your organization.

Find out how you can analyze risk and build out your network of high-performing physicians and post-acute care organizations today! **Request your personalized demo of Mosaic** from Trella Health.



Level	Provider Type	Patient Count	Percentage	Average Length of Stay	Hospitalization Rate	Readmission Rate	Average Reimbursement for Care Setting
1	Inpatient	4,877	100%	6	–	16.92%	$9,911
2	Skilled Nursing Facility	1,141	23.40%	34	22.87%	21.82%	$10,195
3	Home Health Agency	224	4.59%	35	15.18%	–	$3,124

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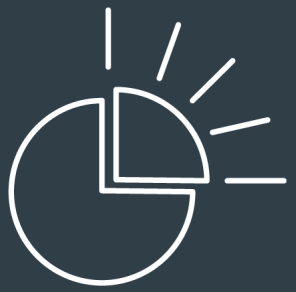
A note about the data

The leader in provider performance insights and analytics, Trella Health has access to all Medicare Parts A and B data providing a FULL market view of the FFS data. Because Part A data includes inpatient stay information and Part B data includes other services and post-acute care, you are getting a clearer picture into patient flows and physician referral behaviors throughout the continuum of care. In this guide, we reference Medicare FFS data and data that we gathered from interviews with nearly 50 ACO leaders with a range of payer mixes – all of which had some FFS aspect to their payer mix.

Some respondents were executive directors or CEOs of organizations that comprised multiple ACOs. Others were performance leaders in roles such as vice president of network management or operations.

In addition to interviewing ACO leaders representing a range of payer mixes, we reached out to ACOs with a range of assigned beneficiaries, as well – with ranges from 10,000 to 100,000. With this breadth of respondents, we're confident that we reached a broad cross-section of ACOs for information that can be generalized for most ACOs and other organizations participating in value-based care programs.



To learn more about insights derived from 100% of Medicare Part A and B and Medicare Advantage data - only available from Trella Health - visit us online at www.trellahealth.com.