How to Align Your Population Health Strategy with the 5 CMS Strategic Objectives

A Guide from the Population Health Experts at Johns Hopkins Medicine

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In 2024, the Center for Medicare and Medicaid Innovation (CMMI) updated a set of five strategies that are crucial for the success of Integrated Delivery Networks (IDNs) and Accountable Care Organizations (ACOs). These strategies tackle core challenges that health care systems face, including plans to reduce disparities, deliver value-based care, and address social determinants of health (SDOH) and other inequities that often contribute to higher costs and poorer outcomes.

Efforts to enhance data collection, promote health equity and address systemic barriers to care provide a blueprint to help CMS support these organizations. By aligning with the CMS strategies, IDNs and ACOs can position themselves to thrive in an evolving health care landscape that increasingly rewards accountability and outcomes.

In this handbook, Johns Hopkins population health experts share the importance of each strategy and how to use the ACG® System to take effective action.

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What are the 5 CMS initiatives, and why are they important for population health?

1. Drive Accountable Care

- **Why It's Important:** Accountable care models shift the focus from volume-based to value-based care. This emphasizes outcomes, patient satisfaction and cost efficiency. For integrated health systems and ACOs, this means better alignment with payment models that reward quality and efficiency rather than the quantity of services provided.

- **Impact:** By driving accountable care, health care systems can reduce unnecessary spending, improve patient outcomes and align with payer expectations. This is crucial for financial sustainability and competitiveness in the health care market.

2. Advance Health Equity

- **Why It's Important:** Health equity ensures that all patients receive fair and just access to health care services, regardless of their socioeconomic background, race or geographic location. Integrated health systems and ACOs that serve diverse populations must address disparities to provide comprehensive care and meet regulatory and community expectations.

- **Impact:** Advancing health equity can lead to better population health outcomes, reduced disparities and improved community relations. It also positions organizations as leaders in addressing social determinants of health, which is increasingly important for securing funding and partnerships.

3. Support Care Innovations

- **Why It's Important:** Innovation in care delivery is essential for improving patient outcomes, enhancing efficiency and staying competitive. Integrated health systems and ACOs often manage complex populations. This type of challenging care requires novel approaches to meet the diverse needs of these patients while still controlling costs.

- **Impact:** By supporting care innovations, organizations can improve patient care, reduce operational costs and enhance the overall patient experience. This can lead to better outcomes, higher patient satisfaction and stronger financial performance.

4. Improve Access by Addressing Affordability

- **Why It's Important:** Affordable care is a cornerstone of accessible health care. Integrated health systems and ACOs must balance the delivery of high-quality care with the need to keep services both affordable for patients and sustainable for the organization.

- **Impact:** Addressing affordability helps reduce financial barriers to care, ensuring that more patients receive timely and appropriate treatment. This not only improves patient outcomes but also reduces long-term costs associated with untreated or poorly managed conditions.

5. Partner to Achieve System Transformation

- **Why It's Important:** System transformation requires collaboration across the health care ecosystem, including partnerships between providers, payers, community organizations and technology companies. Integrated health systems and ACOs are in a unique position to lead these partnerships. This drives comprehensive changes in care delivery, payment models and patient engagement.

- **Impact:** By partnering for system transformation, these organizations can drive more unified and integrated care models that improve efficiency and enhance patient care across the continuum. This also positions them as leaders in the shift toward a more sustainable and patient-centered health care system.

Overall Importance

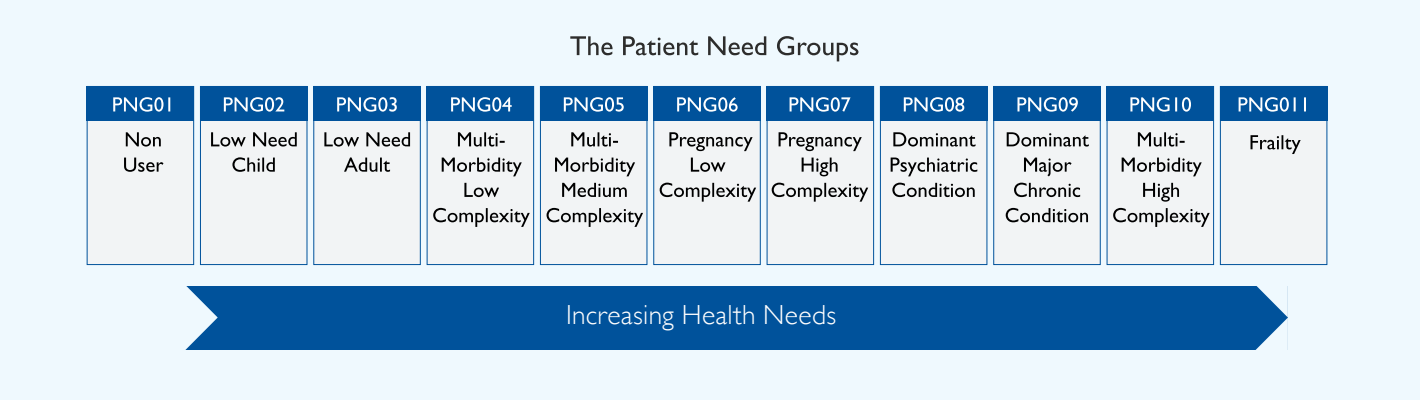
These strategies are vital for integrated health systems and ACOs as they navigate the complexities of modern health care. By aligning with the CMS strategies, they can improve care quality, reduce costs, enhance patient satisfaction and ensure long-term viability in an evolving health care landscape. These strategies also support regulatory compliance, positioning these organizations for success in value-based care models and other emerging health care frameworks.

How the ACG System Supports These Initiatives

The Johns Hopkins ACG System is a world-leading population health analytics tool. The ACG System supports organizations in aligning with each of these key initiatives in the following ways:

1. Drive Accountable Care

- **Risk Stratification and Patient Segmentation:** The ACG System analyzes data across various clinical and demographic factors to identify high-risk patients and those with complex care needs. This enables health systems and ACOs to implement targeted interventions, manage care more effectively and distribute resources efficiently.
- **Cost Management:** The ACG System supports organizations in budget management, reduced overutilization and improved cost-effectiveness. This helps predict future health care costs and identify potentially avoidable costs.
- **Taking a Closer Look:** The ACG System's Patient Need Groups (PNGs) offer a person-oriented approach to health segmentation by categorizing patients into 11 mutually exclusive groups.



While other population health groups identify patients by disease state, care episode or utilization incident, the ACG System focuses on a whole-patient approach to care that applies to all age groups and populations. Patients, particularly those with complex health needs, are often defined in terms of their disease state ("a diabetic") or incident ("a readmission"). The ACG System goes further to allow health care organizations to address the patient, rather than an individual disease state or single occurrence. PNG segmentation takes our multimorbidity approach to the next level by assigning mutually exclusive, hierarchical and clinically relevant categories that make it easier to gather a full picture of a population's distribution of health needs.

Individuals move into and out of various levels of need over the course of their lifetime. Health care organizations use PNG categories to understand a population's health needs, develop clinical programming specific to different patient types, understand utilization patterns and take targeted action to improve service use and costs. PNG segmentation also helps users understand their current health equity structure and direct care improvement where and when it's needed. PNGs can also support a tailored approach to care based on need by reviewing groups broken down by race, location and social needs. For example, less complex PNG groups could receive digital health improvement programs to focus on lifestyle management and prevention of a worsening health state. Highly complex patients with more serious needs can be prioritized for additional focused resources.

For more information about Patient Need Groups, click here.

2. Advance Health Equity

- **Social Determinants of Health (SDOH) Integration:** The ACG System incorporates SDOH data, such as socioeconomic status and community factors, to identify disparities in health outcomes. Health systems and ACOs can use this information to design and implement programs that address these disparities and promote equitable access to care.

- **Targeted Interventions:** By identifying vulnerable populations and understanding their specific needs—including their most pressing social needs—the ACG System enables organizations to deploy targeted interventions that address unmet needs and support underserved communities. This holistic approach ensures that individuals receive comprehensive care that meets both their medical and social needs.

- **Taking a Closer Look:** The ACG System uses sophisticated algorithms to segment populations in many different ways. Additionally, the ACG System's GeoHealth and Social Need Marker capabilities allow providers to gather and analyze the data required by CMS and use it to guide targeted interventions.

  The GeoHealth module allows System users to use geographically relevant SDOH to determine the risks and health challenges a certain population faces due to their geography. When pulled together with the rest of the data available through the ACG System, organizations can create a full view of patient-level risks.

  Additionally, Social Need Markers quantify patient-level social barriers to care. Social Need Markers (SNMs) are patient-level social needs captured in screening tools or in coded diagnoses. This data is invaluable for health care providers and organizations seeking to improve health equity and increase necessary data collection.

  Through its advanced markers, the ACG System helps organizations detect early warning signs in patient populations that might otherwise go unnoticed. By analyzing factors such as pharmacy usage patterns, comorbidities and utilization rates, ACG identifies patients with higher needs or those at risk of adverse outcomes, enabling more proactive care. Layering this information with Social Need Markers and ACG GeoHealth markers not only aids in achieving the CMS equity goals but also improves overall care quality by focusing resources where they are most needed.

Expanding Safety Net Provider Participation

CMMI updated their strategy in 2024 to include a push for greater inclusion of safety net providers. These providers are often best positioned to deliver care to underserved communities but frequently face barriers to participation in advanced care models. The ACG System's predictive risk models and resource allocation tools are essential for safety net providers who must stretch limited resources to meet the demands of high-risk populations.

The ACG System helps providers accurately assess patient risks and needs. This is crucial for effectively participating in CMS's new equity-focused models, such as the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model. With the ACG System's data-driven insights, safety net providers can better demonstrate their value, secure the necessary financial and technical assistance from CMS and ultimately improve care outcomes for their populations.

Categorized by PNGs, the ACG System identifies low- and high-risk pregnancies, dominant psychiatric conditions and concurrent mental health conditions among patients. Providers and organizations alike can use this data to develop strategies to meet goals for initiatives like the Transforming Maternal Health (TMaH) and Innovation in Behavioral Health (IBH) models.

3. Support Care Innovations

- **Predictive Analytics:** The ACG System uses predictive modeling to forecast health outcomes and create innovative care models that proactively manage patient health and prevent complications.

- **Personalized Care Pathways:** By analyzing patient data, the ACG System can help design personalized care plans that cater to individual patient needs, improving outcomes and patient satisfaction.

- **Taking a Closer Look – Case Study: A Layered Approach to Health Equity using the ACG System:** An ACG System customer recently discovered exactly how helpful the data is when developing their health equity strategy. This organization needed a clear view of their Medicaid population. They utilized PNGs, SNMs and ACG GeoHealth to develop a thorough view of patient demographics, health needs and health equity scores. The chart below shows the Medicaid population segmentation, after a thorough analysis using the ACG System. Patients are categorized by need and projected cost and the chart provides considerations for potential levels of care.

PNG	% Population	Avg. Cost
Frail	0.2%	$85,600
Multimorbid High Complexity	6%	$45,000
High Complexity Pregnancy	1%	$10,500
Low Complexity Pregnancy	2%	$5,500
Medium Complexity	12%	$5,300
Low Need Adult	20%	$950

Most cost, utilization and potentially preventable hospitilizations occur in the frail and multimorbid groups. **Are they receiving prospective care-coordination services?**

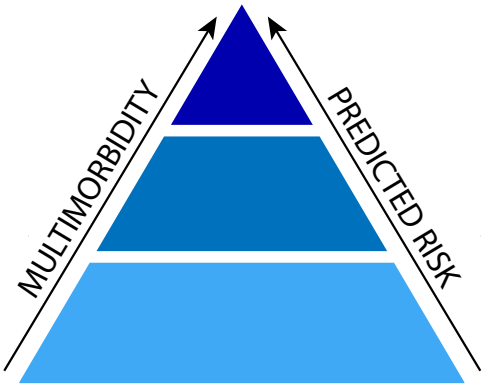
Almost 30% of pregnancies have an underlying risk factor, placing them at high risk of poor maternal/newborn outcome. **How are they being supported in your population health strategy?**

These individuals have meaningful underlying health needs but have not yet escalated to needing inpatient or ED services. **How can we prevent their disease worsening?**

Healthy now - **best target for preventive screenings.**

Illustrative distribution of adults in Medicaid population

Through this analysis, we clearly observe that only a very small part of the population is at the highest level of need and cost. We also see the distribution of patients across groups based on need, which allows the customer to plan current and future predicted resource utilization, drive change and reduce disparities. These methods can be replicated and further customized by other ACG System users for their specific use cases and populations.



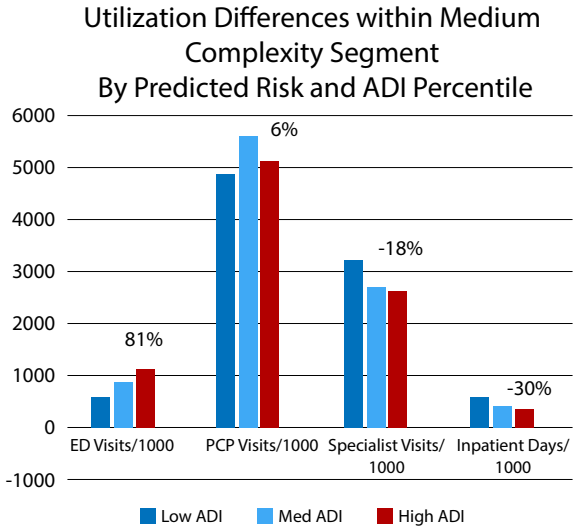
This study also analyzed the distribution of those in various complexities overlaid with predicted risk models. For example, in this graphic we see a pyramid representing the number of patients in each tier. In the table, we explore those within medium complexity and need, currently stratified by medium and high predicted future risk.

This predictive model, a key component of the ACG System, is suitable for building a successful health equity strategy and proactive population health management.

This is achieved by focusing on the rising-risk population and identifying those who will have high health needs in the near future.

Medium Complexity (12%)	Medium predicted risk (8.5%)	High predicted risk (1%)
Opportunities for Care Coordination	5%	11%
Lack PCP Care	8%	8%
Substance Use	15%	28%
Polypharmacy	18%	77%
Social Need	20%	20%
Tobacco Use	22%	25%
One or More Non-Emergency Visits to ED	24%	23%
One or More Medication Gaps	28%	62%
Mental Health Comorbidity	42%	45%
Cardio-Metabolic Risk	60%	75%
2 or More Chronic Conditions	72%	91%

Additionally, this study observed utilization by need segment and ACG GeoHealth/Area Deprivation Index (ADI) score. This segmentation supported a whole-person approach to understanding health needs across a population. It also allowed for a clear picture of the relationship between morbidity, utilization and SDoH, which is critical for program planning and execution. In the chart to the right, those with a higher adversity score were found to be less likely to visit a specialist or be admitted to an inpatient setting, likely due to the lack of availability to specialty care and elective procedures. As a result, this population was more likely to visit the Emergency Department (ED) when care was needed.



Identify Actionable Opportunities

The ACG System's Care Modifiers, overlayed on PNGs, are a proprietary feature that identifies an individual's traits with actionable opportunities for intervention. For every impactable factor, there is an opportunity to improve care and patient health.

Care Modifiers add additional stratification and granularity so users can identify issues that are modifiable such as substance use, tobacco use, severe polypharmacy (or the simultaneous use of multiple prescription drugs), care coordination and lack of primary care. If addressed, these patient attributes can generate meaningful improvement in overall patient health and prevent individuals from moving into a higher PNG category.

- Patients using tobacco can benefit from a smoking cessation program.
- Those with impactable cardiometabolic risk factors, such hyperlipidemia or pre-diabetes, have opportunities for intervention to improve their care and quality of life.

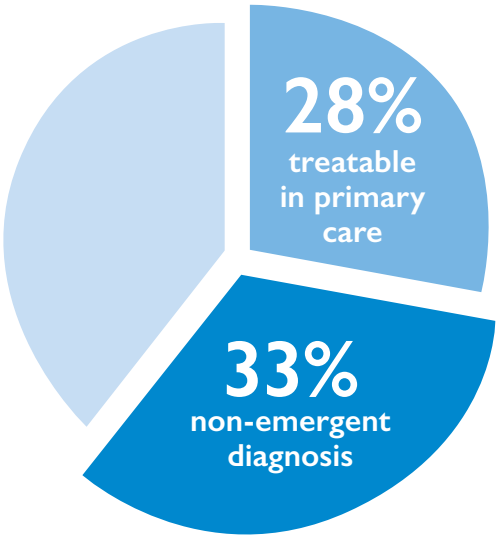
When forming a population health strategy, it can be difficult to discern where to make meaningful advances in the patient population. By addressing actionable opportunities, doctors and patients can see real improvements in patient health. These indicators can also be used to refine a care management or outreach strategy, focusing on where actions can be taken to help patients live healthier lives.

4. Improve Access by Addressing Affordability

- **Utilization Management:** The ACG System provides insights into patterns of health care utilization, identifying opportunities to reduce unnecessary services and redirect care to more cost-effective settings. This helps integrated health systems and ACOs manage costs and improve access to affordable care.

- **Cost Predictability:** By forecasting health care costs at the population level, the ACG System allows organizations to provide care that is both high-quality and affordable.

- **Taking a Closer Look: Reducing Avoidable ED Visits** The ACG System can reveal specific trends in ED visits for a certain population, specifically, patients who visited for non-emergent care or primary care (PCP) treatable conditions. By drilling down into this data, ACG System users can understand root causes of ED use and segment patients into groups depending on their unique health care needs. With this information in hand, System users can develop an effective strategy to reduce ED use and associated health care costs.



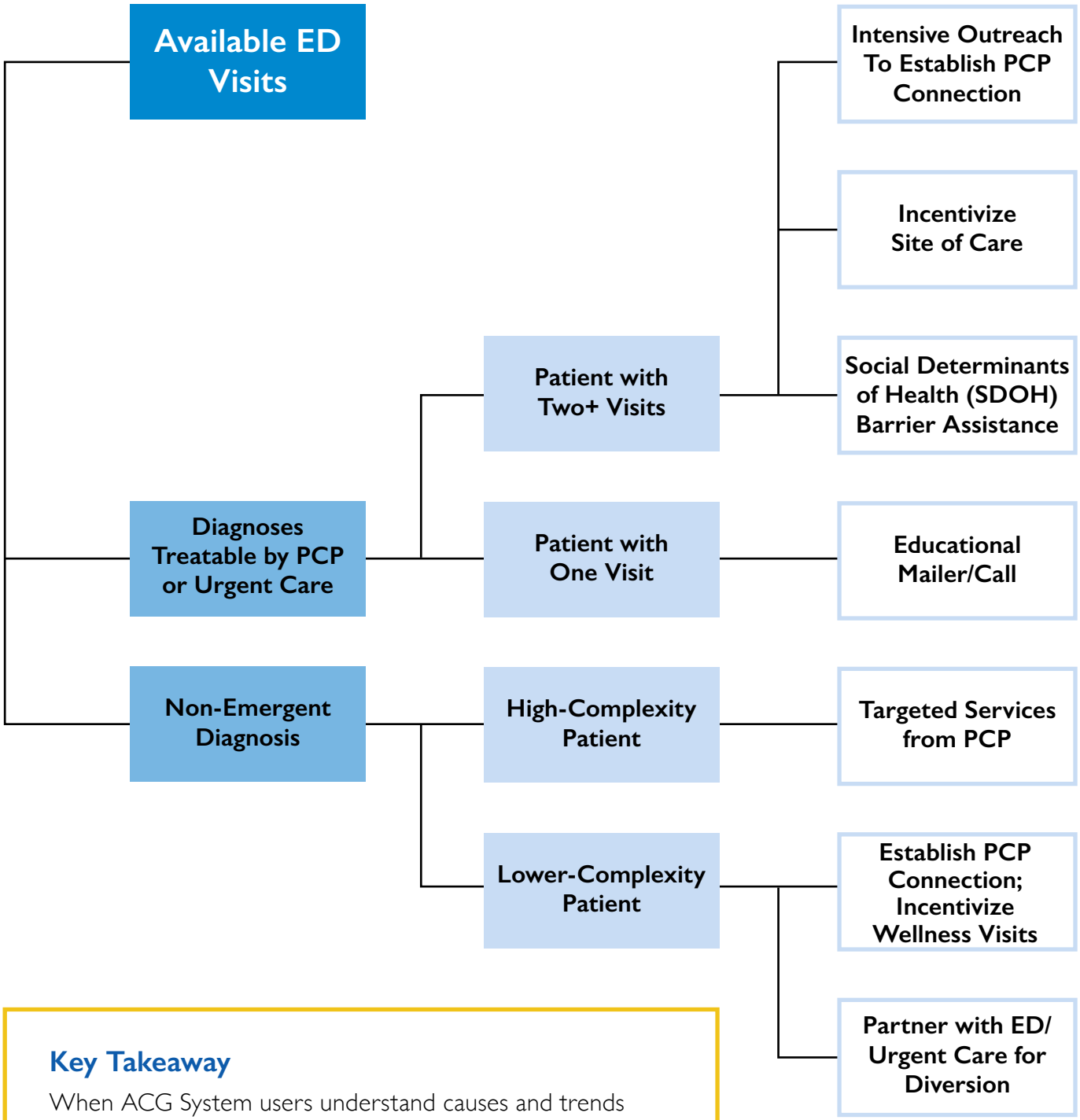
100% of ED Visits
Based on insured patients' emergency department visit data covering a one year period

Data from Johns Hopkins HealthCare. Includes emergency department visit data for Medicare, Medicaid and employer-insured patients covering a 1-year period.

Following a detailed ACG-driven analysis, System users can use patient-level outputs to deploy tactics to reduce potentially-avoidable ED visits. Patients with multiple ED visits for PCP-treatable diagnoses may benefit from outreach from their PCP, or assistance locating and working with a PCP if they do not have an existing relationship. The organization may wish to assess systemic access barriers as well, such as transportation challenges, PCP office hours/appointment availability or prohibitively high co-pays for PCP visits.

Another impactable patient group are those visiting ED departments for non-emergent diagnoses. ACG System users can identify and target relatively healthy patients (those with lower Resource Utilization Band (RUB) levels, for instance) with educational campaigns and incentives for PCP visits. Likewise, individuals with more complex needs, multiple chronic conditions or care coordination challenges can be directed to targeted preventive services and guidance from their PCP. The ability to tailor a specific approach maximizes impact while meeting patient-specific care needs.

The diagram to the right shows how the ACG System can support strategy creation and provides a tactical approach to reducing ED utilization. The ACG System helps understand patient groups and utilization patterns, facilitating a targeted approach to interventions.



Key Takeaway

When ACG System users understand causes and trends in ED use at this granular level, they can proactively target patients with potentially avoidable visits and deploy interventions to reduce avoidable ED use. The result? Improved PCP relationships and lower unnecessary ED visits.

5. Partner to Achieve System Transformation

- **Data Sharing and Interoperability:** The ACG System's ability to analyze data across different systems and settings makes it a valuable tool for collaboration among health care providers, payers and community organizations. This facilitates system-wide transformation by promoting coordinated care and shared accountability.
- **Performance Measurement:** The ACG System supports performance tracking and benchmarking against national standards. This helps organizations align their goals with CMS strategies and drive continuous improvement.
- **Taking a Closer Look: Using Population Health Analytics to Support System-wide Change**
  In 2023, Johns Hopkins Medicine created a department to improve population health, create data-driven care models and reduce health disparities. This department, the Office of Population Health (OPH), supports the Johns Hopkins Health System in the execution of value-based care (VBC) initiatives. The OPH's initial priority was to identify newly high-risk and high-utilizing patients. Detailed analysis with ACG System tools provided both historical information and projected future risk including:

    - Patients with more than two hospitalizations or observation stays in the last six months
    - Patients with more than three visits to the ED in the last six months
    - Patients with an ACG risk score that indicated a higher likelihood of hospitalization in the next six months

A master list of these high-risk patients was created every two weeks and shared with other patient-centered departments within Johns Hopkins Medicine. This ensured improved coordination between inpatient and outpatient teams and helped everyone provide better care for these patients.

The OPH then identified key focus areas using an advanced strategic planning process with dozens of stakeholders across the enterprise, all collectively agreeing on two guiding missions: 1) to bend the utilization curve and 2) to reduce health disparities.

This process led the group to develop the following tactics to support their strategic plan:

An advanced analytics roadmap, supported by the ACG System and subsequent analytics.

Clinical service delivery tied to population health.

Monitoring engagement and performance in VBC contracts.

Aligning health system goals across Johns Hopkins Medicine entities, focusing on population health.

The OPH strategic plan was a catalyst of harmonized population health activities across Johns Hopkins Medicine. These efforts leveraged VBC incentives in order to improve overall health and performance.

Supported by resources like the ACG System, health systems can use these best practices when assessing their own transition to value-based care.

- **Data is analyzed at every opportunity.** Using the ACG System, patient groups are identified and supervised to ensure they receive appropriate care. Eventual patient outcomes and total cost of care are reviewed to confirm performance standards.

- **Over-utilization and other trends are reviewed to identify places where resources may be used excessively.** The total cost of care is analyzed to find opportunities for savings, increased efficiencies and to increase the value of care provided to patients.

- **Data is reviewed to see what type of care can provide the most impact for a population, then that care is introduced to additional groups in need.** That data is also shared among different departments to better coordinate care.

Conclusion

CMMI has developed their core strategies to help organizations combat prevalent health care challenges. From reductions in care disparity to affordable treatments, all patients deserve the best care access to ensure they can reach their best health.

To improve these and other metrics, it's important to focus on the specific social needs of different groups. When organizations use this information to create strategies that promote fairness and reduce differences, we will see fewer poor outcomes and increased patient satisfaction.

The Johns Hopkins ACG System delivers important features and insightful analytics to help your organization reduce disparities in patient care, address social needs that contribute to poorer health outcomes and address the increasingly important need to deliver value-based care. By using the Johns Hopkins ACG System, your organization can improve health care delivery, support fairness and manage costs better, all while adapting to rapidly changing health needs.

ABOUT THE **ACG SYSTEM**

The Johns Hopkins ACG System is the world's leading population health analytics software. The system continues to evolve, providing ever-more refined tools used in the US and across the globe for over 30 years, from commercial health plans and governments to health systems and large employers. The beauty of the ACG System is its ability to combine data from an array of sources to reveal powerful insights that go beyond just medical records.

By identifying risk and tracking patients over time, the ACG System can help you plan ahead and reduce health care costs—especially valuable to risk-bearing health systems and provider organizations. Most importantly, the ACG System allows you to be proactive rather than reactive when it comes to your population's unique health care needs. The system helps you combine a population-level perspective with patient-level behaviors and conditions. And because the system is incredibly flexible and responsive to new information, you can rest assured that no matter what comes next, the ACG System will continuously adapt to your health care management needs.

To Learn More

Please visit www.hopkinsacg.org or email acginfo@jh.edu