Accelerating Health System Transformation

What role for ACOs? How might we do better?

Overview

Conceptual framework: what are we trying to achieve?

Where are we now?

- National policy context
- What do we know about ACO capabilities?
- What do ACOs think is important?

What role for certification?

What else might we do?

Moving forward

Conceptual Framework

What are we trying to achieve?

Purpose: improve care, improve health, lower costs

- For patients served by health systems
- For all residents of communities they serve

Sources of leverage

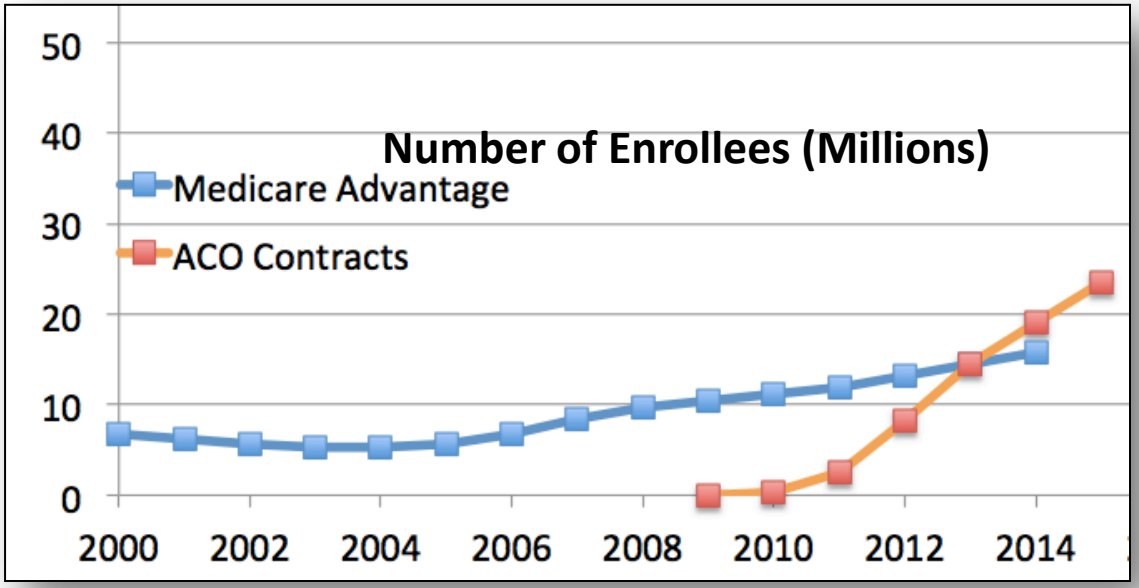
- Financial incentives
- Regulation
- Performance measurement / public reporting
- Learning / feedback / technical support

Where are we now?

National Policy Context

ACO payment model continues to expand

- 749 ACOs (February)
  - Physician Group: 295
  - Hospital led: 314
  - Insurer 54
  - Government 404
  - Commercial 220
  - Both: 104



Sources: Kaiser Family Foundation; Leavitt Partners

Where are we now?

National Policy Context

Early evidence: glass half full

- Quality
  - ACO systems performing better than FFS (selection)
  - ACOs improving on almost all measures (selection less likely)
- Cost: modest savings (MSSP, Pioneer, AQC)
- Contributing to slowing of Medicare spending growth?
- Medicaid ACOs appear promising

Early evidence: glass half empty

- Medicare: half achieved savings; one quarter got bonus
- Major concerns about MSSP and Pioneer
  - Financial model too unpredictable; too little early return
  - Difficult for ACOs to engage patients (MedPAC: 1/69)
- Many still on sidelines; many playing volume / price game

Where are we now?

National Policy Context

Federal commitment to moving forward appears strong

- Secretary Burwell's announcement
  - ACOs: 30% by 2016; 50% by 2018:
- CMS moving forward
  - Revision of MSSP rule underway
  - Additional CMMI programs likely ("Vanguard"?)

Private sector? Health Care Transformation Taskforce

- Purchasers, Payers, Providers and Patients -- together
- Commitment to 75% Triple-aim based contracts by 2020

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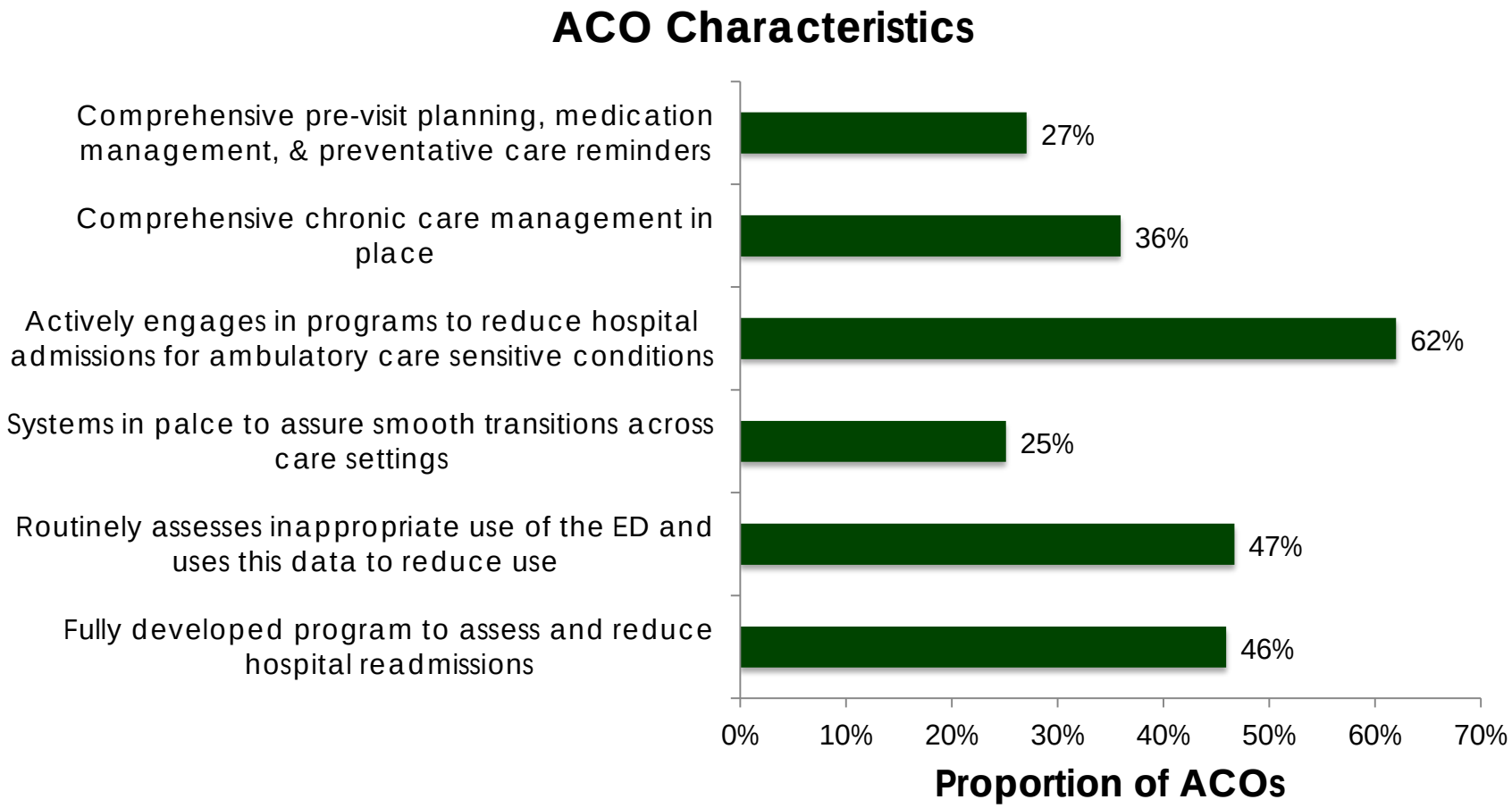
Where are we now?

ACO Capabilities



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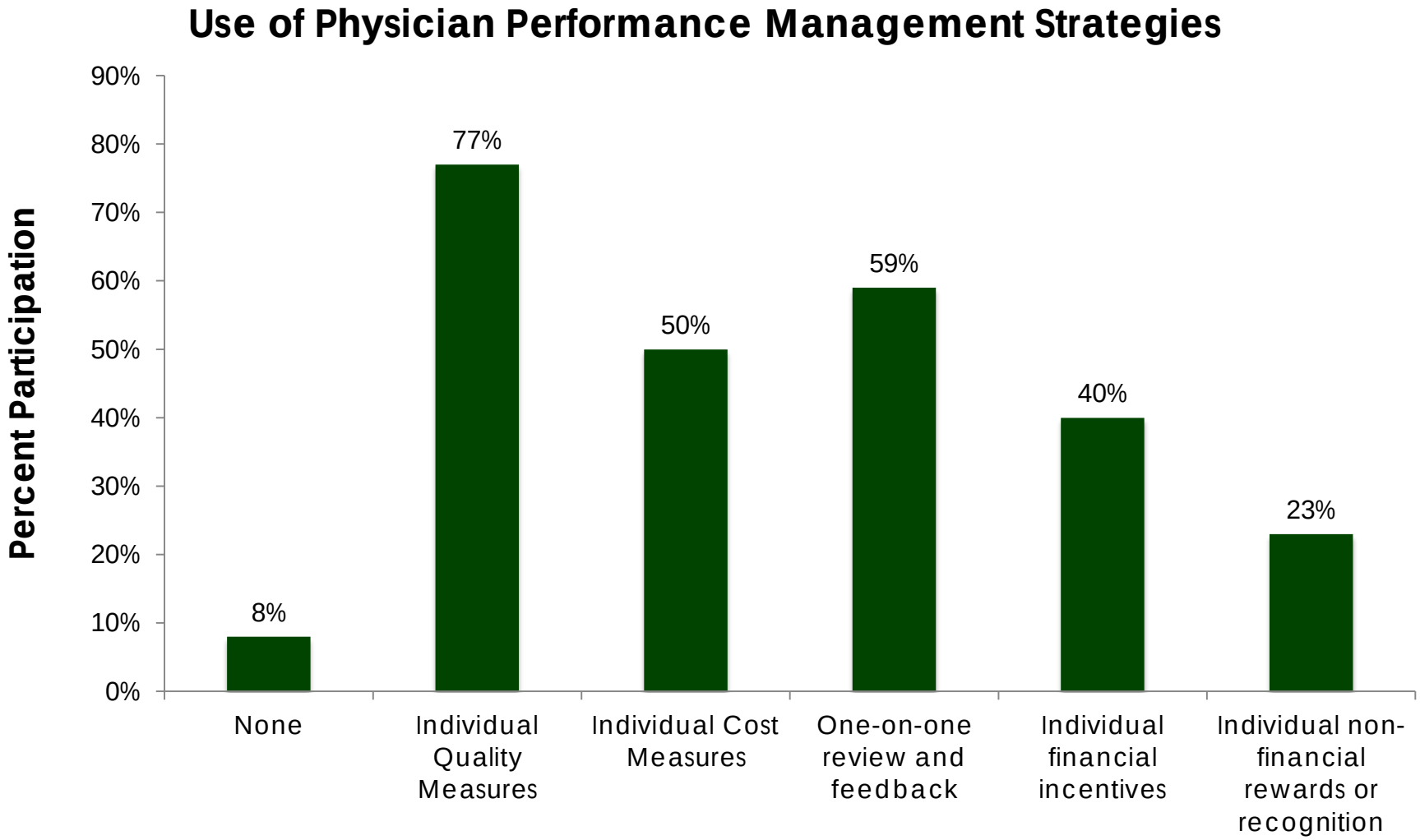
Where are we now?

ACO Capabilities



Where are we now?

What do we know about what ACOs think is important?

ACO Readiness Tool – Origins

- Developed with health system executives
- Help them answer question: "What should I do?"
- Content: NSACO, AMGA, executives under APMs
  - Priorities: "How important is this to success?"
  - Competency: "How are you doing on this?"
- Gaps are informative:
  - Between priorities and self-assessed competency
  - Between executives and front-line providers

Data now includes

- 14 systems
- Two Pioneers

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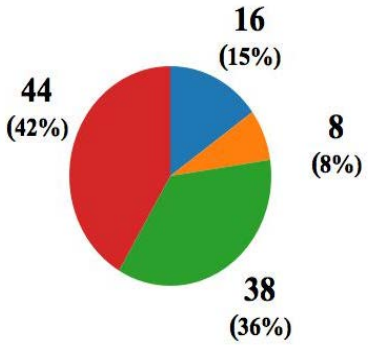
Where are we now?

What do we know about current perceptions of priority for value-oriented Domains?

Evaluator Role Legend

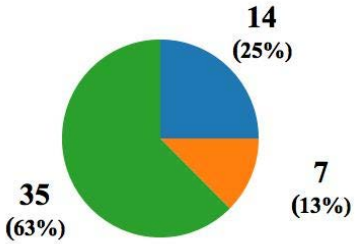
- Executive Leader
- Senior Leader
- Business or Clinical Leader
- Care Provider

Pioneer A



106 Total Respondents

Pioneer B



56 Total Respondents

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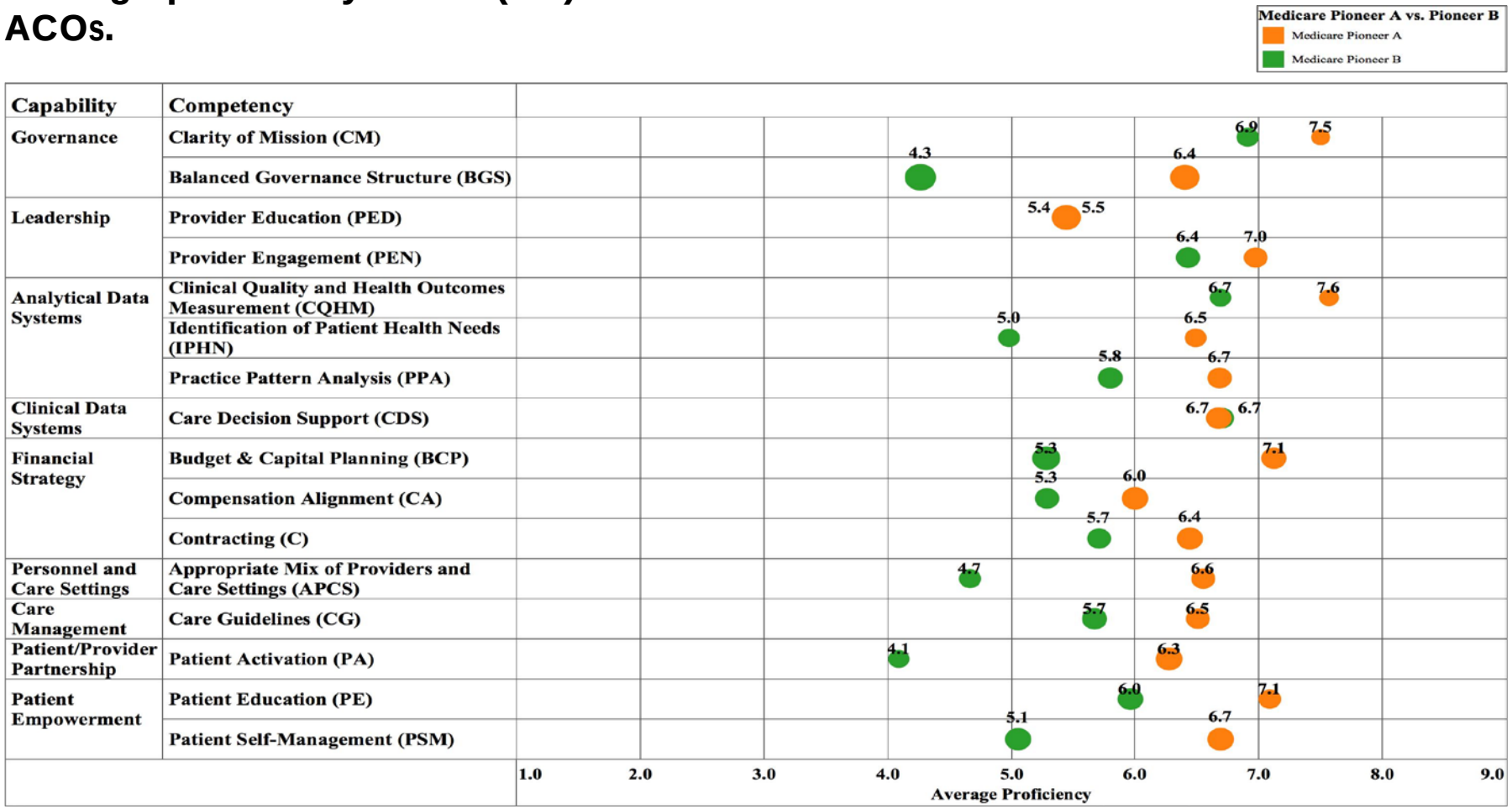
Where are we now?

What do we know about current perceptions of proficiency for value-oriented Competencies?

Average proficiency scores (1-9) for two Medicare Pioneer ACOs.



Bubble size indicates level of agreement across respondents – a bigger bubble indicates a wide variation in responses

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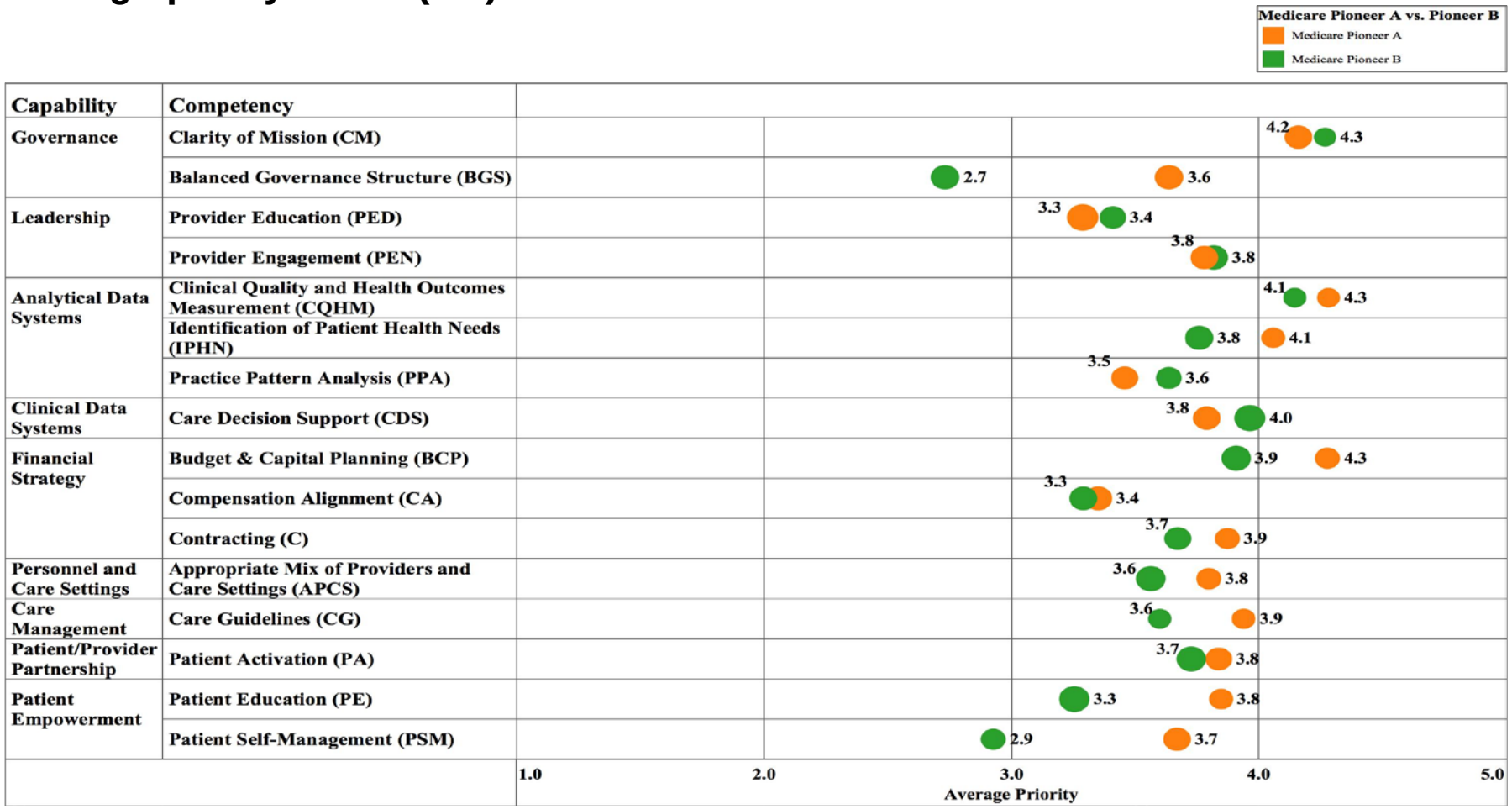
Where are we now?

What do we know about current perceptions of priority for value-oriented Domains?

Average priority scores (1-5) for two Medicare Pioneer ACOs.



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Certification: General thoughts

Challenges:

- Current evidence on link between capabilities and performance is thin
- Exceptions:
  - Leadership: essential (but hard to regulate)
  - Insurance oversight if risk bearing
  - Performance reporting (so we know how they are doing)
- *Context matters* – organizational and market level
  - Remarkable diversity in current models

Over-specification likely harmful

- Reduces likelihood of innovative models emerging
- Precludes learning from variation

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Certification: Minimum standards, ACO Level 1

What I would hope for:

- Align with MSSP to extent possible
  - Encourage systems to move to all-payer ACO contracts
- Minimize burden of starting down APM pathway
- Allow flexibility, innovation, learning

Legislative language seems clear

- ACO must report how they are meeting requirements
- Avoid specifying exactly how (would allow flexibility)

Consider:

- Standardized reporting on structure, contracts, capabilities
- (Again – to support learning)

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Certification: Progression to higher levels

What is the purpose of Levels 2 and 3?

- Higher levels of risk bearing? Insurance regulation wise
- Higher rewards? (reasonable idea)
- Motivation? (gold star? Support marketing?)

A few thoughts:

- Link levels to:
  - Proportion of primary care patients under ACO model
  - Degree of risk bearing
  - Ability to report on advanced measures (PROMs, health risk)
  - Price reductions for remaining FFS contracts
- What might alternative be?
  - *Transparency on performance*
  - *Graduated shared savings*

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Specific issues

Cross-continuum network

- Goal: coordination, effective transitions, information flow
- Concern: what if best care is outside ACO?

Clinical integration, practice guidelines, EBM, performance improvement, population health management

- Information systems; risk stratification, gap analysis; teams
- Process improvement (team); provider feedback (individual)

Aligned incentives within ACO

- Proportion of patients under APMs important
- Likely varies by site / provider (PCPs vs Hospital vs post-acute)
- How to encourage referral outside when better/cheaper care
- Might transparency help? (unit price)

What else might we do?

Leveraging certification process to accelerate learning

Sources of leverage

- Regulation; financial certification
- Payment model concordance (push other payers)
- Performance measurement / public reporting
- Learning / feedback / technical support

How certification could help:

- Design the certification process to accelerate learning
- Standardized data collection; link to performance tracking
- Use assessments to identify peer-coaching opportunities

And:

- Technical support (NAACOs); Access to evidence
- Data support;