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
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
Where are we now?

ACO Capabilities

ACO Characteristics

- Comprehensive pre-visit planning, medication management, & preventative care reminders: 27%
- Comprehensive chronic care management in place: 36%
- Actively engages in programs to reduce hospital admissions for ambulatory care sensitive conditions: 62%
- Systems in place to assure smooth transitions across care settings: 25%
- Routinely assesses inappropriate use of the ED and uses this data to reduce use: 47%
- Fully developed program to assess and reduce hospital readmissions: 46%
Where are we now?
ACO Capabilities

Use of Physician Performance Management Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percent Participation</th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td>8%</td>
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<tr>
<td>Individual Quality Measures</td>
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<tr>
<td>Individual Cost Measures</td>
<td>50%</td>
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<td>One-on-one review and feedback</td>
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<tr>
<td>Individual financial incentives</td>
<td>40%</td>
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<td>Individual non-financial rewards or recognition</td>
<td>23%</td>
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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
Where are we now?  
What do we know about current perceptions of priority for value-oriented Domains?

Pioneer A
- 16 (15%) [Executive Leader]
- 8 (8%) [Senior Leader]
- 38 (36%) [Business or Clinical Leader]
- 44 (42%) [Care Provider]

106 Total Respondents

Pioneer B
- 14 (25%) [Executive Leader]
- 7 (13%) [Senior Leader]
- 35 (63%) [Business or Clinical Leader]

56 Total Respondents
**Average proficiency scores (1-9) for two Medicare Pioneer ACOs.**

<table>
<thead>
<tr>
<th>Capability</th>
<th>Competency</th>
<th>Average Proficiency</th>
<th>Medicare Pioneer A</th>
<th>Medicare Pioneer B</th>
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<td>4.3</td>
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<td>Balanced Governance Structure (BGS)</td>
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<td></td>
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<td></td>
<td>Practice Pattern Analysis (PPA)</td>
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Bubble size indicates level of agreement across respondents – a bigger bubble indicates a wide variation in responses.
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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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
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)
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
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;