Third Annual
National ACO Summit

June 6–8, 2012

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The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
Opening Plenary Session

Welcome and Overview

Mark McClellan, MD, PhD
Director, Engelberg Center for Health Care Reform, The Brookings Institution; Former CMS Administrator and FDA Commissioner
Opening Plenary Session

Summit Opening Address: Overall Approach to Delivery System Reform and Health Insurance Exchanges

Marilyn Tavenner, MHA
Acting Administrator, Centers for Medicare & Medicaid Services, US Department of Health and Human Services
Opening Plenary Session

National Trends in Health Care Reform

Elliott S. Fisher, MD, MPH
Director, Population Health and Policy; Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice

Mark McClellan, MD, PhD
Director, Engelberg Center for Health Care Reform, The Brookings Institution

Susan Dentzer
Editor-in-Chief, Health Affairs, Bethesda, MD; Health Policy Analyst, The News Hour with Jim Lehrer (Moderator)
The move towards accountable care

7 June 2012

Elliott Fisher, MD, MPH
Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice
Origins: problems and principles

Underlying problem

Confusion about aims: is it about money or something more?

Poor data leaves practice unexamined and unable to improve, choices uninformed by evidence

Flawed conceptual model. Health is produced by face-to-face visits with physicians. More is always better.

Wrong incentives reinforce model, reward fragmentation, induce more care and entrepreneurial behavior.

Key principles

Clarify aims: Better health, better care lower costs – for patients and communities

Better information that engages physicians, supports improvement and informs consumers and patients

New model: It’s the system. Establish organizations accountable for aims and capable of redesigning practice, eliminating waste and managing capacity

Rethink our incentives: Realign incentives – both financial and professional – with aims.
ACOs: 2009

**Private Sector**

🌟 = Brookings-Dartmouth (3)

**Public Sector**

● = Medicare Physician Group Practice Demo (10);
   Medicare Health Care Quality Demos (3)

🌟 = AQC (8 in Massachusetts)
ACOs and Medicare

Principles:
- **Support diversity**: support provider collaboration across continuum of care as a real or virtually integrated local delivery systems
- **Robust performance measurement**: to ensure focus on demonstrably improving care
- **New payment models**: based on existing fee-for-service payment system, total cost accountability, shared savings, graduated risk bearing
- No beneficiary “lock-in”

**Affordable Care Act Sect. 3022: Medicare Shared Savings Program**
- National program began with 27 organizations April 1, 2012
- Second wave to start July 1, 2012

**ACA-Created Center for Medicare and Medicaid Innovation**
- Pioneer ACOs – greater rewards, multi-payer, required risk bearing
- Advanced Payment ACOs – CMS provides some up-front payments for smaller/rural organizations
Key Features:

- **Diverse providers**: support diverse provider collaborations across continuum of care - ranging both integrated systems that also offer insurance products and virtual systems based around physician groups.

- **Improving performance measurement**: enable focus on demonstrably improving care, while dealing with measurement limitations.

- **New payment models**: based on existing fee-for-service payment system, total cost accountability, shared savings, graduated risk bearing – including some early adoption of partial capitation models and models with explicit limits on overall premium growth – and overlap with medical homes and other payment reforms.

- **Increasing alignment with benefit reforms**: lower premiums, co-pays for beneficiaries participating in ACOs.
Early results from the private sector

**BCBS- Massachusetts Alternative Quality Contract**

**Cost:** $2.5 million in saving due to lower cost settings over the first 2 years

**Utilization:** 2% reduction in surgical admissions compared to market
Early results from the private sector

**Norton-Humana ACO**
- **Quality:** 6.1% improvement in diabetic testing, 8.6% improvement in diabetic cholesterol management
- **Utilization:** 12.9% improvement in appropriate emergency room visits
- **Coordination:** 36% improvement in visit 7 days post discharge

**Advocate Health Care**
- **Utilization:** 10.6% reduction in hospital admissions, 5.4% reduction in Emergency Room use
- **Coordination:** 60 full time case managers for high-risk and post-acute cases

**Cigna ACOs**
- Dartmouth-Hitchcock achieves 10% better at closing gaps in care than market
- Cigna Medical Group, Phoenix lowered annual costs by $336 per patient: reducing ambulatory surgery by 11% and increasing preventative visits by 3%
- Cigna has 26 current ACOs with the goal of 100 ACOs by 2014

http://newsroom.cigna.com/knowledgecenter/aco
Early results from the private sector

Blue Shield of California & Hill Physician Medical Group
Promised to not raise premiums from 2009-2010 for 42,000 CalPERS employees
Target goal to save $15 million, achieved $20 million in savings

Aetna ACOs
Offering lower premiums (30%) through commercial ACO with Carilion
Collaborating with Medicare in Ohio and Arizona to improve coordination through improved technology and dedicated care managers
Plans to double the number of ACO contracts by the end of 2012

Widespread ACO interest and commercial expansion

http://healthaffairs.org/blog/2012/05/15/early-lessons-from-a-shared-risk-integrated-care-organization-serving-a-commercial-population/
Implementation in the public sector

3 Active ACO programs: MSSP (27), Pioneer (32), PGP Transition Demo (6)

1.1 million beneficiaries served by Medicare ACOs

Diverse participants in Medicare Shared Savings Program
- 375,000 Beneficiaries across 18 states
- 10,000 participating physicians, 10 hospitals, 13 small physician driven organizations
- Over 150 application for July 1 start date

Dual Eligible Financial Alignment Initiative: 2 models, 15 eligible states

Capitated Model: State/CMS/Health Plan 3-way contract with blended prospective capitated payment for full continuum of benefits. State/CMS share in savings

Managed FFS Model: States make upfront investment in care coordination and qualify for retrospective performance payment based on savings net of Federal Medicaid costs.

*Quality will be measured in both programs, a portion of prospective payments will be withheld to be earned back based on quality performance
Implementation in the public sector

State-led Medicaid ACO reforms:

**New Jersey:** Enacted a 3 year ACO demo (P.L. 2001. Ch.114) in August, 2011, Rutgers Center for State Health Policy currently working to finalize technical methodology
- ACOs take responsibility for all Medicaid beneficiaries in a designated geographic area. ACOs that reduce per capita spending while meeting standards for quality and patient experience of care are eligible to share in savings.

**Oregon:** Passed (HB 3650, SB 1580) to create Coordinated Care Organizations
- CCOs will have a budget for all Medicaid services including metal, physical and eventually dental care.
- Oregon is accepting applications for organization to start August 1, 2012.

**Colorado:** Launched the Accountable Care Collaborative in 2011
- Organized into 7 Regional Collaborative Care Organizations (RCCO)
- Providers paid FFS with additional PMPM payments to Medical Home and RCCO
- A portion of PMPM payments are withheld in incentive quality pool
- State provides data reports to support management and coordination
ACOs: Today

Private Sector
- Brookings-Dartmouth Pilots (5)
- Premier Implementation (23)
- CIGNA (22)
- AQC (16 in Massachusetts)
- AMGA Collaborative (16)
- Other private-sector ACOs (37)

Public Sector
- PGP, MHCQ (13)
- Pioneer (32)
- MSSP (27)
- State and Medicaid Initiatives (13 Regions)
Where we go from here:
Implementing Accountable Care

7 June 2012

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

• Fiscal and political outlook
  – Supreme Court ACA ruling
  – 2012 elections

• Implementation challenges
  – Aligning payment reforms
  – Steps for providers
  – Steps for payers

• Collaborating on effective health reform implementation moving forward
  – Brookings-Dartmouth ACO Learning Network

• Summit Objectives
Health care costs continue to put pressure on Federal spending

CBO Long-Term Spending as a % of GDP
(Alternative Fiscal Scenario)

Source: CBO Long-Term Budget Outlook 2012
Political implications on health care reform implementation

Affordable Care Act and the Supreme Court
• Medicare payment reform provisions not directly implicated by Constitutional questions
• Private payers, states committed to accountable care reforms

2012 Elections
• Pressure to reduce health care spending growth, Federal and overall, will remain regardless of election outcome
• Medicare payment tightening similar to current law remain in Republican budget proposals - and ACOs offer a more flexible alternative to cutting provider payment rates
Moving forward: alignment across payment reforms

- Common core performance measures across reforms and a rapid but feasible pathway for improving measures and the underlying outcomes of care
- Timely and consistent methods for sharing underlying data with providers to improve performance
- Evolve and integrate rapid evaluation methods based on common measures

### Medical Homes (PCPs)
- Supports care coord, prevention, chronic disease mgmt, and other key primary-care activities
- Rewards reductions in primary care-related cost trends

### Bundled Payments (Specialty Care)
- Combine payments across providers/settings for specific episodes to promote coord & efficiency
- Linked to quality measures to support accountability

### Accountable Care (System-wide)
- Reimburses population-level improvements in quality and overall per-capita costs
- Encourages coordination across the continuum of care
- Can reinforce/support “piecewise” accountable-care reforms
Provider steps to align payment reforms

1. Engage senior provider, payer and purchaser leaders to align on common strategic goals and key action steps, building shared commitment and trust (e.g. new contracting focus, data sharing agreements)

   Identify specific opportunities for care improvement, and feasible pathway for making improvements (e.g. improvements in chronic disease management linked to medical home payments with performance improvement)

2. Implement feasible, ongoing process for improving care (e.g. LEAN) and assuring that care improvements are financially sustainable

3. Develop improving capacity for ongoing measurement of quality and cost trends, using improving registries and other data systems to support better care

4. Support development of common measures and ACO contracting methods to reduce time and cost of implementation
Payer steps to use accountable care effectively

1. Use common performance measures to test a range of reforms and lay out a rapid but feasible pathway for making them more reinforcing and outcomes-oriented

2. Share data that will be incorporated in performance measures in a timely way with providers to help them improve on performance measures (raw claims with significant delay unlikely to be adequate)

3. Align incentives across payment reform initiatives – they are more than additive

4. Develop a plan for integrated evaluation methods, based on common measures and encompassing the cumulative impact of the combination of reforms

5. Support development of common measures, evaluation methods, and ACO contracting methods to reduce time and cost of implementation
Collaborating on effective health reform implementation moving forward

Brookings-Dartmouth ACO Learning Network Services

- Enhanced ACO Implementation Webinars
- Member-Driven Conferences
- Implementation Work Groups
- Online Tools and Resources

http://www.acolearningnetwork.org
*Visit booth 21 in the exhibit hall to learn more*
Implementing Performance Measures

- Glide path for ACO performance measure implementation over time informed by an evaluation of current ACO measurement experiences

Accountable Care Payment Strategies

- Payment strategy decision making framework to align quality with payment and effectively match payments to staff alignment

Clinical Transformation

- Playbook that defines clinical transformation domains, a self-assessment tool and capability relationship framework to help guide ACO transformation efforts

High-Risk and Vulnerable Populations

- Playbook for ACOs to evaluate and choose care plans based on efficacy, as well as choose population-specific risk identification stratification models based on desired outcomes

Member informed decision-making tools to help ACOs make strategic investments to improve care & lower costs
ACO Summit objectives

1. Learn from early and ongoing ACO efforts to make implementation efforts more efficient and effective
   - Align and synergize reform strategies to support multi-payer accountable care delivery systems

2. Collaborate to build strategies to address core ACO implementation and management challenges
   - Gen Session: Early Experiences in Medicare
   - Track 5: Accountable Care in the Private Sector

3. • Gen Session: Moving Towards Accountable Care in States
   • Gen Session: Creating a Pathway for Multi-Payer ACOs
   • Track Sessions: 1 - 8
Summit track sessions: Addressing ACO implementation challenges

**Summit Day 1**
- Payment strategies and financial transparency to reduce costs and improve care *(Track 1)*
  - e.g. aligning incentives for PCPs and specialists
- Implementing and aligning progressively sophisticated performance measures *(Track 2)*
  - e.g. timely data sharing
- Addressing high-risk & vulnerable populations *(Track 3)*
  - e.g. incorporating mental and behavioral health
- Leading clinical transformation efforts *(Track 4)*
  - e.g. building care management teams

**Summit Day 2**
- Patient engagement and participation in ACOs *(Track 5)*
  - e.g. preventing leakage through patient engagement
- Incorporating dual eligible & Medicaid populations into ACO initiatives *(Track 6)*
  - e.g. integrating HC providers and social service providers
- Coordinating across the continuum of care *(Track 7)*
  - e.g. approach to primary care delivery for AMCs
- Engaging and empowering clinical leadership *(Track 8)*
  - e.g. identifying and training physician leaders
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Early Experiences in Medicare: Pioneer ACOs and the Medicare Shared Savings Program

Caroline Blaum, MD, MS, Professor of Internal Medicine and Geriatrics, Assistant Dean for Clinical Affairs; Associate Director Faculty Group Practice, University of Michigan Medical School

Richard Merkin, MD, President and Chief Executive Officer, Heritage California ACO

Judy Rich, RN, President and Chief Executive Officer, Tucson Medical Center

Jonathan Blum, MMP, Deputy Administrator and Director of the Center for Medicare, Centers for Medicare & Medicaid Services

Elliott S. Fisher, MD, MPH, Director, Population Health and Policy; Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical
Opening Plenary Session

Moving Toward Accountable Care in States

Melanie Bella, MBA, Director, Medicare-Medicaid Coordination Office, Centers for Medicare & Medicaid Services, US Department of Health and Human Services

Jeffrey Brenner, MD, Founder and Executive Director, Camden Coalition of Healthcare Providers

Bruce D. Greenstein, MS, Secretary, Louisiana Department of Health and Hospitals

Julian Harris, MD, MBA, Medicaid Director, Massachusetts Department of Health and Human Services

Mark McClellan, MD, PhD, Director, Engelberg Center for Health Care Reform, The Brookings Institution (Moderator)
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