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# ACO Rule "Deep Dive:" 5 Critical Questions on Population, Network and Data Strategy

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# Context for Discussion

*#1:* My Assumption: You've read the proposed rule, understand the framework - risk glide path, program flexibility, benchmark adjustments, and are preparing a response

*#2:* My Take: CMS' Proposed ACO rule builds on progress, offers more strategic choices, and introduces greater data sharing, patient engagement pathways

*#3:* Questions for Today's Discussion

-What Population Should We Serve?

-What Participants do We Enlist?

-How Experienced is our Network?

-How Might We Operationalize Waivers?

-How Might we Leverage the "MyHealthEData" Initiative?

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# My Bias on Delivery IT Infrastructure: Open Data, APIs, Care Model Code

**PROPOSED STRATEGY FOR EXECUTION OF THE HEALTH INFORMATION TECHNOLOGY INVESTMENT PROGRAM**

**Draft, February 24, 2009**

**EXECUTIVE SUMMARY**

The $19 billion health information technology (HIT) investment authorized in the American Recovery and Reinvestment Act (ARRA) represents a landmark opportunity to improve health care. In considering how best to execute on this opportunity, it is critical to understand that to treat the HIT investment program as a pure technology implementation program is to effectively guarantee its failure. HIT is not magic. In the absence of provider payment reform and care delivery innovation, it is all too easy to imagine spending $19 billion on HIT adoption and producing little tangible social benefit. However, there is a clear path to victory:

- If we avoid focusing the HIT investment program narrowly on HIT adoption and instead focus it explicitly on the actual improvement of population health, and
- If we use the HIT investment to catalyze a "virtuous cycle" of (1) provider payment reform, (2) care delivery innovation, and (3) HIT adoption
- Then: the HIT investment can literally transform health care as we know it.

To accomplish this, we propose a strategy in five parts:

1. Establish clear *population health* improvement goals for the HIT investment program (not just HIT adoption goals) -- with the aid of an HHS "enterprise program office"

2. Set the right criteria for receiving HIT incentive payments – criteria derived from the program's population health goals and not by arbitrary use cases and technological specifications

1. Clear pop health goals, not IT adoption
2. IT incentives tied to pop health goals, care models
3. "HIT Bullpen" tied w/ CMS payment reform team (care model code mapping)
4. Extension centers to aid physician practices
5. "x-Prize" to seed radical innovation

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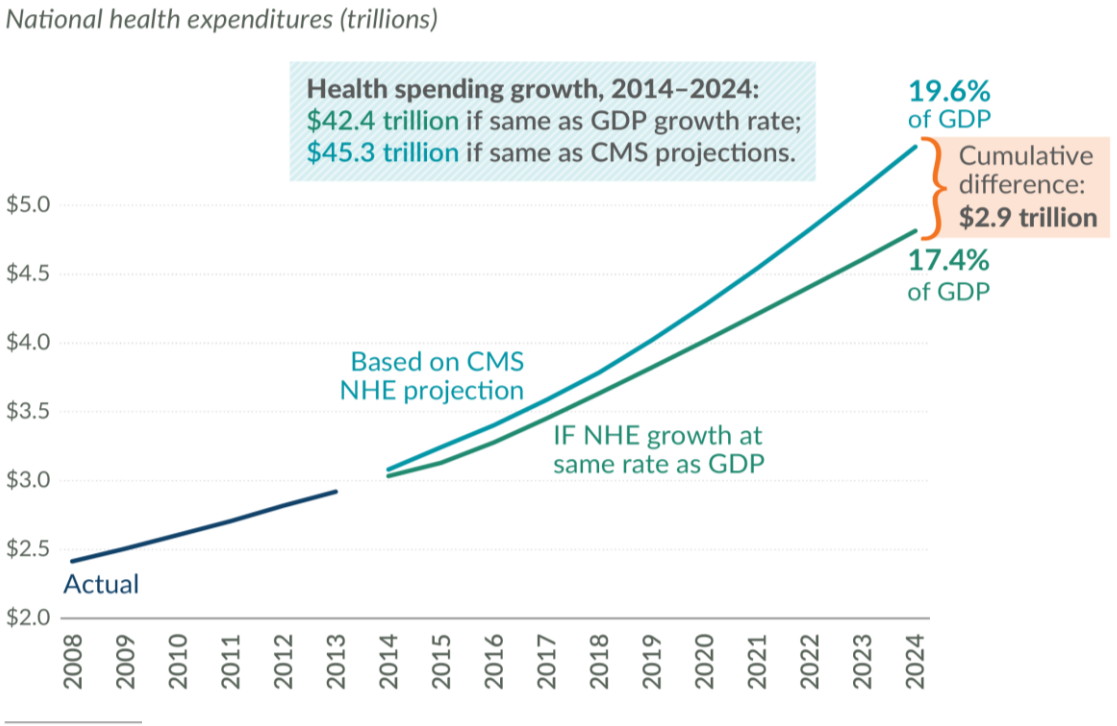
# CMS Proposed Rule Offers “Glide Path” to Realize ACO Program Potential




Source: Author's a
Health Expenditu
NationalHealthEx

## Table 4. Performance by Cohort

| Start Date | Number of Records | Per Capita Benchmark (Total) | Per Capita Exp. (Total) | Per Capita Savings | Per Capita Earned Savings | Net Savings Per Capita |
|---|---|---|---|---|---|---|
| 4/1/2012 | 15 | $11,208 | $10,807 | $401 | $210 | $191 |
| 7/1/2012 | 48 | $10,862 | $10,705 | $158 | $125 | $32 |
| 1/1/2013 | 62 | $10,699 | $10,469 | $230 | $138 | $92 |
| 1/1/2014 | 79 | $10,524 | $10,317 | $207 | $92 | $115 |
| 1/1/2015 | 76 | $10,583 | $10,515 | $69 | $66 | $3 |
| 1/1/2016 | 96 | $10,454 | $10,420 | $34 | $60 | -$26 |
| 1/1/2017 | 96 | $10,204 | $10,183 | $20 | $41 | -$20 |
| Grand Total | 472 | $10,554 | $10,433 | $122 | $87 | $35 |

## TABLE 14—PY 2016 RESULTS BY SHARED SAVINGS PROGRAM TRACK

| Track | Two-sided Risk? | Number of ACOs Reconciled | Parts A and B Spending Above Benchmark [A] | Parts A and B Spending Below Benchmark [B] | Shared Savings Payments from CMS to ACOs [C] | Shared Loss Payments from ACOs to CMS [D] | Net Effect in Aggregate [A minus B plus C minus D] | Net Effect per Beneficiary per year |
|---|---|---|---|---|---|---|---|---|
| Track 1 | No | 410 | $1.021 billion | $1.562 billion | $590 million | $0 | $49 million | $7 |
| Track 2 | Yes | 6 | $0 | $42 million | $24 million | $0 | −$18 million | −$308 |
| Track 3 | Yes | 16 | $25 million | $95 million | $64 million | $9 million | −$14 million | −$39 |

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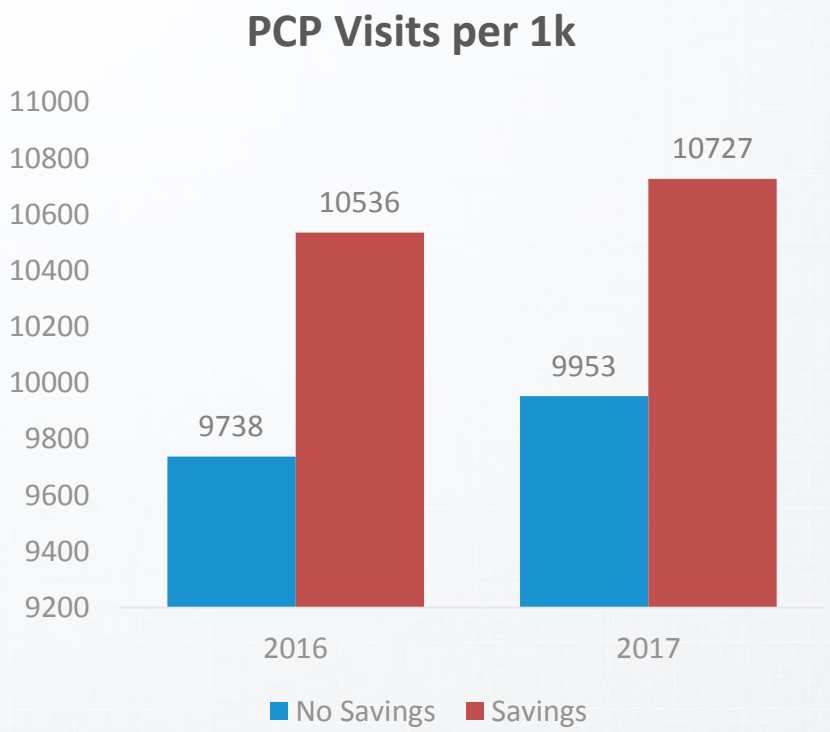
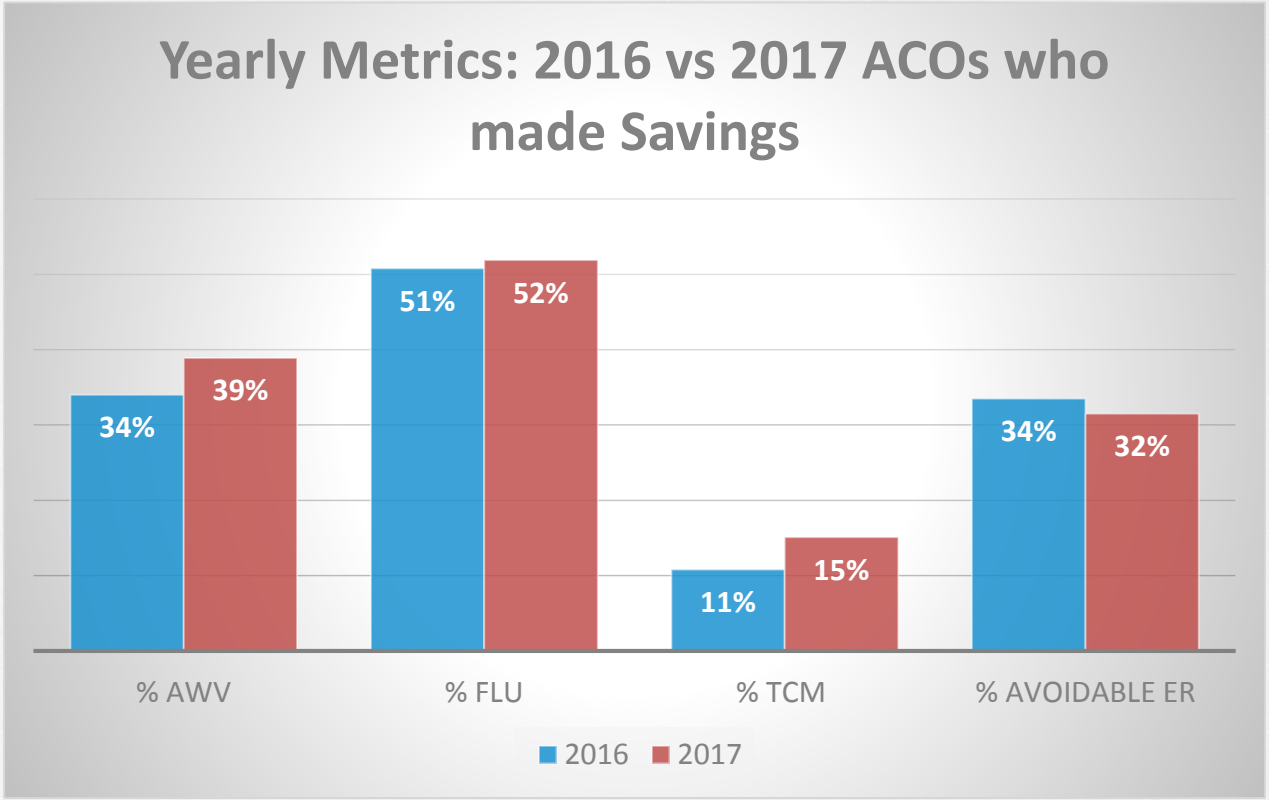
# Early Evaluation of 2017 ACO Results

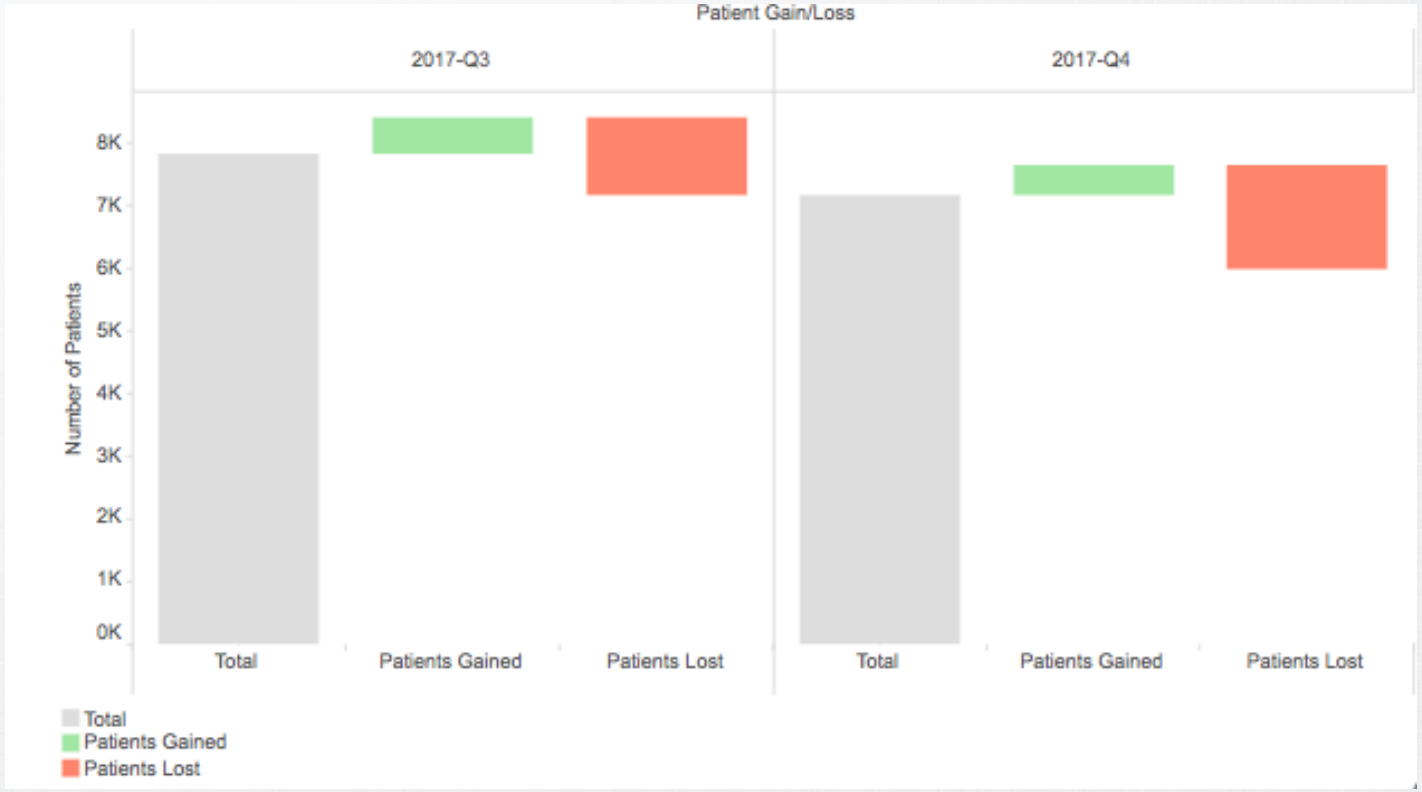


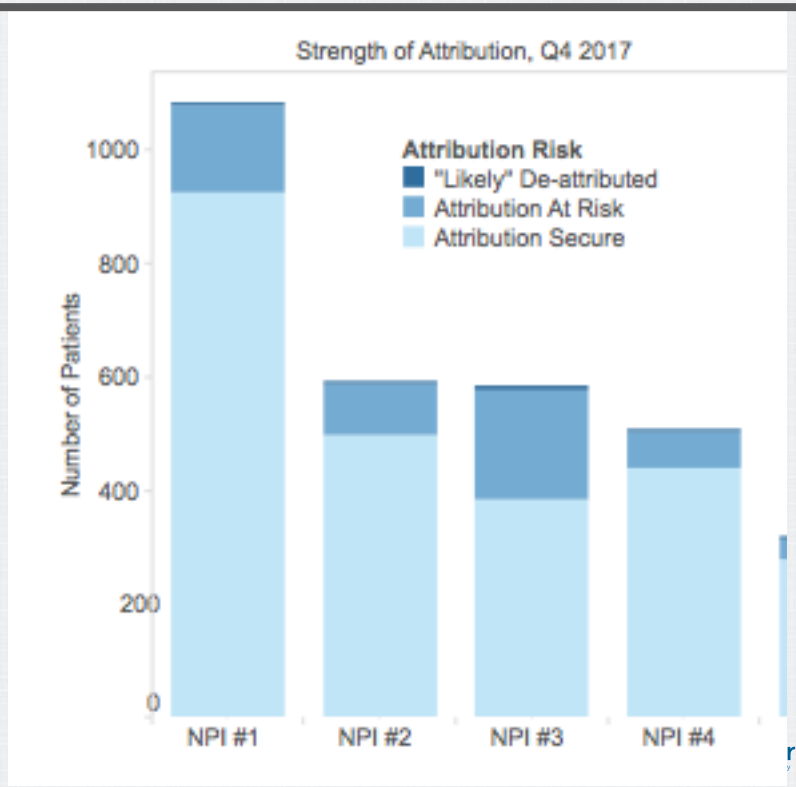




| | Number of ACOs | Per Capita Benchmark | Per Capita Expenditures | Per Capita Savings (Loss) |
|---|---|---|---|---|
| Physician-Led | 191.0 | 10641.141798 | 10433.640429 | 207.501369 |
| Hospital-Led | 281.0 | 10516.969160 | 10432.272863 | 84.696296 |
| **Total** | 472.0 | 10554.397322 | 10432.685075 | 121.712246 |

# #1) What Population Should We Serve?

- What is the patient population we are best prepared to serve?
- Which of the following strategies will maximize the population defined above?
  - Prospective Assignment with Retrospective Reconciliation
  - Prospective Assignment
  - Voluntary alignment

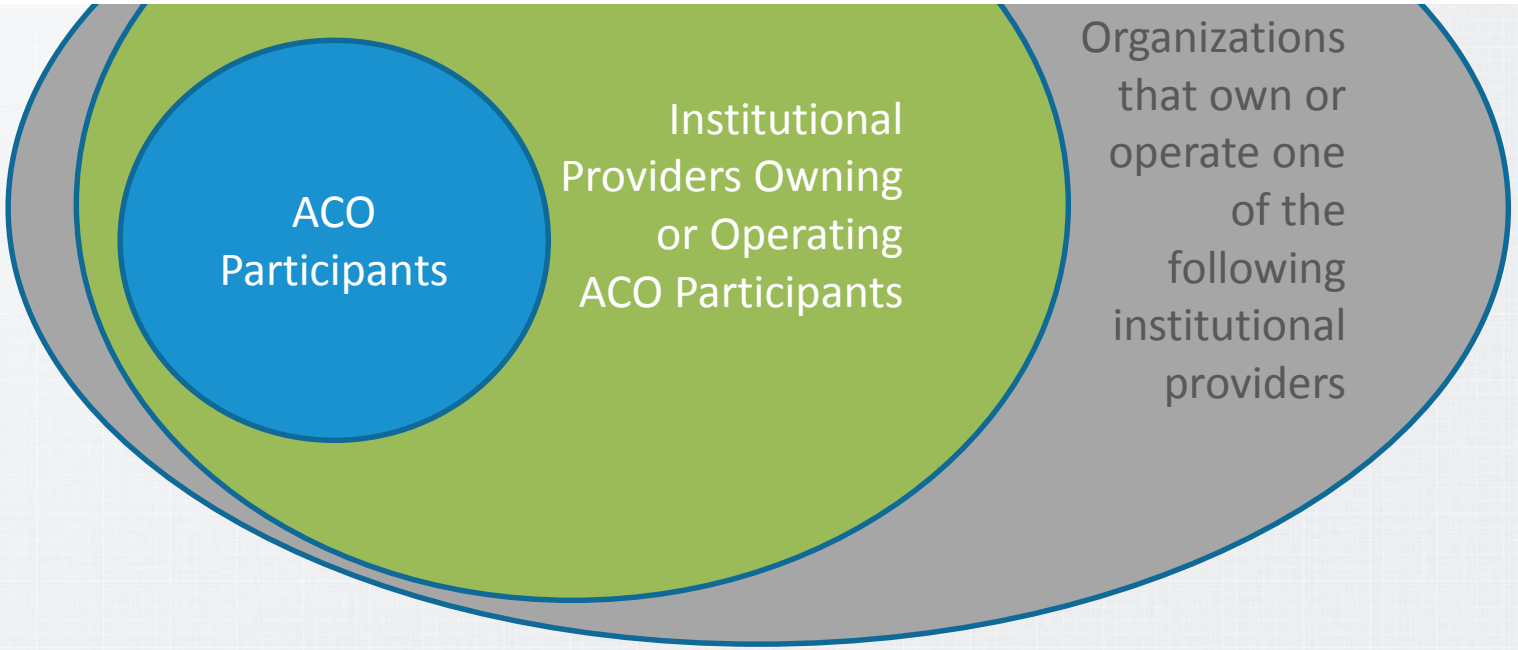


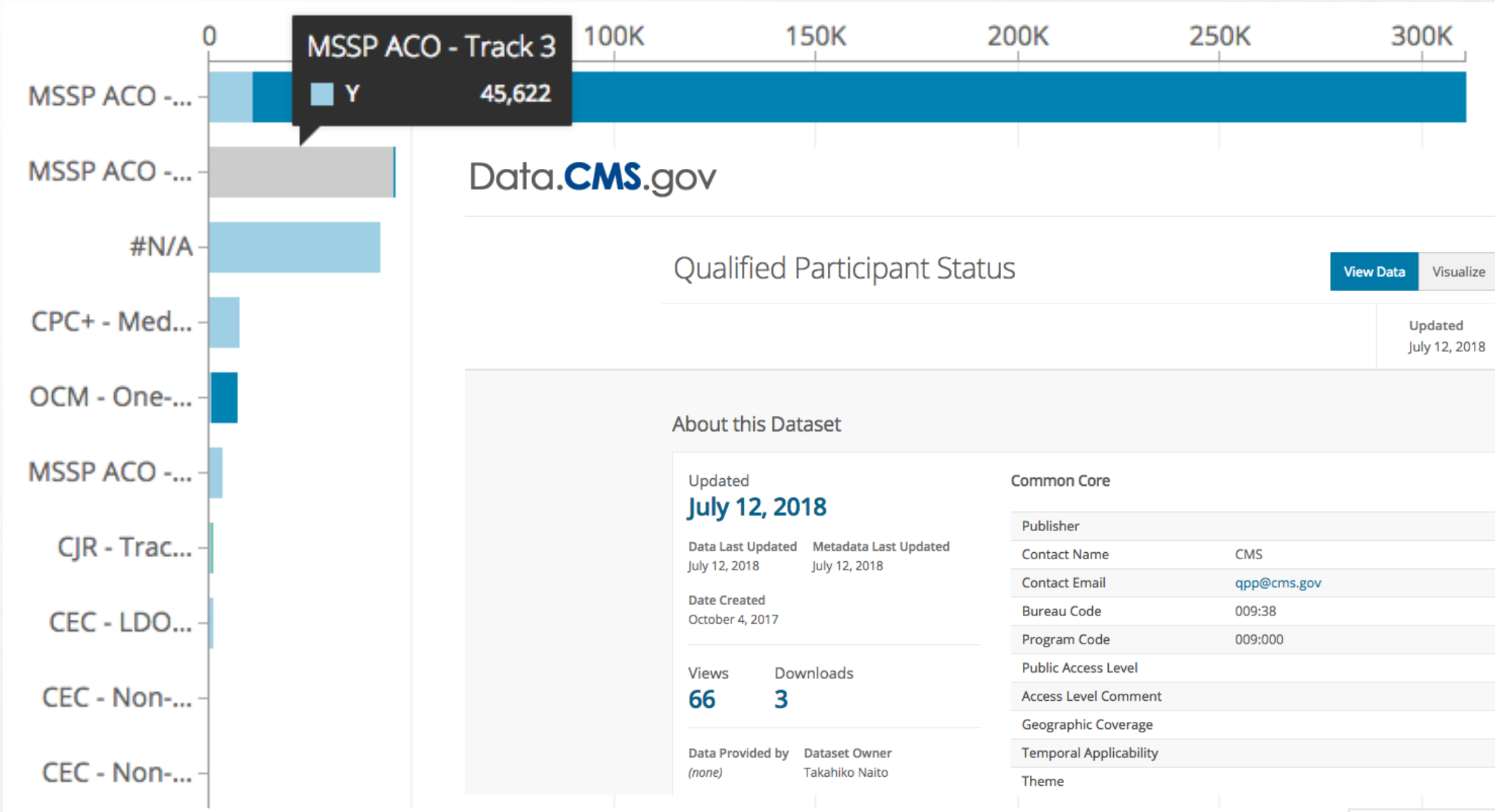
# #2) What Participants Do We Enlist? Are We “High” or “Low” Revenue?

**TABLE 15—PY 2016 RESULTS FOR LOW REVENUE AND HIGH REVENUE TRACK 1 ACOs**

| Track 1 ACO Composition | Number of ACOs (Total 410) | Parts A and B Spending Above Benchmark [A] | Parts A and B Spending Below Benchmark [B] | Shared Savings Payments from CMS to ACOs [C] | Shared Loss Payments from ACOs to CMS [D] | Net Effect in Aggregate [A minus B plus C minus D] | Net Effect per Beneficiary per Year |
|---|---|---|---|---|---|---|---|
| Low revenue | 188 | $339 million | −$863 million | $343 million | $0 | −$182 million | −$73 |
| High revenue | 222 | $682 million | −$698 million | $247 million | $0 | $231 million | $46 |



# #3) How Experienced is our Network? (Hint: Open Data Can Help)




Source: White House Office of the CTO

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# #4) How Might We Operationalize Waivers?

CMS expands the availability of waivers for eligible ACOs; how does this approach build upon our existing work to segment the population, match them to care interventions, and operationalize waivers into workflow?

- Might the **telehealth waiver** help us meet TCM patient contact requirements?
- Are there standardized assessments to determine whether a patient is eligible a good candidate for the 3-day **SNF waiver?**
- How can the **beneficiary incentives** allow us to begin conversations around care models such as Shared Decision Making with eligible beneficiaries?

# Matching High-Need Patient Segments to Emerging Care Models

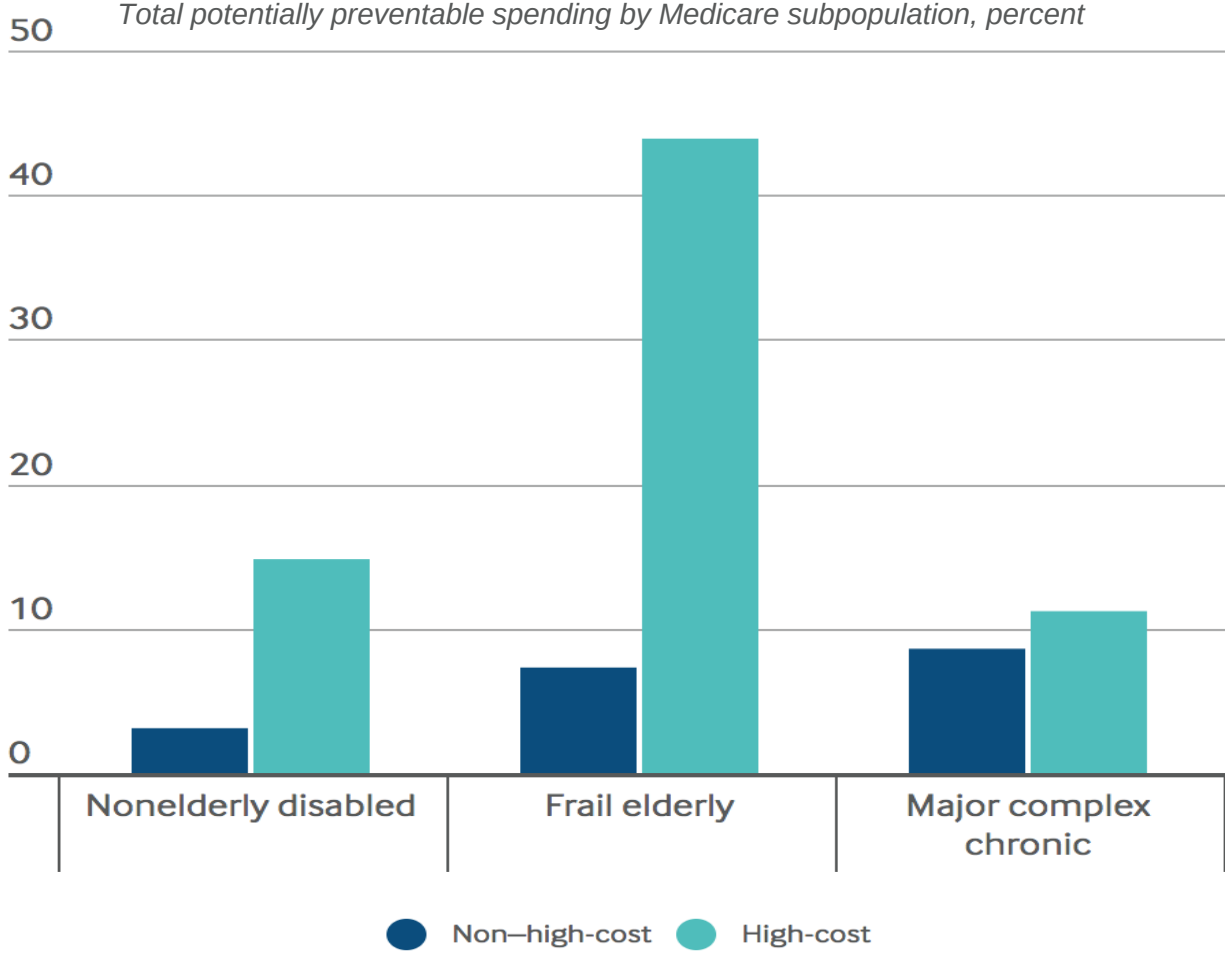
NATIONAL ACADEMY OF MEDICINE

## EFFECTIVE CARE FOR HIGH-NEED PATIENTS

OPPORTUNITIES FOR IMPROVING OUTCOMES, VALUE, AND HEALTH

| Leading Care Models |
| --- |
| Annual Wellness Visit |
| Chronic Care Management |
| Transitions of Care |
| Diabetes Prevention |
| End of Life Planning/Care |
| Collaborative Care |
| Accountable Health Communities |
| Million Hearts |
| Shared Decision Making |
| Oncology Care Model |

Proportion of Total Potentially Preventable Spending, by high-Cost Subpopulation




Adapted from J. F. Figueroa, K. E. Joynt Maddox, N. Beaulieu et al., "Concentration of Potentially Preventable Spending Among High-Cost Medicare Subpopulations," *Annals of Internal Medicine,* published online Oct. 17. 2017.

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# Case in Point: Oncology Care Model Telehealth Waiver

## Stats on OCM Cancer Pop

**+ Time period:** CY2017

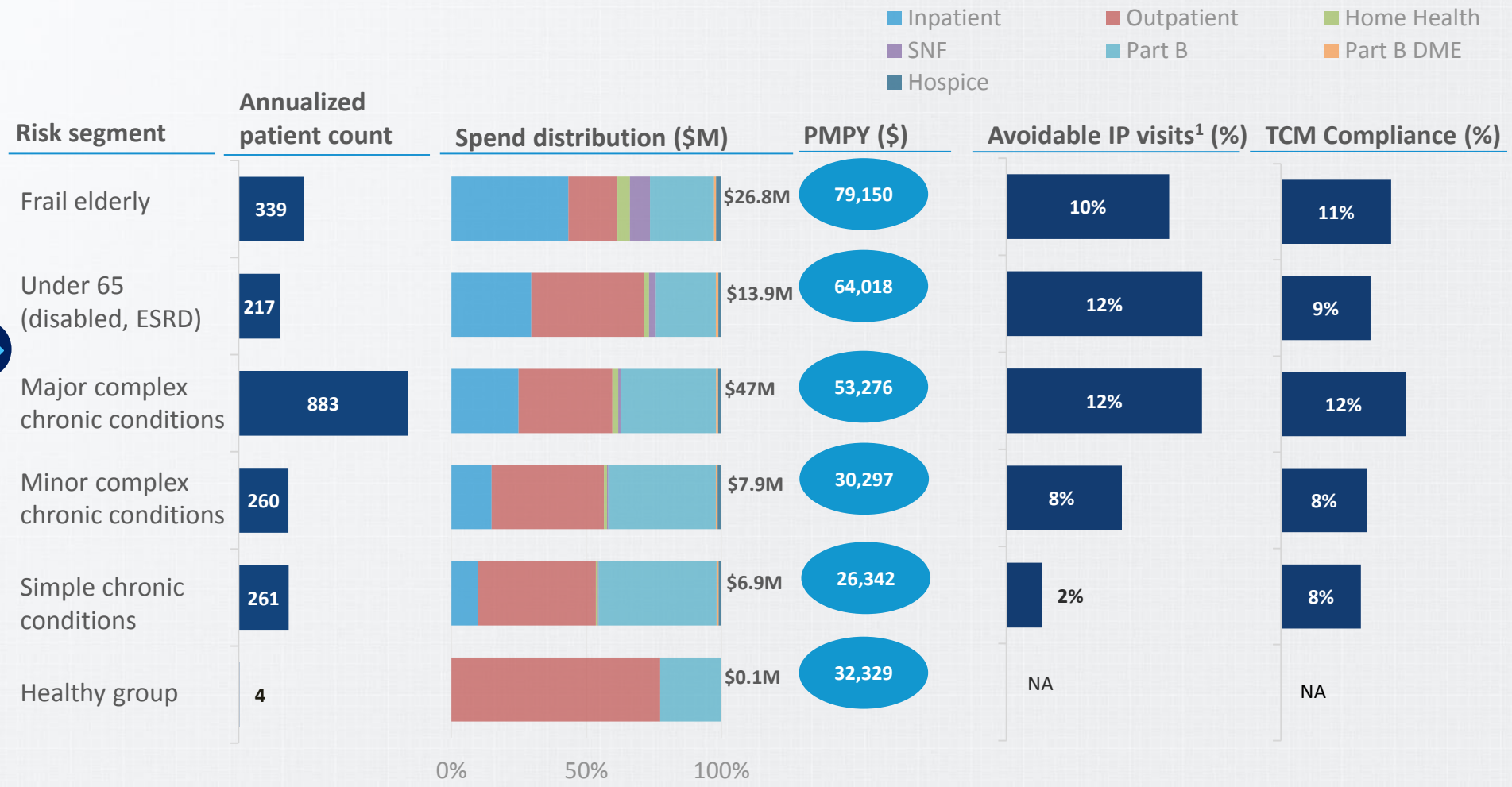
**+ Patient count & total spend:** **1,964 (3%)** out of ~81K annualized members in [Sample] are OCM active cancer patients and make up **~$103M (13%)** of **$810M** total spend at [Sample]

**+ Average PMPY Spend:** **$52,281** PMPY in the [Sample] OCM cancer pop vs **~$10K** PMPY in the general [Sample] population

**+ Percent of avoidable IP visits:** About **10%** of IP visits are avoidable in the cancer pop by AHRQ definition

**+ Average % TCM compliance:** About **10%** in cancer pop vs **~21%** in the [Sample] general pop

## [Sample] OCM active cancer population by frailty segments: spend, utilization and quality metrics




1 Avoidable IP visit here is defined as presence of AHRQ PQI measure during an IP stay

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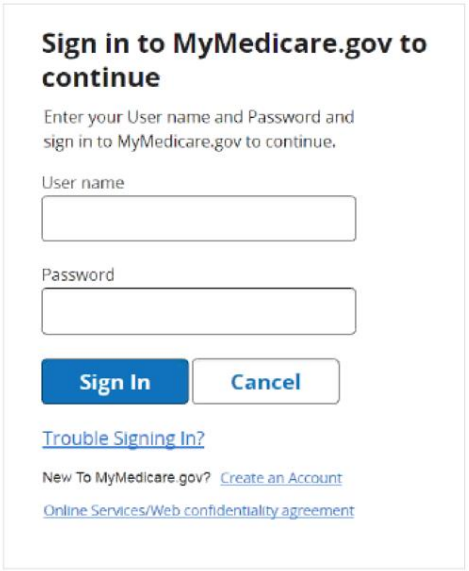
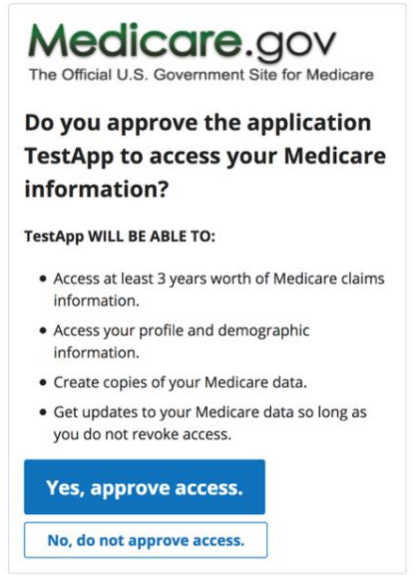
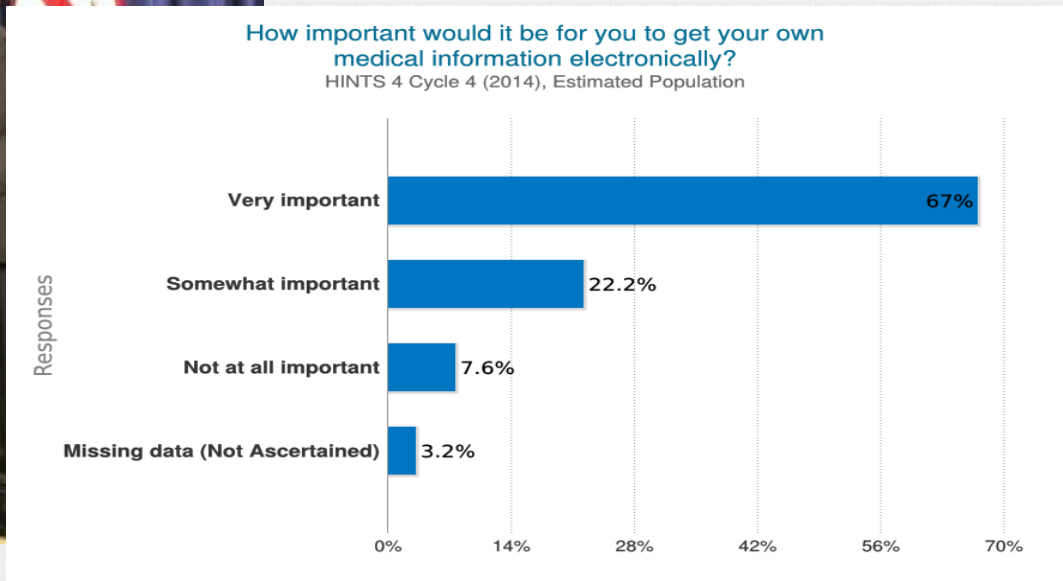
# How Might we Leverage the “MyHealthEData” Initiative?

MyHealthEData initiative emphasizes consumer data access rights via open APIs to consumer-designated apps; CMS challenges MA plans to “meet or exceed” Blue Button FHIR API by CY2020, celebrates “cloud platform” API commitment

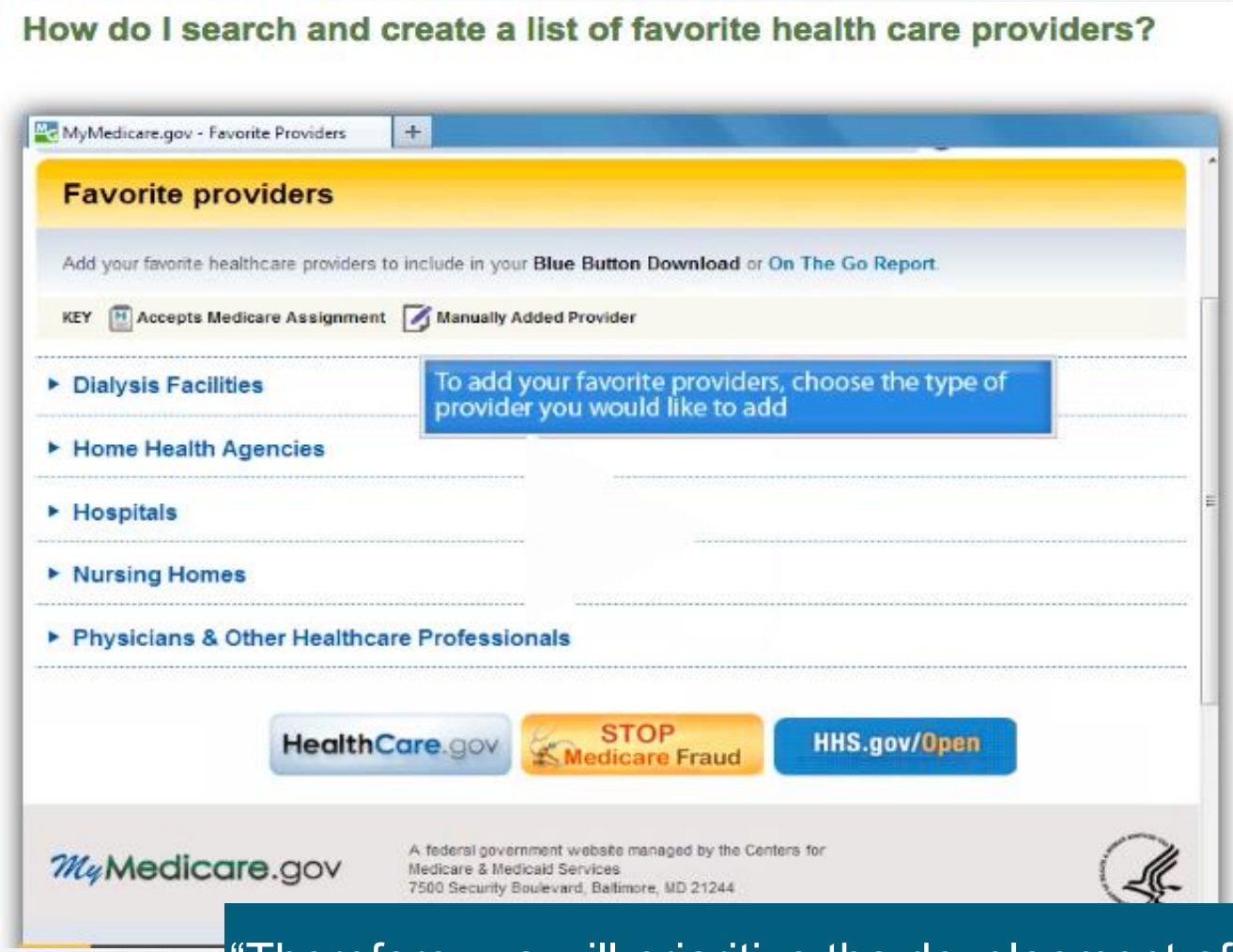


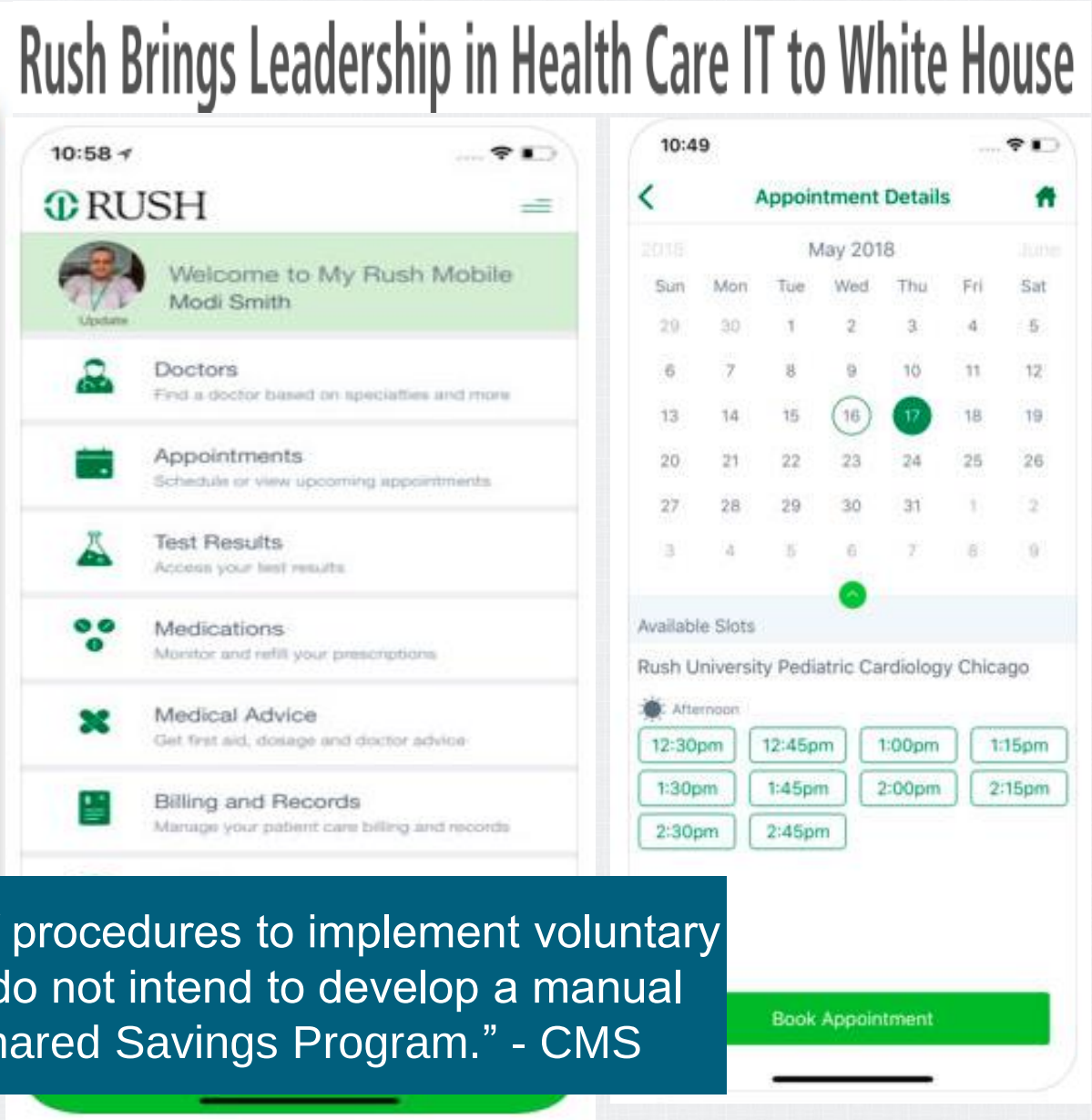




Source: CMS Blue Button Developer Conference; HINTS Survey

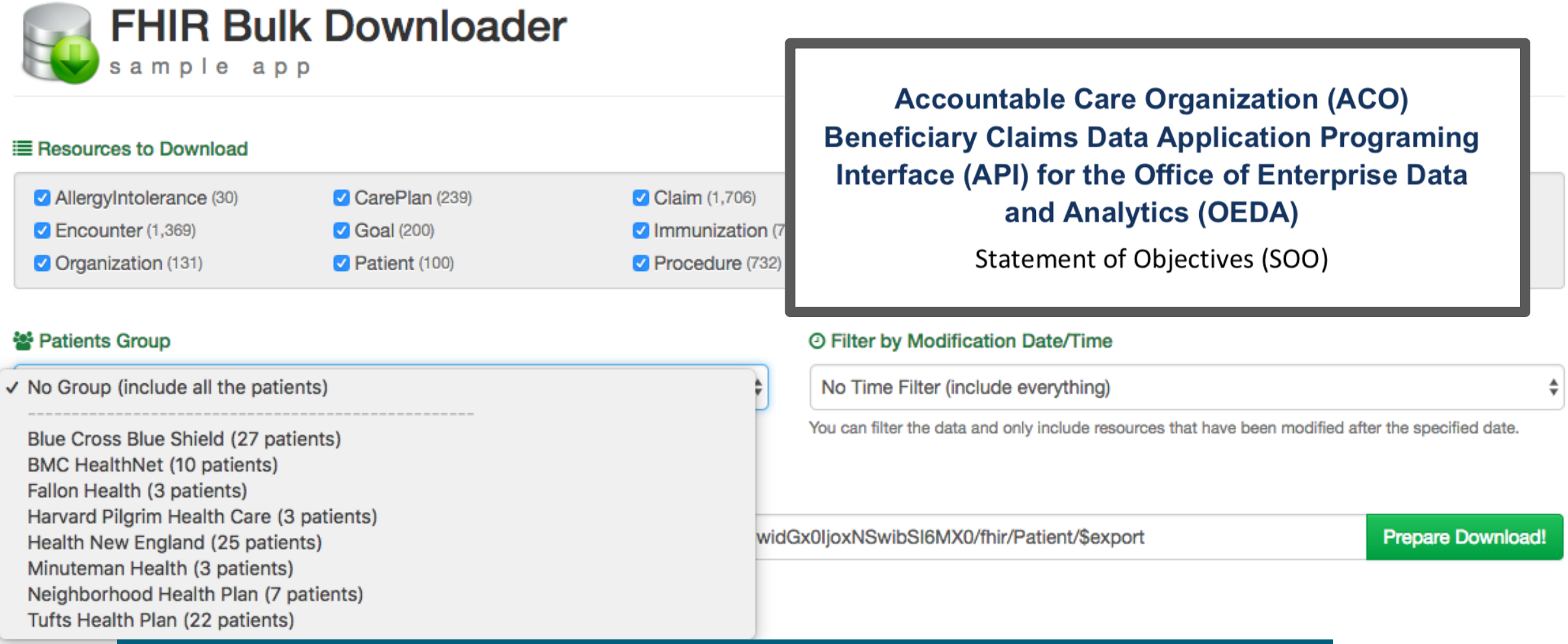
# Idea #1: Digital Voluntary Alignment




"Therefore, we will prioritize the development of procedures to implement voluntary alignment using an automated process…We do not intend to develop a manual beneficiary attestation process under the Shared Savings Program." - CMS

# Idea #2: “Bulk Access” APIs for Data Sharing (ACO Seeks Comments on Rx)




**Accountable Care Organization (ACO) Beneficiary Claims Data Application Programing Interface (API) for the Office of Enterprise Data and Analytics (OEDA)**

Statement of Objectives (SOO)

“ONC also supports the ongoing work to extend this open API technology to population-level data transfer…Central to a value-based health system is expanding the ability to find and move data for more than one patient at a time.”
ONC Director Don Rucker

Source: https://github.com/smart-on-fhir/fhir-bulk-data-docs; https://www.healthaffairs.org/do/10.1377/hblog20180618.138568/full/

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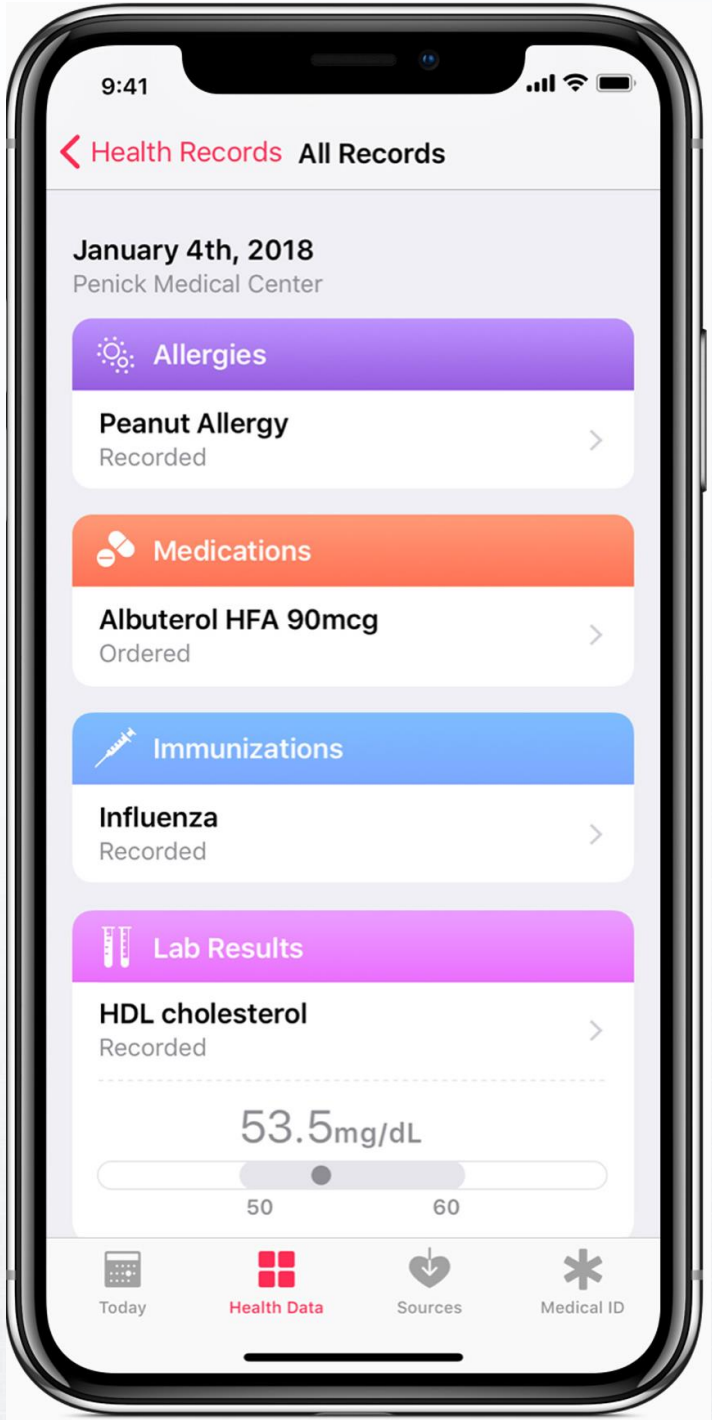
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All Records
January 4th, 2018
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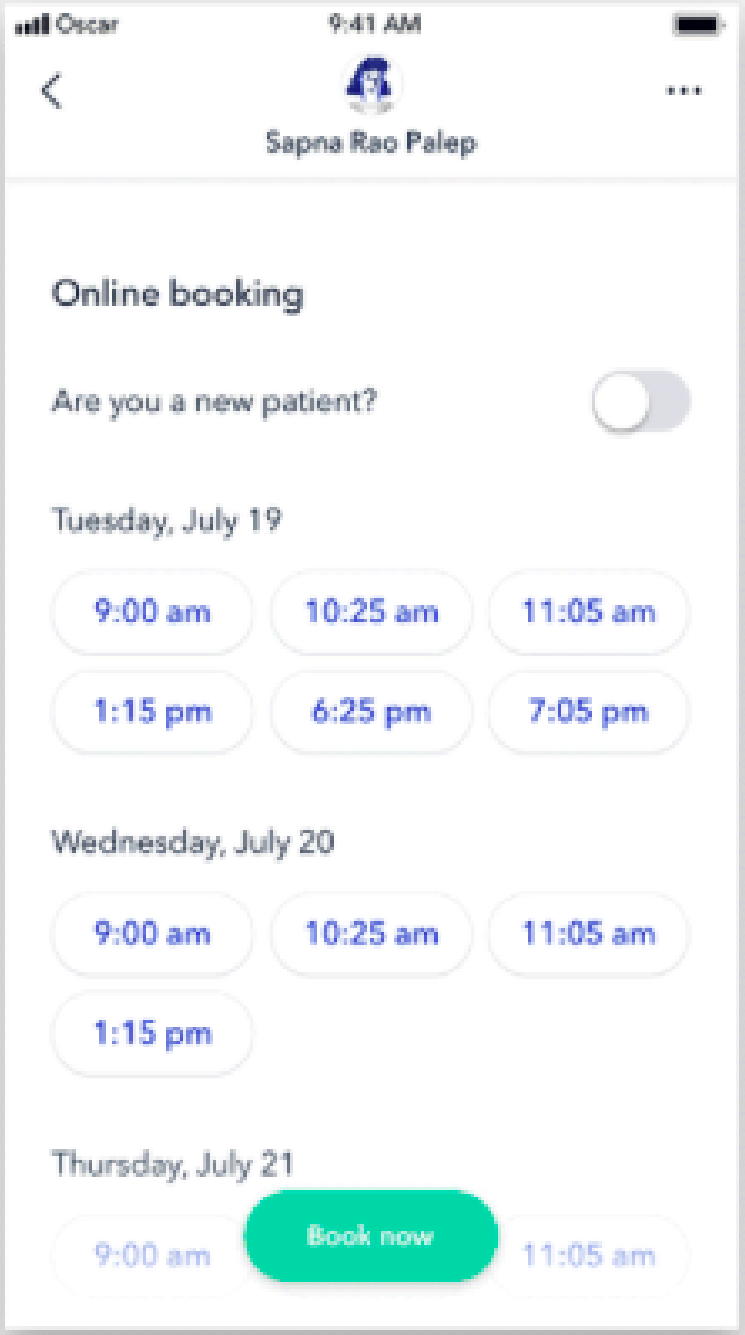
Allergies
Peanut Allergy
Recorded
Medications
Albuterol HFA 90mcg
Ordered
Immunizations
Influenza
Recorded
Lab Results
HDL cholesterol
Recorded
53.5mg/dL
50
60
Today
Health Data
Sources
Medical ID


Oscar
9:41 AM
Sapna Rao Palep
Online booking
Are you a new patient?
Tuesday, July 19
9:00 am
10:25 am
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1:15 pm
6:25 pm
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Wednesday, July 20
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10:25 am
11:05 am
1:15 pm
Thursday, July 21
9:00 am
Book now
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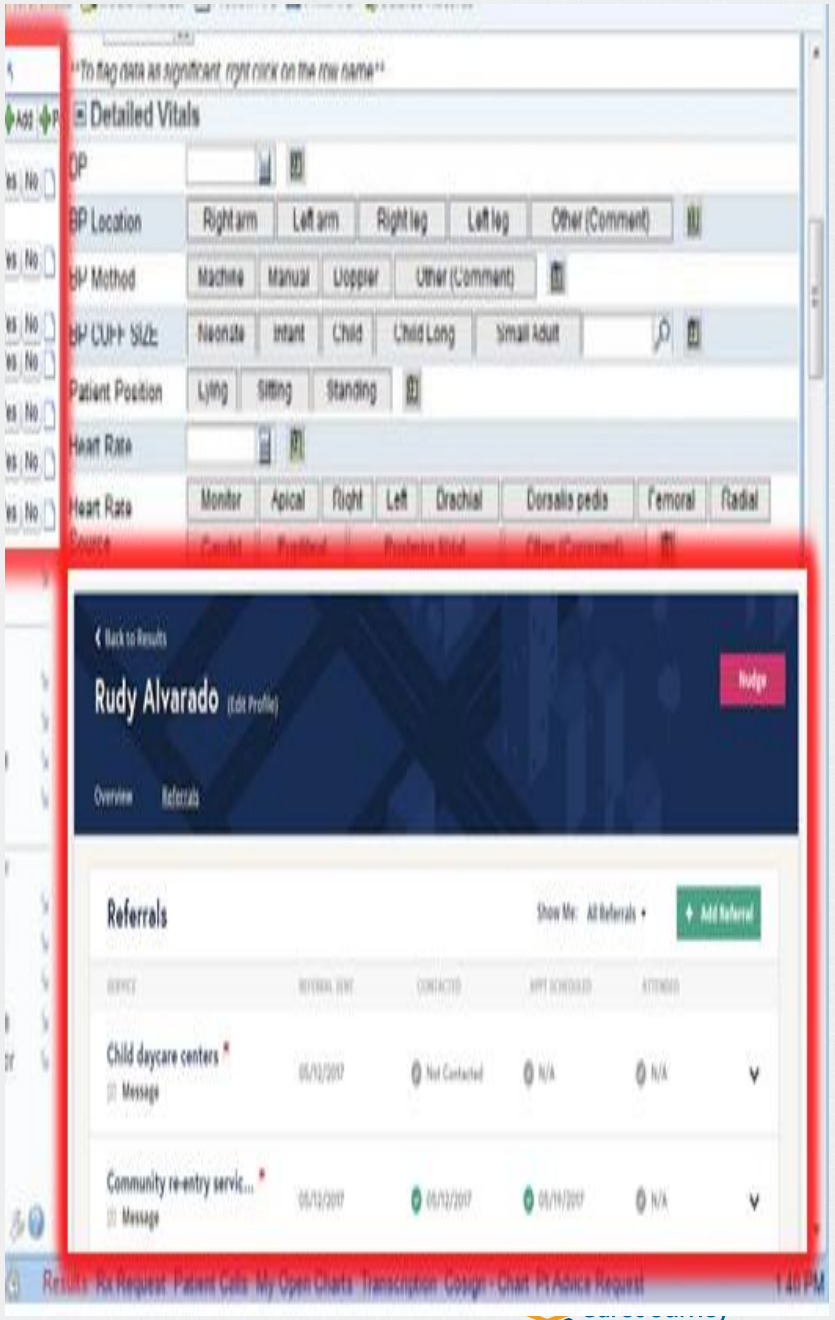
Detailed Vitals
Rudy Alvarado
Referrals
Child daycare centers
Community re-entry servic...