Second National ACO Summit:
Moving Towards Value-Based Health Care

Mark McClellan, MD, PhD
Director, Engelberg Center for Health Care Reform
Senior Fellow, Economic Studies
Leonard D. Schaeffer Chair in Health Policy Studies
Brookings Institution

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ENGELBERG CENTER for Health Care Reform at BROOKINGS

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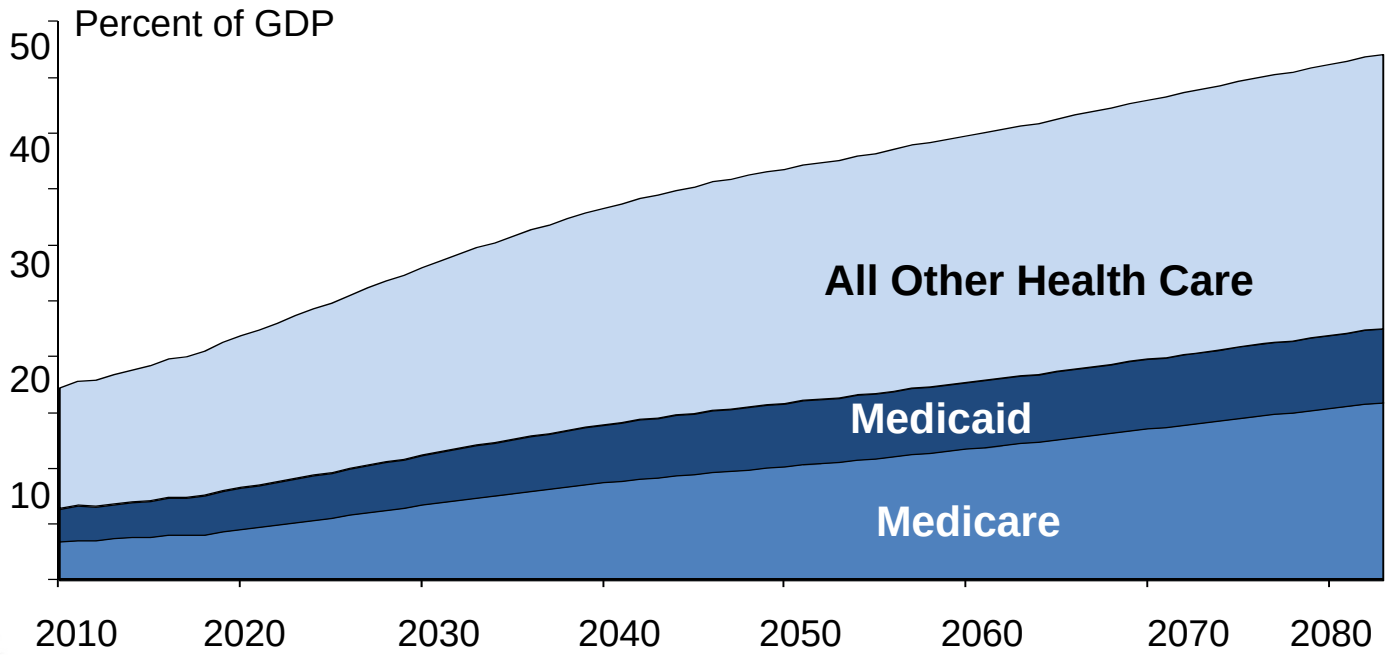
National health care spending continues to grow

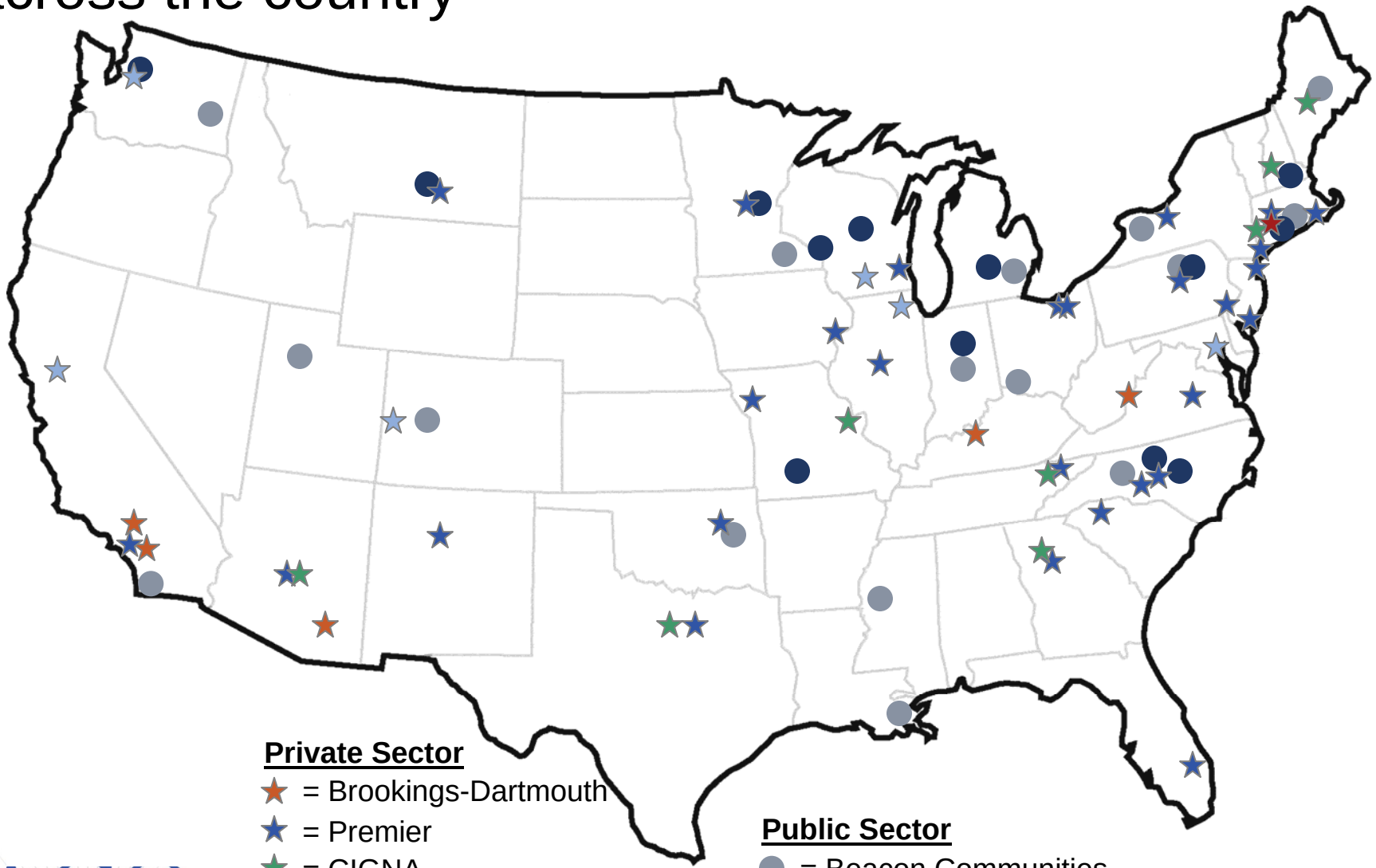
Health care spending projected to nearly double in the next 10 years

- $2.5 trillion in 2009 to $4.5 trillion in 2019
- 17.6% of GDP in 2009 to 19.6% of GDP in 2019
- CBO's 2011 Long-Term Budget projects two different spending scenarios
  - Extended-baseline scenario: federal health care spending growing from 6.9% of GDP in 2021 to 9.4% of GDP in 2035
  - Alternative fiscal scenario: federal health care spending growing from 7.1% of GDP in 2021 to 10.4% of GDP in 2035



SOURCE: CBO

Critical time for accountable care: real implementation across the country



Private Sector

- = Brookings-Dartmouth
- = Premier
- = CIGNA
- = AQC (9 organizations in MA)
- = Other private-sector ACOs

Public Sector

- = Beacon Communities
- = PGP, MHCQ

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Learning and leading through implementation: Brookings-Dartmouth ACO pilot sites

	Payor partners	Performance measurement	Downside risk?*	Other clinical transformation & reform efforts
Norton Healthcare	Humana	B-D	✓	• Electronic data feeds and dashboards; ambulatory access pilots; CER pilots
HealthCare Partners Medical Group	Anthem Blue Cross	B-D	Yr 1 ✓	• Homebound program; disease mgmt programs; MD incentives; care reminders
TMC Healthcare	UnitedHealth Group	B-D	✓	• Level 6 (of 7) EHR capacity; 3rd party analytics and HIE platform; medical home
Monarch HealthCare, A Medical Group, Inc.	Anthem Blue Cross	IHA	Yr 1 ✓	• EHR deployment in process; patient registries
Carilion Clinic	TBD	TBD	✓	• Enterprise-wide EHR; P4P; outcome reporting; physician compensation

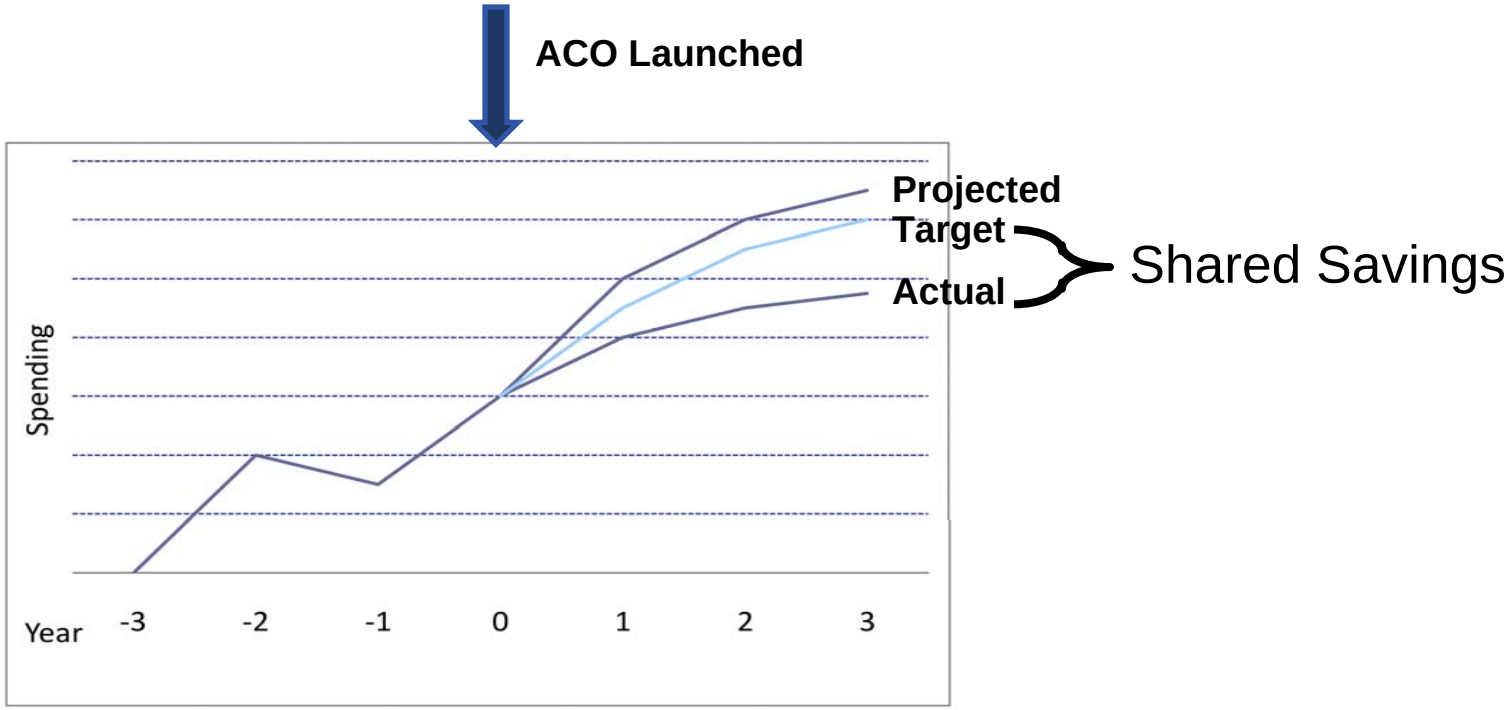
*All pilots plan to introduce downside risk within five years

Wide variety of possible models for ACO implementation

Integrated Delivery System	Multispecialty Group Practice	Physician-Hospital Organization	Independent Practice Association	Regional Collaborative
One or more hospitals & large group of employed physicians Insurance plans (some cases) Aligned financial incentives, advanced health IT, EHRs, & well-coordinated team-based care	Strong physician leadership Contract with multiple health plans Developed mechanisms for coordinated care (sometimes arranged through another partner)	Joint venture between one or more hospitals & physician group Vary from focusing contracting with payers to functioning like multi specialty group practices Many require strong management focused on clinical integration & care management	Small physician practices working together as a corporation, partnership, professional corporation or foundation Often contract with health plans in managed care setting Individual practices typically serve non-HMO clients on a standalone basis	Independent or small providers Leadership may come from providers, medical foundations, non-profit entities or state government Sometimes in conjunction with health information exchanges or public reporting

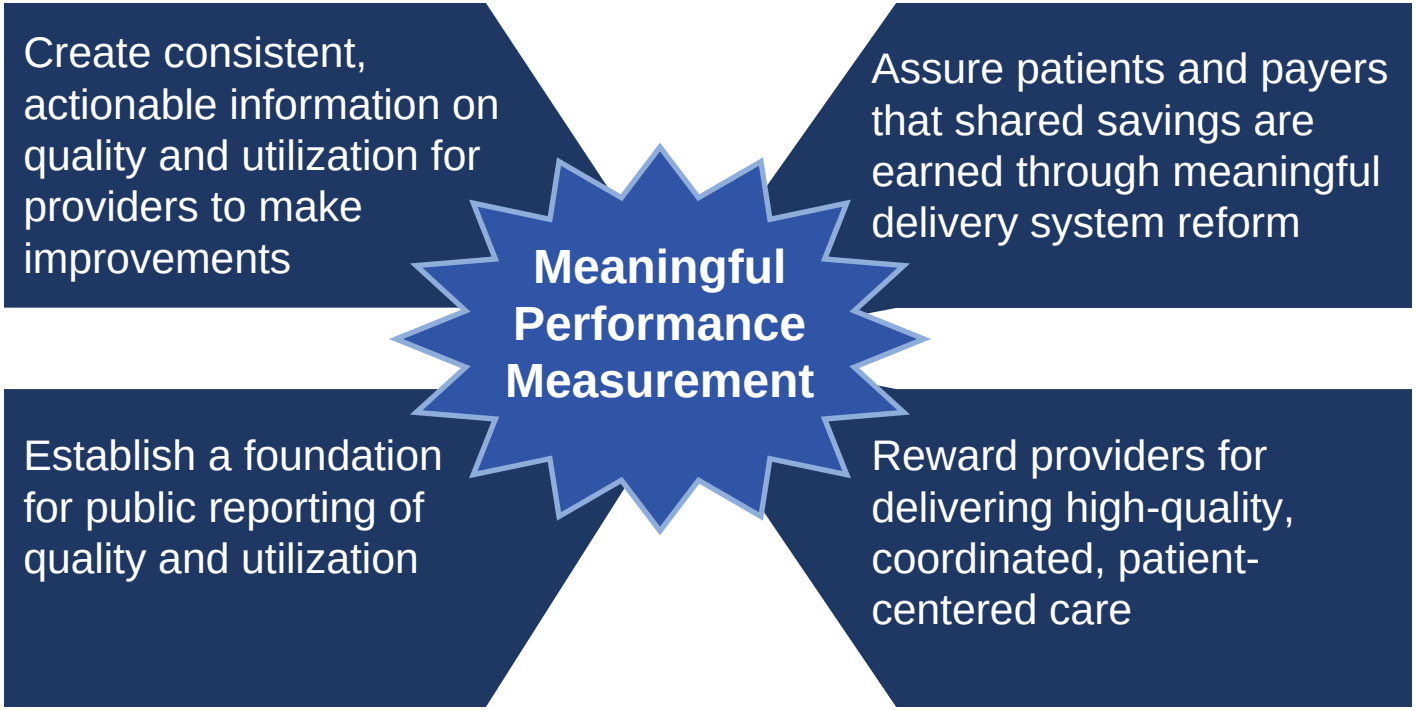
Advancing payment models to support improved performance

- **Core payment reform: shared savings when quality improves**
  - Benchmark bsed on per-capita spending for assigned patients
  - If actual spending lower than target AND quality measures improve, providers receive additional payments
- **Going further**
  - Transitions to “two-sided risk” and partial capitation



Measuring and rewarding performance

Measures should be outcome-oriented, span population and continuum of care, and become more sophisticated along with care capabilities



Core competencies for ACO implementation

1. Use and invest in **health IT** that supports measurement for both improvement and accountability

2. Develop **care management** programs that allow teams comprised of nurses, pharmacists and other health professionals to maintain health while preventing costly complications of chronic diseases

3. **Coordinate care** – especially for the frail elderly or for those with multiple chronic conditions – across clinicians and sites of care

4. Create **governance and leadership** structures that can strategically deploy the resources and project management required to implement new models of care

Steps to get there: ACO implementation lessons

Develop a process

- **Use data to inform a move towards value and identify a payer-partner to initiate discussions**
- **Develop an implementation plan that identifies opportunities to improve care delivery and population management**
- **Launch initiatives that reinforce payment changes (PCMHs, episode-based payments)**
- **Implement reforms with a long-term contract to ensure success**

Secure ongoing commitments

- **Commit to ongoing adjustments to the ACO contract – from both payers and providers**
- **Harmonize the assets of both payers and providers**
- **Receive commitments from the payer for: timely data, management of insurance risk, and possibly sharing of performance risk**

Distinguish risk from uncertainty

- **Develop realistic estimates of ACO start-up costs**
- **Review past data to understand organizational performance**
- **Align on clear and realistic expectations for both quality and costs**

Medicare ACO program and demonstration

Medicare Shared Savings Program

CMS is establishing a shared savings program to facilitate coordination and cooperation among providers to improve the quality of care and reduce costs for Medicare FFS beneficiaries. *CMS has received over 1,200 comments on the proposed MSSP rule and is now reviewing them.*

ACO Pioneer Model

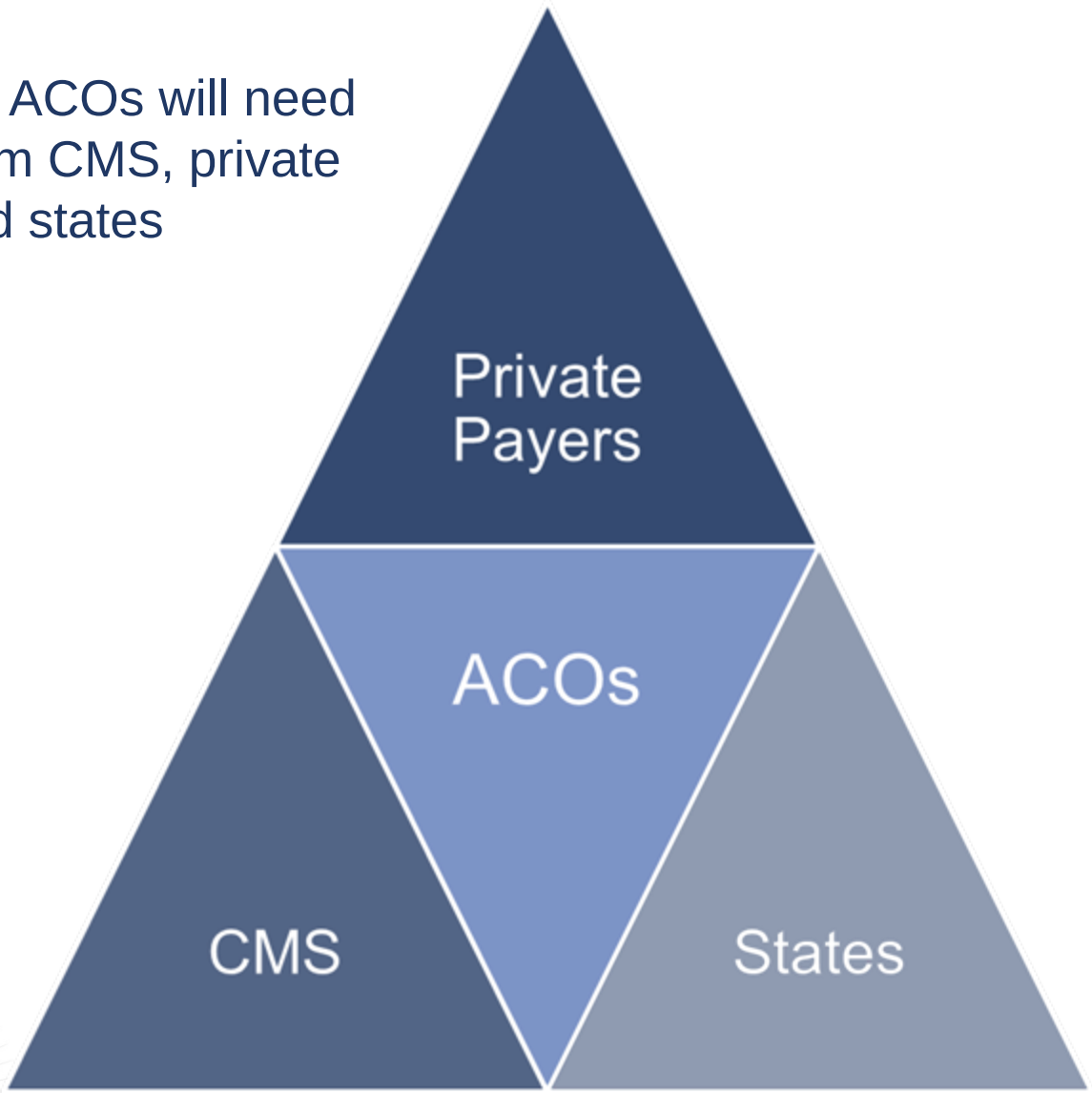
The CMS Innovation Center announced the ACO Pioneer Model demonstration for approximately 30 organizations already experienced in coordinating care and bearing risk to transition from a FFS to a population-based payment system through escalating levels of financial accountability. *Letter of intent due Thursday, June 30th 2011; applications due Friday, August 19th 2011.*

Create a clear path forward and reinforce support for accountable care

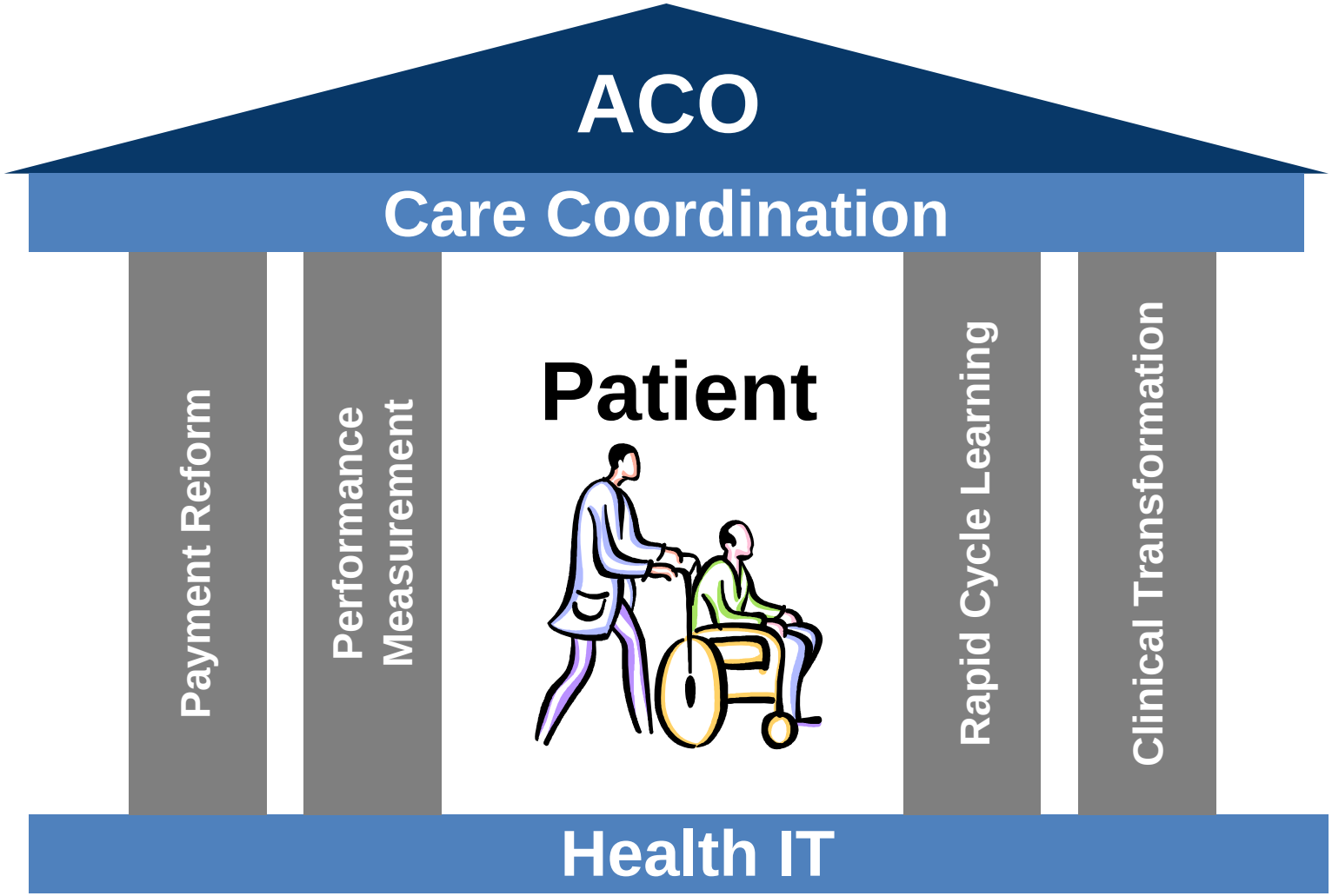
Key ACO Design Elements	Brookings-Dartmouth key recommendations for the MSSP
Effective and aligned leadership, governance, organizational structure	1. Reduce administrative burden and implementation costs, and offer greater flexibility to allow existing organizations to participate
Health IT infrastructure that enables data-drive decision making	2. Optimize data-sharing, assignment, notification, and benchmarking to support patient-centered care
Quality improvement and measurement	3. Build a sustainable pathway to improving quality
New payment models that reward value	4. Increase early rewards relative to costs 5. Reduce uncertainty by providing predictive data and a longer window before risk-bearing
Alignment with other reforms	6. Better leverage and align with other private and public initiatives

Multi-payer efforts critical to successful ACO formation

Successful ACOs will need support from CMS, private payers, and states



ACOs are synergistic with other reforms



Synergy in payment reform

Aligned Performance Measures

- Quality (Including Impact on Outcomes, Population Health)
- Cost/Efficiency Impacts

Aligned Payment Reforms

- HIT Meaningful Use
- Payments for Reporting/
- Performance
- Medical Homes
- Episode Payments
- Accountable Care
- Others

Aligned Reform Priorities and Support

- Chronic disease management, care coordination, major specialty care
- Timely data for patient care
- Supportive health plan and regional systems

Sufficient Scale

- Sufficient capital to provide time, effort, and technical support for real delivery change (payers, providers-including physicians, equity)
- Strategy for using and augmenting Federal payments
- Systemwide leadership: regional collaborations; business groups; states; Federal government?

Second National ACO Summit: Day 1

Monday, June 27, 2011

8:30 a.m. – 9:00 a.m.	Secretary Sebelius: Transforming Medicare with Accountable Care
9:15 a.m. – 10:45 a.m.	Core Competencies of Successful ACOs
10:45 a.m. – 12:15 p.m.	Models for ACO Implementation
1:15 p.m. – 5:30 p.m.	Advancing Payment Models to Support Improved Performance
1:15 p.m. – 5:30 p.m.	Multi-Payer ACOs
1:15 p.m. – 5:30 p.m.	ACO Legal Issues
1:00 p.m. – 5:30 p.m.	Health IT and Delivery System Reform
5:30 p.m. – 7:00 p.m.	Networking Reception

Second National ACO Summit: Day 2

Tuesday, June 28, 2011	
9:00 a.m. – 12:00 p.m.	Clinical Transformation
9:00 a.m. – 12:00 p.m.	Performance Measurement
9:00 a.m. – 12:00 p.m.	Payment Models and Patient Assignment
9:00 a.m. – 12:00 p.m.	Funding ACO Start-Up Costs
1:00 p.m. – 3:00 p.m.	Fostering Better Care Coordination
1:00 p.m. – 3:00 p.m.	Other Providers Helping to Support ACOs
1:00 p.m. – 3:00 p.m.	Patient Notification in ACOs
3:30 p.m. – 3:45 p.m.	John Iglehart: Opportunities for Public-Private Partnerships
3:45 p.m. – 4:30 p.m.	Rick Gilfillan: Testing the Future of Accountable Care
4:30 p.m. – 5:00 p.m.	Elliott Fisher: The Next Steps for ACOs

ACO Learning Network: moving ACO implementation forward through peer-learning

2009-10 ACO Learning Network

- >60 provider & payer organizations
- Focused on defining core ACO concepts
- Included webinars, ACO materials, and conference discounts

2010-11 ACO Learning Network

- >125 organizations from across the health care spectrum
- Spotlight ongoing examples of ACO implementation
- In-depth analysis of emerging Federal an State regulation

Implementation-focused webinar series

Member-Driven Conferences

ACO Newsletter

Web-based resources

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Thank you

Visit www.ACOLearningNetwork.org for more information