



Provider Engagement Toolkit

Introduction

Numerous Medicare accountable care organizations (ACOs) have achieved shared savings since 2012 by using various strategies to improve population health and quality while reducing costs. Recognizing that each ACO is unique and therefore has a different approach to providing value-based care, the Centers for Medicare & Medicaid Services (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 some ACOs to deliver value-based care while also providing actionable ideas to current and prospective ACOs to help them improve or begin operations, particularly as they consider a shift to a two-sided risk model.

This toolkit presents an array of innovative strategies that Medicare ACOs use to help primary care and specialty providers in the ambulatory setting to improve health care quality and patient outcomes. ACOs approach the engagement of these health care providers from multiple organizational levels. At the administrative level, many ACOs develop driver diagrams and other tools to convey strategies and care improvement initiatives to providers and staff. At the practice level, ACOs create and distribute data reports to providers that capture provider performance on key measures and draw attention to improvement opportunities. Many ACOs also offer hands-on guidance and coaching for providers to act on the data reports and improve the efficiency and effectiveness of care delivery. In addition, ACOs motivate providers to improve care by offering them financial rewards for helping the ACO to achieve its cost and quality goals.

Overview of the CMS ACO Learning System and Toolkit

Since 2012, CMS has supported ACOs in their efforts to improve the delivery of care for their attributed patient populations through learning systems for each Medicare ACO initiative. These learning systems provide ACOs with a forum in which they can collaborate with and learn from one another. Across these learning systems, CMS hosts approximately 70 virtual events and 18 in-person events each year on topics tailored to the needs and interests of current ACOs.

This provider engagement toolkit describes a variety of strategies used by ACOs to engage providers in the ACO and in quality improvement activities. ACOs encourage providers to see the organization as a trusted partner in improving care delivery by fostering transparent communication about ACO goals and strategies, offering providers customized support and resources, and incentivizing high-level performance improvements through shared savings distributions.

This is the third toolkit in a broader series of resources that will explore different aspects of how ACOs operate to provide value-based care. The toolkits bring together insights gathered during CMS-sponsored learning system events and through focus groups with the ACOs. 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 to help them improve or begin operations.

Regardless of which strategies ACOs choose to implement, incorporating providers' perspectives into operations and care delivery is important to meeting their quality and financial goals. In exploring the development and implementation of the ACOs' provider engagement strategies, this toolkit looks at how ACOs:

- [Communicate with providers about the ACO as a value-based care organization](#)
- [Use data to identify and address opportunities for improving care](#)
- [Offer customized support to primary care providers \(PCPs\) and specialists](#)
- [Implement financial incentives](#)

To produce this toolkit, the CMS ACO learning system conducted focus groups and individual interviews with representatives from 22 ACOs that participate in the Medicare Shared Savings Program and in the Next Generation ACO Model. The learning system offered ACOs that had shared effective provider engagement strategies during past learning system events an opportunity to participate; it also extended an open invitation to ACOs with innovative provider engagement initiatives via newsletters for each Medicare ACO initiative.¹ During each focus group, the participants described strategies for engaging providers in the ACO and in quality improvement activities. For a list of the ACOs that contributed strategies to this toolkit, please see page 17.

While many of the ACOs who contributed to this toolkit focused on strategies that yielded positive results, some ACOs candidly discussed programs that were less successful than expected or for which results were not yet available. This toolkit includes lessons learned from ACOs' attempted interventions along with snapshots that offer current and prospective ACOs a more complete picture of available options and possible implementation challenges.

¹ When considering which ACOs to include in the focus groups, we did not limit invitations strictly to ACOs that had consistently achieved shared savings. Doing so could have inadvertently excluded ACOs that were starting out in new, higher-risk programs or who were investing in infrastructure, creating situations in which they accepted short-term losses to position themselves for longer-term financial and quality successes.

Disclaimer: This document discusses strategies that some Medicare ACOs have used and is being provided for informational purposes only. CMS employees, agents, and staff make no representation, warranty, or guarantee regarding these strategies and will bear no responsibility or liability for the results or consequences of their use. If an ACO wishes to implement any of the strategies discussed in this document, it should consult with legal counsel to ensure that such strategies will be implemented in a manner that will comply with the requirements of the applicable Medicare ACO initiative in which it participates and all other relevant federal and state laws and regulations, including the federal fraud and abuse laws. This toolkit was financed at U.S. taxpayer expense and will be posted on the CMS website.

Communicating With Providers About the ACO as a Value-Based Care Organization

Communicating with, and educating providers about, the ACO as a value-based care model can reduce the potential for confusion and promote provider engagement in care improvement strategies. When reflecting on their years of experience in engaging providers, ACOs note the importance of clearly describing their operations, goals, and strategies, and explaining how participating providers can support these strategies, both prior to and after organization launch. These conversations build on requirements for ACOs to articulate expectations through agreements, such as those signed between a Medicare Shared Savings Program ACO and its participating providers. Providers also appreciate information about the additional care coordination activities and access to benefit enhancements that may be available to enhance the delivery of care. This section describes ACOs' multifaceted approaches to communicate with providers, which may be useful for organizations that participate in multiple alternative payment models. These include clearly conveying ACO goals to promote provider buy-in, offering resources to educate providers about shifting from an entirely fee-for-service (FFS) environment to value-based care, and eliciting provider input and feedback to inform decisions about ACO operations.

ACOS' APPROACHES TO CONVEYING GOALS AND STRATEGIES

Providers who are accustomed to FFS payment may be unfamiliar with risk-based payment methodologies and population health strategies that are designed to better meet the health care needs of their diverse patient populations. ACOs have therefore developed strategies for introducing the concepts and vocabulary of the ACO, addressing potential confusion about ACO goals and strategies, and providing a mechanism for promoting organizational transparency. Based on their experience in implementing these strategies, ACOs note the following best practices for communicating with and educating providers.

Leveraging leadership to promote culture change.

ACO administrators engage provider leadership throughout the organization to promote culture change and to encourage participating providers to buy into ACO goals and strategies. ACOs' focus on changing the culture emphasizes promoting new behaviors that are both related to population health and required for navigating the transition to value-based care, including coordinating care, engaging beneficiaries, and making community-based supports available to address the social determinants of health. In order to encourage this change, many ACOs meet one-on-one with leaders of primary care and specialty practices to establish a relationship and create open lines of communication. As a result, these providers are well positioned to share their insight into the ACO with their practice staff who, in turn, facilitate changes in operations and in the delivery of care.



We didn't really talk [directly] about . . . culture change, because that was an overwhelming notion. We attacked this on a step-by-step basis . . . to educate [providers on] what it means to move from fee-for-service to value.



—ACO administrator

When engaging practice leadership, ACO administrators focus on the value of the ACO for both beneficiaries and providers. For example, ACOs describe improvements in both care coordination and access to benefit enhancements that augment the beneficiary care experience and outcomes.² In addition, ACOs point to the availability of quality improvement coaching for providers (see page 10

² Examples of benefit enhancements offered by eligible Medicare ACOs include the waiver of the three-day inpatient requirement for coverage of skilled nursing facility (SNF) care (also known as the 3-Day Rule Waiver) and the Post-Discharge Home Visits. For more information about these two benefit enhancements, see the following documents:

Centers for Medicare and Medicaid Services (CMS). "Notice of Intent to Apply: July 1, 2019 or January 1, 2020 Start Date for the Medicare Shared Savings Program, SNF 3-Day Rule Waiver, and Beneficiary Incentive Program. Guidance Document." Version #5, April 2019. Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/SSP-NOI-Memo.pdf>. Accessed March 23, 2020.

CMS. "Next Generation ACO Home Visits Benefit Enhancements: Frequently Asked Questions." April 2019. Available at <https://innovation.cms.gov/Files/x/nextgenaco-pd-caregmt-homevisit-waivers.pdf>. Accessed March 23, 2020.

for more information about coaching strategies). They may also point to a lighter burden associated with the Merit-based Incentive Payment System (or MIPS) because the ACO submits performance data to CMS on behalf of providers.³ ACO administrators also emphasize the role of the ACO as a trusted partner that provides information about the initiative, including payment methodology and quality measures.

Using visual tools to clarify the organization's strategy. ACOs bring together internal stakeholders who have administrative, clinical, and information technology skills in order to support the development of visual tools. These tools aim to clarify and convey ACO strategies and action steps for practice leadership, individual providers, and frontline staff. One common tool is the driver diagram, which shows the relationship between the overall goals of the ACO, the primary and secondary drivers that move the ACO closer to these goals, the action steps associated with these drivers, and the metrics for assessing success in completing the action steps.⁴ ACOs often consider these diagrams to be living documents, refining the drivers and redefining metrics and goals before the start of each performance year as new improvement opportunities and lessons learned emerge.

Many ACOs rely on the concepts captured in their driver diagrams to guide their descriptions of the ACO in the early days of organization launch or when bringing new participating providers on board. ACOs also encourage practices to develop their own driver diagrams to promote change at a local level and to articulate their goals and strategies to all their providers and staff.

“Those driver diagrams point to . . . our overall objectives and strategic goals as an organization, so it's aligning the work from the strategic standpoint and also from what is needed under our value-based contracts.”

—ACO administrator

Staying on message. ACOs ensure that they use the same concepts and vocabulary to describe the organization to all providers and their staff. This approach creates,

among other advantages, a mechanism for promoting transparency in organizational decision making. To that end, ACOs develop talking points for administrative staff to communicate the message to providers and their staff to increase their awareness and motivate their adoption of ACO strategies. ACOs may also use these talking points to motivate ongoing participation in the ACO by communicating the benefits available to providers as a result of their participation. The talking points describe the ACO as a collaborator and a resource in the effort to improve the delivery of care and beneficiary outcomes.

By involving ACO leadership in the development of the message, an ACO ensures that the information communicated to providers is consistent and that it aligns with the organization's goals and priorities. ACOs include the following key themes in both oral and written messaging:

- To give participating providers more targeted support, encourage a discussion about the confusion or challenges that they have encountered;
- Note how the providers' participation in a value-based organization helps the ACO to achieve cost and quality goals, and results in incentive payments; and
- Connect the providers' motivation for participating in an ACO to the organization's goals and strategies.

COMMUNICATING ABOUT THE SHIFT TO VALUE-BASED CARE

How an ACO communicates with its providers is an important component of shifting to value-based care. Different providers, however, prefer to receive information in different ways. To accommodate these individual preferences, ACOs use multiple forms of communication when they engage providers in value-based care operations and when they describe their approaches to improving the delivery of care. These include written electronic communications, podcasts and online trainings, and interactive meetings.

Leveraging written electronic communications.

Most ACOs use direct, electronic communication methods as a low-cost means to deliver information to providers and their staff throughout the organization. Examples include web-based portals and emailed newsletters. ACOs use these

³ Eligible clinicians participating in an ACO that is participating in a model or payment track that is an Advanced Alternative Payment Model (APM) may also qualify as a Qualifying APM Participant (QP) and be exempt from the requirement to report under MIPS, in addition to receiving an APM incentive payment.

⁴ For more information, see the Agency for Healthcare Research and Quality (AHRQ) "EvidenceNOW Key Driver Diagram." Available at: <https://www.ahrq.gov/evidence-now/tools/keydrivers/index.html>. Accessed March 13, 2020.

mechanisms to distribute new and important information about organizational strategies, model or program policy, and incentives available to participating providers. The information may also include tips to both improve the quality of care and succeed in a value-based payment environment, such as how to address a new pneumococcal vaccine requirement or how to use tools to administer depression screenings.

ACOs deliver these communications at regular intervals—such as weekly, monthly, or quarterly. However, ACOs note that information delivered too frequently can overwhelm providers, which discourages them from engaging in the ACO. One ACO determined the frequency of its communications by fielding a survey to providers and found that they prefer a monthly, rather than a biweekly schedule. Some ACOs archive newsletters and other email-based communications in an ACO portal to promptly and easily address providers' questions.

Incorporating technology. ACOs also use various technologies to communicate new and important information about the organization, review key concepts and vocabulary related to value-based care, and educate providers about actionable strategies for supporting the shift to value-based care. To increase access for providers and their staff who are spread across a large geographic region, ACOs house these resources on portals or on public platforms (such as their websites).

Podcasts are available on demand for providers and staff with busy schedules. One ACO launched a monthly podcast series hosted by two participating physicians to discuss developments in ACO operations and to raise awareness of ACO priorities. The podcast also delves into recent performance on key quality and utilization metrics and covers tips for improving outcomes.

Online training modules or other orientation resources help to streamline the onboarding process for providers new to the ACO or to participating in a value-based payment environment. These modules include an overview of the concepts and vocabulary related to value-based care, descriptions of the ACO's goals and strategies, and examples of steps that providers can adopt to improve the delivery of care (such as related to annual wellness visits or beneficiaries' self-management of chronic conditions). Some ACOs expand the training modules to also engage providers who are experienced participants in the ACO. For example, online trainings for experienced providers might describe recent changes in model or program policy or highlight best practices related to clinical documentation and diagnostic coding.

Conducting interactive meetings. ACO administrators often meet with providers to discuss goals and priorities, answer questions in real time, and build a sense of community. ACOs may encourage all participating providers to attend the meetings, or they can focus on providers that care for a large number of attributed beneficiaries. ACOs hold these meetings regularly—such as monthly, quarterly, or annually—to ensure that providers have up-to-date information about ACO strategies. Some ACOs track meeting attendance to determine whether a particular provider is eligible for incentive payments for a given year (see page 15 for more information on additional metrics included in the calculation of shared savings distributions).

Many ACOs allocate time during these meetings to discuss recent performance on quality and utilization metrics, and progress toward reaching annual goals. Some ACOs do this by inviting speakers, such as an external expert to describe an innovative program to help providers achieve quality and utilization goals. ACOs also encourage discussion of new processes that support improvements in the delivery of care and strategies for increasing the likelihood that providers will receive shared savings. For example, one ACO used meetings about performance to share a checklist of steps through which providers can deliver effective care in a value-based care environment; the steps can include completing an annual wellness visit or having goals-of-care conversations with patients when appropriate.

Hosting informal gatherings. ACOs host informal gatherings to build a sense of community among participating providers and to encourage collaboration. These events, such as happy hours or breakfast gatherings, enable providers to socialize with one another and learn about their peers' experience in the ACO. These gatherings can also provide an opportunity for providers to share challenges or best practices and to continue to form connections with their peers in the same geographic area.

ELICITING PROVIDER INPUT AND FEEDBACK

To elicit input from providers on the organization's priorities and operations, ACOs often identify a lead point of contact from among their participating providers to facilitate peer-to-peer communications with practices and staff. These points of contact are uniquely positioned to engage with, inform, and elicit feedback from peer providers and practice staff. ACOs often select multiple individuals to play this role—known as a liaison, champion, or ambassador—depending on the size of the ACO, the geographic dispersion of providers and staff, and the

ACO Snapshot 1: Identifying Physician Liaisons to Promote Provider Engagement

Objective: Convey information about the ACO to providers and their staff in order to succeed in a value-based care environment.

Tactic: Identify providers to serve as physician liaisons who communicate ACO goals and strategies to participating providers and their staff and bring provider feedback to ACO leadership.

Strategy: One Shared Savings Program ACO established a physician liaison program to convey information about ACO operations and strategy to providers and their staff, as well as elicit provider feedback about the ACO. Through an application process, the ACO solicited interest in the program from participating providers, noting that liaisons receive compensation for their time. The criteria for selecting the four physician liaisons included active involvement in the ACO, early adoption of population health strategies, and a schedule that allowed enough flexibility for meetings with the ACO's participating providers. The ACO selected liaisons with a diverse set of perspectives—such as practice- and hospital-based, as well as primary care and specialty physicians—who could build strong relationships with peers and leverage their insight to identify solutions to challenges facing the ACO's providers.



To launch the liaison program, ACO administrators provided the four physicians with in-depth background on the organization, including an overview of its operations, policy, and support available for participating providers to improve the delivery of care. The liaisons then traveled to primary care practices to speak with providers and their staff about the ACO and their expected contributions as participants. In these meetings, the liaisons answered PCPs' questions, addressed their concerns, and collected feedback to be incorporated into the ACOs' decision making. ACO administrators and the governing board rely on the insight from the liaisons to better understand the providers' perspective.

Physician liaisons meet with provider practices at least quarterly. In the future, the ACO plans to use the liaisons' insight into the PCPs' perspective to expand the liaison program to specialists, to increase the frequency of the liaisons' touchpoints with PCPs, and to incorporate findings from relevant data analyses and reports into the conversations to more fully engage providers in strategies for meeting quality and utilization targets.

provider composition (e.g., PCPs versus specialists, private practice versus academic medical center). ACOs may select liaisons through an application process or identify them by asking providers to elect their liaison. Liaisons meet with providers and practice staff by phone or in person, and they describe changes in ACO operations or strategy, answer questions, and bring the providers' concerns and other feedback to ACO administrators. ACOs note that the liaisons' one-on-one conversations with providers and practice staff allow for candid conversations (see ACO Snapshot 1 above for more information).

Another approach to eliciting provider feedback and insight involves identifying provider representatives to serve on the ACO's governance structures, such as committees or physician advisory councils. CMS requires that ACOs offer providers with opportunities to meaningfully participate in

governance to ensure provider control of operational decision making, such as through serving on ACO governing bodies. In addition, ACOs may find value in establishing physician advisory councils as further means of offering providers with an opportunity to meaningfully participate in governance. These committees and councils meet regularly—such as monthly or quarterly. Their purpose is to (1) ensure that ACO leaders have timely insight into the provider perspective, which informs organization-wide decisions; and to (2) empower the provider representatives to advance the organization's high-level priorities at a local or practice level. These representatives and the ACO leaders discuss how initiatives directly affect providers and the delivery of care. The representatives also raise providers' concerns and points of confusion, which enables the ACO to develop appropriate guidance documents and to support the liaisons' one-on-one conversations with providers.

Strategies for Communicating With Providers About the ACO as a Value-Based Care Organization

- Convey ACO goals by engaging provider leadership in the effort to promote culture change, developing visual tools such as driver diagrams to describe ACO objectives and strategies, and ensuring consistency in messaging for all types of communications.
- Use multiple forms of communication to describe the ACO and to support providers in the shift from full FFS to value-based care, including written electronic resources, podcasts and online trainings, and meetings.
- Elicit input and feedback by identifying liaisons to lead peer-to-peer communication among providers and their staff, and by inviting provider representatives to join ACO governing committees.

Using Data to Identify and Address Opportunities for Improving Care

ACOs enable PCPs, specialists, and their staff to use data to improve patients' outcomes without increasing the burden of delivering care. To engage practices and individual providers in opportunities to improve quality and efficiency, ACOs produce data feedback reports that highlight the practices' and individual providers' performance on key measures. The reports use data on the quality of care already collected by practices for submission to CMS⁵, as well clinical data and claims extracts. The reports may also provide comparison data for peers in the practice, group, or region. ACOs are committed to delivering reports in which the analyses are timely and actionable, including insights that anticipate potential concern and skepticism from individual providers about the accuracy of the underlying data sources. Many ACOs supplement these feedback reports with action-oriented data reports on the gaps in beneficiaries' care, which help providers and their staff deliver targeted interventions to beneficiaries with specific health needs or unmanaged chronic conditions.

DEVELOPING AND DELIVERING PROVIDER-LEVEL FEEDBACK REPORTS

Many ACOs develop data feedback reports that capture each individual provider's performance on quality, utilization, and cost measures. In doing so, ACOs not only help PCPs and specialists to better understand their care delivery patterns but also draw attention to potential improvement opportunities. These reports, commonly called "dashboards" or "scorecards," typically include CMS-prescribed and/or ACO-developed measures that align with the ACO's priorities. Examples of these measures include the total cost of care, the hospital admission rate, the use of the emergency department (ED), and the completion rate of preventive services, such as annual wellness visits, flu vaccinations, and mammograms. ACOs often use graphs and tables in the reports to present the information, and visual effects such as icons and colors to draw attention to successes or highlight areas for change.

Feedback reports often include comparison data to provide context for an individual provider's most recent performance, such as the current performance of peers and regional and/or national performance benchmarks. The reports may also include information on the provider's past performance in order to support analyses of trends and of the impact of initiatives implemented in the practice, such as refining a care delivery workflow or adding a care coordinator to clinic operations. To encourage healthy competition, some reports may also include unblinded peer-to-peer comparisons of individual providers participating in the ACO. ACOs have found that unblinded data emphasizes transparency and addresses potential skepticism from providers about the analyses.

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Providers are very competitive. When they see that they're doing poorly compared with the average or compared with someone else, that drives [their] competitive nature in a friendly and professional way.

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—ACO administrator

ACOs deliver these reports regularly, such as daily, weekly, monthly, or quarterly. ACOs find it easier to engage practices and individual providers in quality improvement opportunities if the report contains recent data. In addition, the regular distribution of reports allows providers to observe trends and changes over time. However, ACOs also recommend caution when considering how frequently to share the feedback reports, as delivering them too frequently increases the ACO's administrative burden and overwhelms practices with information.

For more information on scorecards, see the case study on Silver State ACO's provider engagement strategy: <https://innovation.cms.gov/Files/x/aco-casestudy-silverstate.pdf>.

⁵ Participating Medicare ACOs must report quality data to CMS after the close of every performance year in order to be eligible for any earned shared savings and, if applicable, to avoid sharing losses at the maximum level. Quality measures fall into four domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations. In addition, ACOs may request from CMS the monthly Claim and Claim Line Feed (CCLF) files. For more information about these quality measures and CCLF files, see the CMS "Program Guidance & Specifications." Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-guidance-and-specifications>. Accessed March 13, 2020.

ACOs distribute the feedback reports electronically, in hard copy, or both to increase access to the data. ACOs whose participating providers use the same electronic health record (EHR) platform may be able to automatically produce feedback reports daily or on-demand to reflect recent data. ACOs without this EHR functionality may still distribute reports electronically using email—especially for aggregated analyses that do not include personally identifiable information—or encourage providers to download reports from a secure portal. Hard copy reports are delivered by mail or in person during coaching sessions (see page 10 for more information about how ACOs use feedback reports to enhance the support for practices). In-person delivery has two other advantages—it allows an ACO representative to (1) discuss the reports with providers and their staff and (2) draw attention to the performance measures that the practice should focus on to receive incentive payments (see ACO Snapshot 2 below for an example).

ACOs encourage individual providers to share feedback reports with office staff who play critical roles in the delivery of care, including practice managers, nurses, and administrative staff. As experts in practice operations, these staff offer valuable insight into what strategies can move the needle on providers’ performance on key measures. The reports also give ACOs an opportunity to encourage support staff in practices to proactively identify quality

improvement opportunities and streamline workflows, which allows all staff to operate at the top of their license. To further engage practice staff in the data and analyses, some ACOs send the feedback reports directly to a practice point-of-contact (such as a practice manager or lead nurse) to review the recent analyses and relay their insights to the rest of the practice to further improve performance.

PROVIDING ACTION-ORIENTED REPORTS

As a supplement to the feedback reports, many ACOs provide action-oriented reports that focus on specific areas of improvement. The data and analyses in these reports are designed to help provider practices identify and implement small-scale, manageable steps that can improve patient outcomes and the quality of care they deliver. The reports may target population health measures, such as completion rates for diabetic foot exams or flu vaccinations, or list beneficiaries who could benefit from extra support from their providers. Regardless of their focus, the reports are typically limited to a discrete number of action items in order to avoid overwhelming providers and staff.

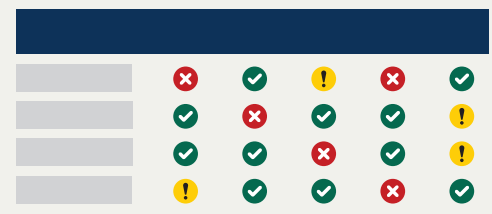
When choosing population health measures for the action-oriented reports, ACOs begin by reviewing aggregate data on select measures to identify areas that have the greatest potential for improvement and/or the greatest effect on

ACO Snapshot 2: Encouraging PCPs to Improve Their Performance on Key Measures Using Data Feedback Reports

Objective: Provide PCPs with actionable information to help them improve performance and meet targets for receiving shared savings.

Tactic: Produce and distribute scorecards that help PCPs to focus on beneficiaries who have the greatest potential to affect the PCP’s performance.

Strategy: A Next Generation ACO develops scorecards to support quality improvement efforts at primary care practices. The scorecards report data at the level of the National Provider Identifier and have a five-tier system that characterizes each PCP’s performance on select measures. The five tiers range from “below baseline” to “extra credit” and correspond to the calculation of an individual provider’s eligibility for shared savings related to that measure. Each year, the ACO’s governing board considers adjustments to the measures included in the scorecard and the criteria for the tiers. The measures represent various aspects of utilization and quality (such as ED visits and mammogram completion rate) and are selected based on two criteria: likely impact on the ACO’s health care costs and degree to which individual providers can affect results. The ACO’s provider relations managers deliver hard copies of the scorecards to primary care practices each month and hold quarterly in-person meetings with individual PCPs to review the scorecards. During the meetings, they discuss beneficiaries whose risk scores have changed substantially, as well as changes in the PCP’s performance on the quality and utilization measures. If the PCP has an opportunity to improve performance on specific measures, the provider relations manager will also suggest steps for getting there. The manager also gives individual PCPs lists of beneficiaries to prioritize for an office visit in the next quarter based on changes to their risk status or gaps in care, such as a beneficiary who has recently been diagnosed with diabetes or is overdue for an annual wellness visit.



For more information on strategies to increase collaboration between practice staff and cultivate their leadership skills, see the case study on Coastal Medical’s Leadership Academies: <https://innovation.cms.gov/files/x/aco-casestudy-coastalmedical.pdf>.

the provider's eligibility to receive shared savings from the ACO. With these areas in mind, the ACOs create lists of beneficiaries with care gaps, thus helping individual providers to identify beneficiaries who have unresolved health care needs or who are due for preventive services. For example, one ACO described how it decided to focus only on improving mammogram screening rates for one month. During that month, the ACO provided PCPs with a list of beneficiaries due for a mammogram in the coming year to help practices identify and reach out to the appropriate beneficiaries.

In addition to care gap lists, many ACOs produce action-oriented reports that focus on improving the outcomes of high-risk, high-cost beneficiaries. Rather than focusing on a specific measure, these reports (sometimes called "pursuit lists") focus on beneficiaries who would benefit from more comprehensive and intensive primary care services. ACOs vary considerably in the methodology they use to identify high-risk and high-cost beneficiaries. Some focus on overall health costs, utilization (such as frequent ED visits, inpatient admissions, or readmissions), or diagnoses (such as diabetes, congestive heart failure, or multiple complex conditions). Other ACOs use predictive analytics to assess the likelihood of an increase in health care needs in the future. Regardless of the methodology used to develop these action-oriented reports, ACOs note

the importance of limiting the number of beneficiaries to avoid overwhelming practices. For example, one ACO said that each individual provider's pursuit list should include no more than 20 beneficiaries.

To supplement the action-oriented reports, many ACOs suggest next steps for providers and their staff as they address the identified health care needs of their beneficiaries. Some ACOs work with provider practices to build point-of-care reminders into their EHR platforms. The reminders, which use the same information in the action-oriented reports, prompt individual providers to consider additional services during the office visit, such as preventive services or care management interventions. Other ACOs combine the action-oriented reports with educational materials to inform practices about general strategies and possible approaches to improving their delivery of care. For example, an ACO that sought to improve its mammogram screening rate gave provider practices educational materials that highlighted strategies on how other practices within the ACO had improved their mammogram screening rates. The materials included tips for practice staff on how to encourage beneficiaries to schedule mammograms via telephone outreach, incorporate mammogram scheduling into the workflow of an office visit, and answer common questions about mammograms from beneficiaries.

Strategies for Using Data to Identify and Address Opportunities to Improve Care

- Regularly distribute data feedback reports to engage individual providers in monitoring and in improving their performance on the ACO's priority quality, utilization, and cost measures.
- Distribute action-oriented reports—such as lists of beneficiaries who have gaps in care or high-risk/high-cost beneficiaries—that identify small-scale, manageable tasks that providers and staff can implement in order to improve patient outcomes and the quality of the care they deliver.

Customizing Support for Primary Care and Specialist Providers

ACOs consider the viewpoints of primary care and specialty providers when customizing strategies to engage them in the delivery of high quality, population-based health care. When speaking with PCPs, ACOs have learned that time and staff constraints limit their ability to effectively coordinate care and to educate beneficiaries with complex conditions about managing their own health. In contrast, ACOs have learned that specialists want to know how to contribute to the ACO's population health goals and initiatives, given their focus on specific diagnoses and conditions that seem unrelated to many quality measures. Specialists also note that the beneficiaries they treat are often sicker than the average Medicare beneficiaries, making it more difficult to provide population-based health care that improves beneficiary experience and outcomes.

Despite the somewhat different concerns voiced by PCPs and specialists when discussing approaches to population health, ACOs have found that similar strategies are effective in supporting both types of providers. Many ACOs offer individual providers access to hands-on guidance and coaching to help them identify and test initiatives that are intended to make the delivery of care as efficient and effective as possible. In addition, ACOs often establish population health teams to help providers deliver more comprehensive and coordinated care to beneficiaries by giving them access to clinical and nonclinical staff, such as nurse care coordinators, pharmacists, social workers, and dieticians.

When designing customized support, ACOs note the importance of tailoring engagement efforts to the specific needs of different specialty types. To this end, ACOs meet with leaders of specialty practices to discuss team culture and previous exposure to the concepts that underlie population health. In addition, some ACOs target a small number of specialty types in care improvement efforts, focusing their administrative resources on specialties that emphasize preventive health services, provide support for beneficiaries with chronic conditions in managing their own health, and have established long-term relationships with beneficiaries. Examples of specialists that ACOs commonly engage in population health include nephrologists, cardiologists, endocrinologists, and pulmonologists.

COACHING TO SUPPORT QUALITY IMPROVEMENT

The individualized, hands-on coaching offered to primary care and specialty practices enables providers and their staff to continue to prioritize delivery of clinical care while taking steps to address ACOs' quality and performance improvement goals. For example, coaches might engage practices in streamlining their clinical workflows to more efficiently identify beneficiaries' social and health needs, reduce unnecessary imaging, or improve clinical documentation in their EHRs. Multiple ACOs note that they receive positive feedback from providers who value these coaching services and view this support as an enticement to join an ACO.

To start the process, coaches meet with providers and their staff to discuss the practice's recent performance, explore emerging challenges, and consider potential solutions. The coaches are typically either registered nurses or non-clinical analysts with specialized training or experience in quality improvement and employed as part of the ACO's centralized quality improvement or population health team. Although providers and practice staff know how their practices operate, the coaches provide an outside perspective on improvement opportunities and can share strategies and experiences that have been effective in other provider practices. In addition, the coaches' knowledge of ACO-selected improvement priorities can guide practices in designing strategies that target key performance measures identified in feedback reports developed by ACOs for providers (see pages 7-8 for more information about data feedback reports).

The coaches collaborate with provider practices through all stages of the quality improvement process, from identifying an opportunity for change, to operationalizing the initiative, and finally, to considering early metrics of success to fine-tune the initiative. For example, coaches may collaborate with practice staff to review the data feedback reports and complete root-cause analyses⁶ to identify improvement opportunities for specific quality measures. Coaches may then guide practices in conducting plan-do-study-act cycles⁷ in order to support the ongoing monitoring and refining of their strategies.

⁶ A root cause analysis is a tool used to identify the causes of a problem that occurred by tracing its origin in order to identify processes to prevent the problem from recurring in the future. For more information on root cause analyses, see the AHRQ "Root Cause Analysis." Available at: <https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/root-cause-analysis>. Accessed March 13, 2020

⁷ Plan-do-study-act (PDSA) cycles are tools to design, implement, reflect on, and modify an initiative. For more information on PDSA cycles, see the AHRQ "Worksheet for Plan-Do-Study-Act (PDSA) Cycle Planning." Available at: <https://www.ahrq.gov/evidencenow/tools/pdsa-worksheet.html>. Accessed March 13, 2020.



Our practices' coaches do proactive education, as opposed to just telling the provider that something needs to be fixed. They're really helping the physicians be accountable for how we can all work together to streamline processes.



—ACO administrator

The intensity and format of ongoing coaching varies according to the practices' needs and interest in improving the quality of care they deliver, as well as the ACO's administrative capacity to provide coaching services. Some ACOs encourage coaches to connect monthly or quarterly with every practice that participates in the ACO, whereas other ACOs direct coaching services to specific practices based on their recent performance on key measures or the number of attributed beneficiaries. Based on geographic constraints and individual provider preferences, coaches may meet practice representatives by phone or travel to meet them in person. Prioritizing certain practices for

coaching helps ACOs to focus their resources on providers whose changes in performance would have the largest impact on overall ACO performance.

IMPROVING ACCESS TO SERVICES TO ADDRESS BENEFICIARIES' POPULATION HEALTH NEEDS

Given the increase in value-based payment models, PCPs and specialists are becoming more aware of how the clinical complexity of their beneficiaries—including unmet social or behavioral health needs—can affect the success of the care they deliver. Many ACOs employ population health teams to help address these broader clinical, social, and behavioral health needs that affect traditional care. With access to these teams, ACOs hope to reduce the burden on individual providers and their staff while enhancing the effectiveness of their care delivery. The ACOs' population health teams employ multiple types of clinical and nonclinical experts in order to give individual providers access to a diverse array of expertise and to enable practice staff to operate at the top of their license (see ACO Snapshot 3 for more information). The teams commonly consist of nurse care coordinators, pharmacists, behavioral health specialists, social workers, dietitians, health coaches, and/or patient navigators.

ACO Snapshot 3: Employing Care Managers to Support Providers in Improving Health Outcomes

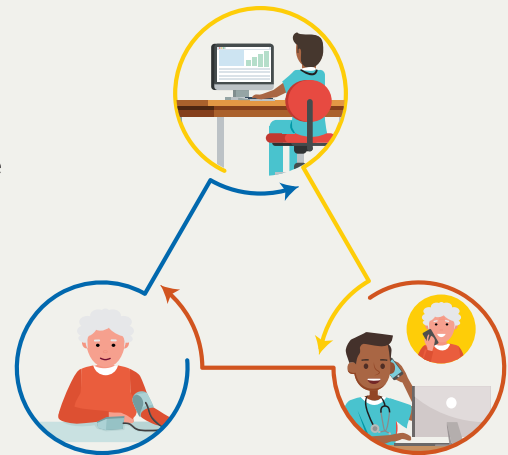
Objective: Reduce avoidable ED and inpatient use by high-risk beneficiaries.

Tactic: Employ care managers to enhance PCPs' care delivery for beneficiaries with recent inpatient admissions or ED visits.

Strategy: To reduce the burden on individual providers to address their beneficiaries' population health needs, one Shared Savings Program ACO employed care managers to provide care management services and enhance the effectiveness of providers' care delivery. The ACO developed criteria to identify beneficiaries who might benefit from care management services. To do so, the ACO considers the number of recent inpatient admissions and ED visits that did not result in a hospital admission and conducts an analysis of claims and clinical data collected in its data warehouse. The ACO uses these data in an algorithm to produce "impactability scores," which estimate the degree to which a beneficiary's health status would be impacted by additional support.

A second approach to identify beneficiaries for care management support is through the ACO-employed care managers who are embedded in primary care practices. These care managers review the charts of each identified beneficiary and collaborate with their PCPs to confirm which beneficiaries are appropriate for their services. For example, the care manager may exclude beneficiaries in hospice or those who are already receiving care management services through another program.

For each beneficiary who is determined to be appropriate for care management services, care managers fill out a template with information about the beneficiary's diagnoses and health status and create a care management plan that outlines how to stabilize the beneficiary's health in the short and long term. After incorporating input from the PCP into the plan, the care manager meets with the beneficiary to discuss their health goals and their response to the care management plan. Care managers then connect regularly with the beneficiary to assess their progress toward goals in the care management plan and to provide or connect the beneficiary to additional services as needed, such as transportation to and from medical visits. The frequency of subsequent meetings and the duration of the beneficiary's involvement in care management varies with the severity of the beneficiary's health needs and their awareness of self-care management strategies.



ACOs give the following examples of how their centralized population health teams have supported practices:

- Nurse care coordinators make weekly telephone calls to beneficiaries who have multiple chronic conditions to monitor their health status and provide services when necessary
- Pharmacists conduct medication reconciliation for beneficiaries who are prescribed multiple medications
- Dieticians provide nutrition counseling for beneficiaries newly diagnosed with diabetes
- Social workers connect beneficiaries to community-based resources that can address various social needs, such as social isolation, lack of transportation, and food insecurity

Depending on the practice's size and needs, the population health staff may interact with individual providers and their beneficiaries on an as-needed basis in person or by telephone, or work as a full- or part-time embedded team member within the practice. For example, a large practice that serves many indigent beneficiaries may value access to a full-time, on-site social worker provided by the ACO, whereas a small practice may have a social worker at the practice for only one day a week. If the ACO's population health team is centrally located, participating providers can consult with or refer beneficiaries to the team at any time. In some cases, the population health team may initiate virtual outreach to beneficiaries

based on their analysis of clinical data and in collaboration with the beneficiaries' PCPs or specialists.

ACOs engage with individual providers to understand the type of support they prefer with respect to population-based health care, recognizing that a customized strategy is the best way to meet the needs and interests of a diverse group of primary care and specialty practices. These conversations shed light on the type of expertise that could be most useful to the practice, whether the staff are needed on a part- or full-time basis, and whether support should be provided remotely or in person. For example, one ACO described how some PCPs requested an embedded social worker to be at their practices for one day a week, whereas other PCPs preferred to collaborate with the social worker virtually.

ACOs regularly highlight the availability of population health teams in newsletter updates and in group or one-on-one meetings (see pages 4-5 for more information about these updates and meetings). These communications remind busy providers about available supports and describe the population health teams to new providers who recently joined the ACO. In response to the providers' discomfort with referring beneficiaries to a centralized population health team, some ACOs expand these reminders to include not only examples of services that the population health team could provide but also stories of how the providers' peers have used the team to improve care for beneficiaries.

Strategies to Deliver Customized Support for Primary Care and Specialty Providers

- Engage with individual providers to understand their preferences for support, recognizing that a tailored strategy is the best way to meet the needs and interests of a diverse array of primary care and specialist practices.
- Provide individualized, hands-on coaching to help practices identify and test initiatives that are designed to make the delivery of care more efficient and effective.
- Employ population health teams to help practices address the population health needs of their beneficiaries and to reduce the burden on individual providers and their staff.

Implementing Financial Incentives

Medicare ACOs use financial incentives to motivate providers to help ACOs to improve the quality of care for their beneficiaries and meet their thresholds for achieving shared savings. The diversity of incentive strategies reflects the fact that Medicare ACOs are heterogeneous in terms of structure, beneficiary population, and risk arrangements with CMS. For example, an ACO may consist of a network of individual provider practices, be rooted in a partnership between provider practices and a hospital system, or it may be overseen by an integrated delivery system. ACOs within the Medicare Shared Savings Program and Next Generation ACO Model serve the broad Medicare FFS beneficiary population, whereas End-Stage Renal Disease (ESRD) Seamless Care Organizations (ESCOs) focus on beneficiaries with ESRD. Additionally, some ACOs are in two-sided risk models, and others are in one-sided, shared-savings-only models. But regardless of composition, beneficiary population, or risk-sharing arrangement, ACOs engage providers through a variety of financial incentives.

The most common financial incentive for providers participating in an ACO is the distribution of shared savings (sometimes called “gainsharing agreements”). ACOs that qualify to receive shared savings from CMS may decide to use these funds to support operations or quality improvement efforts, distribute the funds to providers, or use a combination of these two approaches. ACOs that distribute shared savings to providers often base the amount for individual providers on their performance on quality and utilization metrics. These ACOs may supply providers with data on their performance throughout the year to allow them to adjust their efforts to become eligible for shared savings.⁸

OVERVIEW OF REQUIREMENTS FOR ACHIEVING SHARED SAVINGS AS A MEDICARE ACO

All Medicare ACOs can be eligible for shared savings. Some ACOs elect to face downside risk as well, meaning that they may be liable for shared losses if expenditures are too high. ACOs that choose the two-sided risk option are eligible for a maximum amount of shared savings that is greater than the amount for which they would be eligible in a one-sided model.

⁸ For an example from the Medicare Shared Savings Program, see 42 C.F.R. § 425.116(a)(5), specifying that an ACO’s agreements with its ACO participants must describe how the opportunity to receive shared savings or other financial arrangements will encourage the ACO participant to adhere to the quality assurance and improvement program and evidence-based medicine guidelines established by the ACO. Available at https://www.ecfr.gov/cgi-bin/text-idx?SID=81edc62588d44bd965fa7e3487edbc27&mc=true&node=pt42.3.425&rgn=div5#se42.3.425_1116. Accessed June 15, 2020.

⁹ For more information, see the following document: CMS. “Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology.” Version #7, February 2019. Available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V7.pdf>. Accessed January 23, 2020.

The specific CMS requirements for receiving shared savings vary by type of Medicare ACO initiative, and the Medicare Shared Savings Program provides a representative example. In this program, CMS compares expenditures for an ACO’s attributed beneficiaries to an average per capita expenditure benchmark calculated based on historical spending from the three years prior to the date on which an ACO’s agreement started. To receive shared savings, a Medicare Shared Savings Program ACO must (1) meet or exceed a minimum savings rate derived from the benchmark, (2) meet the quality performance standards, and (3) remain eligible for the Medicare Shared Savings Program. ACOs that meet these criteria may receive some portion of shared savings (for example, a maximum of 50 percent of shared savings under the one-sided risk model or up to 75 percent, depending on the two-sided risk model). The portion of savings an ACO may receive is adjusted for other factors such as performance on quality measures and the application of a shared savings cap; for example, under the one-sided risk model, shared savings are capped at 10 percent of historical benchmark expenditures, but can be up to 20 percent under the two-sided model with the highest level of risk and potential reward.⁹

All Medicare ACOs must publicly report information about their shared savings and losses on their website, breaking out the savings by:

- The amount invested in infrastructure, redesigned care processes, or other resources targeted to improving outcomes or lowering costs for beneficiaries
- The amount distributed among ACO participants

DECIDING HOW TO ALLOCATE SHARED SAVINGS

ACOs that receive shared savings must make several decisions about how to use those savings. One of the first decisions is how much to distribute to providers as payments, as opposed to investing in infrastructure or in redesigning care processes. The ACO’s board decides on the approach to allocating resources often in consultation with other ACO stakeholders, and its decisions may be driven by the structure and needs of the ACO.

For example, an ACO overseen by a physician-owned medical group selected an approach that matched the priorities of the physicians in the group. The board opted to give priority to distributing money back to the physicians and other staff, allocating 80 percent of the shared savings to provider payments and 20 percent to infrastructure and redesigning care processes. After implementing the financial incentive system, the ACO leadership received feedback from clinical staff noting their appreciation for the shared savings and indicating the potential for future payments to motivate further improvement in the quality of care. To ensure that providers drove future changes to the financial incentive strategy, the board formed a value-based care committee comprised of primary care and specialty providers who vote on the measures and benchmarks the ACO will use to determine the distribution of shared savings.

Another ACO distributes shared savings payments both to providers employed by the medical group and to providers who are part of the independent practice association (IPA), as a strategy to make the ACO attractive to new IPAs. To develop its shared savings strategy, the ACO's director and analytics staff proposed an initial incentive plan and then collected feedback from the ACO's IPA, regional medical directors, board president, and regional health care operators. The board then voted on the incentive plan, which lays out the allocation of shared savings for infrastructure, redesigned care processes, and payments to providers. The board also finalized the specific measures and cut-points used to determine the providers' payments. Each year, the board updates these cut-points as needed to drive quality improvement. The ACO now distributes 92 percent of shared savings to providers and reserves 8 percent for reinvesting in infrastructure. Though the ACO participates in a two-sided risk model, the board opted to shield providers affiliated with its IPA from downside risk because it was concerned that this risk would discourage providers from participating in the ACO. For employed providers, the ACO makes payments to the medical group rather than to individual providers. The medical group faces downside risk, and in the event of a loss, the group would be required to pay that loss back from savings received in prior years.

DISTRIBUTING SHARED SAVINGS TO PROVIDERS TO INCENTIVIZE IMPROVEMENTS IN PERFORMANCE

Many ACOs incentivize providers to improve by distributing shared savings to those who perform well on quality and utilization metrics. ACOs that took this

approach based their foundational planning decisions on their answers to the following questions:

- Which providers or entities are eligible for shared savings?
- What metrics should be used to determine the shared savings amount?
- What benchmarks should be used to evaluate performance on metrics?
- What information should be conveyed to providers about their performance on the metrics to support them in meeting the requirements for receiving shared savings?

The following sections discuss considerations raised by ACOs in connection with each of these questions, including examples of decisions made by Medicare ACOs.

Determining eligibility for shared savings

distributions. Before distributing shared savings to providers, ACOs decide whether to award funds at the level of the individual provider, the practice, or the specialty department. Additionally, ACOs determine whether to limit funds to physicians or include other providers and support staff. Finally, ACOs define the share of funding to allocate to employed versus independent providers, as well as primary care versus specialties. For example:

- An ACO formed by an independent multispecialty medical group directs a majority of shared savings to clinicians, but it also directs some shared savings to support staff as an incentive to improve quality across the ACO. Each year, the ACO distributes shared savings to each of the group's 23 specialty departments that perform well enough to merit payment. The departments then determine how to distribute the funds to providers and their staff. Since implementing this approach, the ACO has received feedback that medical group employees appreciate the recognition of exemplary performance through payments and that they realize that their actions help the ACO to improve the quality of care.
- An ACO operated by an integrated delivery system offers shared saving payments to individual providers within the IPA as an inducement to participate in the ACO but does not share savings with employed providers. Also, the ACO absorbs the downside risk for providers within the IPA, which might dissuade them from participating in the ACO. The ACO recently achieved shared savings for the first time and distributed 5 percent of the savings in bonuses to its IPA providers.

Anecdotally, the ACO heard that these bonuses had a positive impact on morale.

- An ACO operated by an integrated delivery system provides the same shared savings payment to both PCPs and specialists regardless of whether they are employed or independent. The ACO opted for this uniform approach for the sake of simplicity because more than 80 percent of its physicians are employed by its medical group. The ACO is in a one-sided, shared-savings-only model and is planning to eventually shift to a two-sided risk model. At that point, the ACO expects that the medical group will take on downside risk but that independent providers will not have to face it.

Selecting metrics to assess eligibility for shared savings distributions. ACOs use a range of metrics to decide whether a given provider or practice is eligible for shared savings payments each year. Many ACOs focus on utilization and quality measures, though some also consider other factors such as measures of provider engagement (e.g., attendance at meetings), in-network referral rates, and compliance with ACO guidelines for assessing patient risk (e.g., updating patients' hierarchical condition category assignment at each visit). When selecting metrics for distributing shared savings, ACOs consider several factors:

- Availability of data for calculating the measure (e.g., a measure may require data pulled from multiple EHR systems)
- Strength of the evidence for connecting measure performance to health care costs or patient outcomes
- Ability of clinicians to take action to improve their performance on the measure
- Conciseness of the measure set (i.e., having a small number of measures)
- Alignment with measures used in other value-based contracts

“ We felt like those core components [of our metrics] were controllable by the doctors, and [the doctors] could have an impact on [the metrics] directly by seeing the patient and having a care relationship with that member. ”

—ACO administrator

Utilization measures may include the total cost of care or the use of high-cost services that may indicate poor care management, such as unnecessary ED use or avoidable readmissions. Quality measures may include many of the formal quality measures CMS uses to assess ACO performance. Table 1 provides examples of both types of measures from ACOs.

Table 1. Metrics for calculating shared savings distributions

Utilization measures

- ✓ Total cost of care
- ✓ Inpatient admissions per 1,000 aligned beneficiaries
- ✓ Unnecessary inpatient and ED use
- ✓ Readmission rates or avoidable readmissions
- ✓ Percentage of patients with office visits within seven days of discharge from an acute hospital stay
- ✓ Percentage of patients without an office visit during the year

Quality measures

- ✓ Annual wellness visits
- ✓ CAHPS: Shared decision making (ACO #6)
- ✓ Preventive care and screening: influenza immunization (ACO #14)
- ✓ Colorectal cancer screening (ACO #19)
- ✓ Breast cancer screening (ACO #20)
- ✓ Diabetes mellitus: Hemoglobin A1c poor control (ACO #27)
- ✓ Nephropathy
- ✓ Hypertension (HTN): Controlling high blood pressure (ACO #28)
- ✓ Anti-lipid therapy for patients with coronary artery disease

Setting benchmarks for awarding shared savings.

Having selected the measures, ACOs then define the benchmarks against which provider performance is assessed. Some ACOs use a tiered structure in which providers receive smaller or larger payments, depending on how they perform on a given measure or measures. For example, one ACO sets a baseline threshold for each measure, and providers scoring below that baseline are not eligible for any payment for that measure. Providers scoring at or above the baseline are eligible for a percentage of a maximum payment for the measure, depending on the tier into which their performance falls: baseline (20 percent), better (50 percent), best (75 percent), or extra credit (100 percent). To make sure that benchmarks continue to encourage providers to improve, ACOs may set new benchmarks each year, raising them for some measures to set new goals or replacing other measures that no longer leave room for growth with new measures (see ACO Snapshot 4 for an example).

Providing interim updates on performance. One challenge involved in motivating providers through shared savings payments is the lag time between performance and the receipt of payment. ACOs have addressed this challenge by giving more timely signals to providers about their performance. Many ACOs use quarterly scorecards or other indicators of performance on the measures that determine eligibility for a shared savings payment. For

example, one ACO gives individual providers a quarterly “funds flow report” that shows the magnitude of the shared savings payment that they are tracking toward, assuming the providers maintain their performance through the end of the year. The fourth quarter report provides the expected distribution pending a settlement report that officially notes the final distribution amount. Anecdotally, some ACOs have found that providers and other staff understand the connection between their efforts and their resulting shared savings payments. Another ACO delivers a quarterly scorecard at the department level. The scorecard reflects the department’s performance on each measure that affects the department’s eligibility for shared savings as well as the department’s targets for those measures.

“Folks [are] reaching out, realizing maybe their department hit the 75th percentile, and they want to know what they should be actively doing in the next quarter so that they hit the 100% level.”

—ACO administrator

ACO Snapshot 4: Working Collaboratively to Select Measures and Targets

Objective: Motivate providers and staff to set ambitious performance targets for cost and quality.

Tactic: Collaborate with departments to set targets for each performance year.

Strategy: A Next Generation ACO established a clinical subcommittee of the ACO board that engages with the 23 specialty departments that comprise its independent multispecialty medical group to define annual performance targets for cost and quality measures. The clinical subcommittee, called the Value-Based Care (VBC) Committee, collaborates with the departments to foster continuous improvement and to inform the distribution of shared savings payments to the ACO’s employees. Each year, every department receives a percentage of a maximum payment—0%, 50%, 75%, or 100%—based on the degree to which it meets the cost and quality performance targets. The department then distributes its portion of shared savings to all employees; providers are eligible for larger amounts. The ACO has distributed shared savings payments for the past two years, and the feedback it has received indicates that staff perceive the shared savings as evidence of the impact of their efforts to improve the delivery of care.

To set the annual performance targets, the VBC Committee reviews the proposals from each department to determine whether the suggested measures and targets advance the ACO’s goal of improving quality and reducing costs. Departments may set more ambitious targets than the prior year or identify a new measure to replace one that offered little opportunity for improvement. The VBC Committee may also request revisions from a department if a target is not aggressive enough to reach the ACO’s goals. The VBC Committee intends to approve all targets by November 2020, which will allow the departments to implement changes before the ACO begins to assess their performance for the next calendar year.



Another approach to addressing the time lag is to provide frequent payments. One ACO distributes quarterly incentive payments to individual providers in the form of bonuses through its provider rewards program. The payments are based on the providers' scores on measures of quality, care coordination, patient satisfaction, patient risk, and number of ACO-attributed beneficiaries treated.

The provider rewards program operates in addition to, rather than in place of, shared savings payments. Through the quarterly bonus payments, the ACO intends to show providers the connection between their performance and their compensation, encourage independent providers to participate in risk-sharing agreements, and meaningfully improve the quality of care.

Strategies for Engaging Providers Through Financial Incentives

- Work with ACO board members and other stakeholders to determine the proportion of shared savings to allocate to shared savings payments, to ACO infrastructure, and to redesigning care processes.
- Evaluate which metrics to use for awarding shared savings payments based on the availability of data, the strength of the evidence base that underlies the metric, the ability of clinicians to take action to improve their performance, the conciseness of the overall measure set, and the alignment with measures used in other value-based contracts.
- Reevaluate benchmarks for shared savings metrics to ensure that they are ambitious enough to encourage ongoing quality improvement.

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