Fourth Annual National ACO Summit

June 12-14, 2013

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

Summit Opening

Mark McClellan, MD, PhD
Director, Engelberg Center for Health Care Reform, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution; Former CMS Administrator and FDA Commissioner

Elliott Fisher, MD, MPH
Director, The Dartmouth Institute for Health Policy and Clinical Practice; James W. Squires Professor of Medicine, Geisel School of Medicine at Dartmouth
Little Formal ACO Activity in 2009

**Private Sector**
* = Brookings-Dartmouth

**Public Sector**
● = Medicare Physician Group Practice Demo;
  Medicare Health Care Quality Dems

{Not exhaustive}
ACO Implementation Accelerating Across the Country

*Upwards of 400 ACOs*

{Not exhaustive}

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
ACO Enrollment is Also Growing Rapidly

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Sector ACOs Beneficiaries</td>
<td></td>
<td>8 to 14 Million</td>
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<tr>
<td>Medicare ACO Beneficiaries</td>
<td></td>
<td>4 Million</td>
</tr>
<tr>
<td>Non-Medicare Patients Served by Medicare ACO</td>
<td></td>
<td>25 Million</td>
</tr>
<tr>
<td>Medicaid ACOs</td>
<td></td>
<td>14 states</td>
</tr>
</tbody>
</table>

Source: “Accountable Care Organizations now serve 14% of Americans.” Oliver Wyman. February 2013
Private-Sector ACOs Expanding, with Promising Early Results

Cigna ACOs
• Cigna is engaged in 58 ACO initiatives in 24 states and plans to increase that number to 100 by the end of 2014, reaching one million customers
• **Early results published in Health Affairs:** Cigna Medical Group of Arizona (CMG) found significantly reduced medical costs compared to other practices
• Dartmouth-Hitchcock (NH) and Medical Clinic of North Texas achieved performance improvements in their per patient, per month costs
• All three organization outperformed comparison group peers on all quality measures, with one exception

Aetna ACOs
• Aetna has 23 ACO agreements in place and has announced plans to enter into hundreds of ACO arrangements over the next three years
• **Early results:** NovaHealth ACO (ME) experienced a 50% reduction in their inpatient hospital days, 45% lower hospital admissions, and 56% fewer readmissions in their Medicare ACO product in 2012
Private-Sector ACOs Expanding, with Promising Early Results

Blue Cross Blue Shield ACOs
Blue Shield of CA now has 8 ACOs delivering care to 135,000 people in CA with plans to have 20 ACOs throughout CA by 2015

• **Early results** from first 2 years of global budget pilot for CalPERS with Dignity Health and Hill Physicians
  - Total compound annual growth rate for per member per month was 3 percent less, or less than half rate of premium increases over past decade
  - Inpatient days fell by 12.1 percent for members; 30 day readmissions fell by 15 percent in first year of pilot
  - Saved approximately $37 million over two years, based on expected growth without pilot

Blue Cross Blue Shield Alternative Quality Contract (MA): 11 total providers

• **Early results:** average savings of 2.8 percent over two years
  - After 2 years, 3.7 percentage point increase per member per year meeting quality performance targets for chronic care management

Humana and Norton Health Care

• One of 5 Brookings-Dartmouth pilot sites

• **Early results:** Cancer screening, routine diabetes tests, and medication management showed improvement in the first year
Implementation in the Public Sector: Medicare

Medicare ACO Programs (Most Recent Statistics):

• Medicare Shared Savings Program (220), Pioneer Program (32), Physician Group Practice Transition Program (6)
  – More than 4 million beneficiaries served by Medicare ACOs
  – Diverse participants in MSSP

• January 2013, CMS announced 106 new participants in the MSSP Program
  – 47 States, DC, and Puerto Rico now included in MSSP
  – Over 1.5 million beneficiaries newly covered
  – About 50% of ACOs are physician-led
  – 15 new organizations are Advanced Payment Model ACOs
Medicare ACO Program Updates

• Medicare Shared Savings Program, Round 4 (2014)
  – Applications due this summer
  – Start January 2014

• Issues with Medicare ACO Quality Metrics
  – April 2013: Pioneers requested revising metrics and delaying any penalties or bonuses based on performance benchmarks until next year
  – Main concerns include details of measure definitions and appropriate benchmark for ACOs

• Medicare ACO Version 2.0 Coming
  – Revisions likely after initial 3-year contract period
  – Expect further discussion, possible proposed regulation in 2014
Implementation in the Public Sector: Medicaid

At least 14 states developing accountable care models in Medicaid and CHIP

**New Jersey:** Enacted a 3 year ACO demo (P.L. 2001. Ch.114) in August, 2011
- 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 mental, 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
Building Blocks for Medicaid ACOs

- Primary Care Medical Home with some Accountability for Population-Type Results (Colorado)
- Episode-Based Payments that could potentially expand to full patient-level accountability (Arkansas)
- Shared Savings Based on Population Quality and Total Cost Benchmarks (Oregon, Illinois, New Jersey, Iowa, Vermont)
- Incorporation of Non-Medicaid Social Services (Minnesota)
ACOs Trending Toward Physician-led

- Initial ACO participation was greatest among hospital systems
- Over time, the trend has shifted heavily toward physician led primary care and multispecialty ACOs

Source: Health Intelligence Network, ACOs in 2012 Report
What Are We Learning about ACOs?

1. Safety net providers are part of a substantial number of ACOs.
   - CMS reported 20% of MSSPs have a critical access hospital or FQHC.

2. ACOs are more diverse than we might have expected.
   - FUHN: Network of 10 FQHCs in the Minneapolis-St. Paul area that has a Medicaid ACO contract with the state of Minnesota
   - Essential Care Partners: Coalition of FQHCs in Texas participating in MSSP
   - Specialty ACOs (Florida Blue), Walgreens ACO model, and others

3. A lot of new partnerships are forming.
   - Members of an Oregon CCO continue to compete for patients in Marion and Polk counties, but as part of the CCO are now coming to the table to contract together
What Are We Learning about ACOs?

4. ACOs are trying a variety of strategies to improve care and costs.
   - Lots of trial and error, innovation, chances to learn
   - Various strategies: Focus on ED use, community health workers, performance improvement coaches, role of nurses

5. ACOs’ focus on cost and quality data is transforming how providers think about delivering care.
   - FUHN: Received data on ED use and reasons for visits, which attributed a lot of the utilization to behavioral health patients. Led to redesign of behavioral health approach and greater emphasis on patients’ physical health within behavioral health case management process.
## Key Challenges for ACO Implementation

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Potential Solutions</th>
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<tbody>
<tr>
<td>Aligning with other reform initiatives</td>
<td>• Develop a common set of performance measures with a pathway for more sophistication over time</td>
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<td></td>
<td>• Commit sufficient leadership support towards shared goals between payers and providers</td>
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<td></td>
<td>• Develop a physician-supported implementation plan to identify costs and quality improvement opportunities</td>
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<tr>
<td></td>
<td>• Analyze data to understand organizational performance and develop realistic start-up costs</td>
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<tr>
<td></td>
<td>• Promote transparency to accelerate learning</td>
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<tr>
<td>Catalyzing leadership from providers and payers</td>
<td>1. Governance and leadership focused on the resources and project management required to implement new models of care</td>
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<td></td>
<td>2. Health IT that supports measurement for improvement and accountability</td>
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<tr>
<td>Reducing start-up costs</td>
<td>3. Care coordination, especially for the frail elderly or for those with multiple chronic conditions – across clinicians and sites of care</td>
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<tr>
<td></td>
<td>4. Care improvement programs allowing teams of providers to maintain patient health and prevent costly complications from chronic diseases and major procedures</td>
</tr>
</tbody>
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The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
ACO Learning Network: Implementation through Collaboration

Our Objective:
Collaborate with members to identify and share effective accountable care implementation strategies and tactics and drive robust member-to-member dialog focused on discussing key challenges and best practices.

Our Members:
Over 65 leading payers, providers, associations, and industry organizations from across the country all committed to driving accountable care practices.

Benefits of Membership
- Library of implementation tools and research products on ACO implementation
- 9 Core Network webinars based on a cutting edge curriculum with industry experts
- 2 Member-driven workshops
- Participation in 5 expert-led workgroups, with 8 webinars each
- Online ACO resources and research, including profiles of organizations implementing ACOs, a library of ACO publications, over 40 archived webinars, and past ACO event materials

Learn more at www.acolearningnetwork.org or e-mail aco@brookings.edu.
ACO Learning Network Workgroups

- **Accountable Care Payment Strategy**
  - Identify essential pathways to successful payment reform implementation and assist organizations as they transition to or consider becoming an ACO, or engage in other accountable care efforts

- **Clinical Transformation**
  - Provide knowledge, skills, and tools necessary to align organizational and physician values and transform the people, processes and technology to a care delivery model that offers value and improves quality

- **High-Risk and Vulnerable Populations**
  - Identify the best practice care pathways and key data requirements that result in the timely identification and effective management of high-risk and vulnerable individuals

- **Implementing Performance Measurement**
  - Understand key challenges for measuring performance in ACOs as well as pathways for implementing increasingly advanced measures over time.

- **Optimizing the Impact of Pharmaceuticals**
  - Identify novel strategies for creating an environment within value-based delivery systems that optimize the impact of pharmaceutical products through engagement with key stakeholders
ACO Summit objectives

1. Learn from early and ongoing ACO efforts to make implementation efforts more efficient and effective

2. Identify core barriers to widespread ACO adoption in the private and public sector

3. Collaborate to build strategies to address core ACO implementation and management challenges
<table>
<thead>
<tr>
<th>ACO Summit Tracks: Addressing Implementation Challenges</th>
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<tbody>
<tr>
<td><strong>Summit Day 1</strong></td>
</tr>
<tr>
<td>• <strong>Track 1</strong>: Strategies and Technology for Innovative Payment Models</td>
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<tr>
<td>• <strong>Track 2</strong>: Performance Measurement for Accountable Care</td>
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<tr>
<td>• <strong>Track 3</strong>: Delivery System Reform and Clinical Transformation</td>
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<tr>
<td>• <strong>Track 4</strong>: Managing Vulnerable Populations</td>
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<tr>
<td><strong>Summit Day 2</strong></td>
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<tr>
<td>• <strong>Track 5</strong>: Optimizing Care Teams</td>
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<td>• <strong>Track 6</strong>: Engaging Patients in Medical Care</td>
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<tr>
<td>• <strong>Track 7</strong>: Analytics and Health IT for Population Management</td>
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<tr>
<td>• <strong>Track 8</strong>: Moving Beyond Readmissions for Quality and Savings</td>
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Keynote Address

Senator Ron Wyden (D-OR)
United States Senate
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Rate of Diabetes by Hospital Referral Region

Source: Leavitt Partners analysis of 2011 Behavioral Risk Factor Surveillance System

ACOs by Hospital Referral Region

Source: Leavitt Partners ACO Database
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Opening Plenary Session

Managing the ACO Balance Sheet: Financing the ACO Operations

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

**Jeffrey Bailet,** Senior Vice President, Aurora Health Care; President, Aurora Medical Group

**Charles Kennedy, MD, MBA,** Chief Executive Officer of Accountable Care Solutions, Aetna

**Mark Wagar,** President, Heritage Medical Systems

**Michael Murphy, FACHE, CMPE,** President and Chief Executive Officer, Accountable Care Organization, Iowa Health System
Managing the ACO Balance Sheet: Financing the ACO Operations

Charles Kennedy, MD, MBA
Chief Executive Officer, Accountable Care Solutions, Aetna
June 13, 2013
ACS Operating Model Functions

enablement:
creation, deployment, and continuous improvement of clinical programs, technologies, and innovations designed to reduce costs, improve quality, and innovate around convenience and differentiated health plan products and services

monetization:
development of economic models, delivery system relationships, and health plan products and services which allow enablement results to be monetized through products and services which leverage differentiated, lower costs of care
Enablement: Creation, deployment, and continuous improvement of clinical programs, technologies, and innovations designed to reduce costs, improve quality, and innovate around convenience and differentiated health plan products and services

Leaders: Gary Anthony Bruce Henderson

Enablement Services:
1. Care Management programs
   A. In office
   B. Inpatient
   C. In home
2. Technology sales
3. Technology deployments
   A. Integrated Solutions
4. Consulting services—
   A. Change Management
   B. Clinical Analytics
   C. Quality Tracking
   D. Innovation management
   E. Learning Lab
   F. Provider integration
   G. On site clinical programs
5. Vendor Management
ACS Operating Model Functions

Current monetization functions have an excessive reliance on contract discounts to achieve needed price points. Activities to allow actuarial sign off of clinical innovations are underway.

Monetization Services:
1. Health plan operations
2. Health plan care management
3. Joint ventures
4. Deal Management—
   A. First Sale
   B. Second Sale
   C. Product pricing
   D. Economic model management
   E. MSSP
   F. Pioneer Program
   G. Actuarial
5. Claims management and TPA functions

Monetization:
Development of economic models, delivery system relationships, and health plan products and services which allow Enablement results to be monetized through products and services which leverage differentiated, lower costs of care.

Leaders:
Gary Thomas
Chris Day, Mike Redmond
Introducing Aetna Accountable Care Solutions: Programs for Success in a Post Reform World

Hospitals must become more integrated with a focus on population management, efficiency, and effectiveness

- Drive Medicare and Medicaid programs toward profitability via population based medicine and governmental payment innovation
- Become recognized leader in commercial marketplace for efficient, effective, convenient care delivery
- Diversify sources of profit through private label health plans, clinical research, and innovations

Doctors, hospitals, and patients must fundamentally change what they do and how they do it

- Clinical integration for optimized workflows
- Technology that innovatively reduces cost, increases quality, improves convenience and access
- Care Management programs which empower the doctor patient relationship across populations and care continuum
- Relentless focus on prevention, early detection, outcomes
Transition to a Sustainable Business Model

Current environment

- Financial impact: The dual-model challenge:
  - Maximize fee-for-service revenue
  - Build a sustainable, value-based model for the future

- Leakage:
  - Challenge of keeping patients in network
  - Loss of revenue due to patients going out of network

- Technology impact:
  - Legacy systems designed for encounter-based care
  - Lack of integration
  - Fragmented data
  - Population insight not readily available

- Fragmented health care system:
  - Slow care delivery
  - Lack of clinical integration
  - Reimbursement models reward volume
  - Cultural shift needed for value-based care

Sustainable business model

A sustainable value-based business model requires total integration across the continuum of care which results in the following benefits:

- Improved quality and outcomes
- Engaged patients
- Competitive narrow network
- Value-based reimbursement
- Clinically integrated networks
- Market share growth supported by scalable operations
Aetna’s Accountable Care activity covers 60% of the U.S. Population
Managing the ACO Balance Sheet: Financing the ACO Operations

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Opening Plenary Session

Emerging Models of Accountable Care

**Moderator:** Elliott Fisher, MD, MPH, Director, The Dartmouth Institute for Health Policy and Clinical Practice

**Wayne Jenkins, MD, MPH,** President, Orlando Health Physician Partners, Orlando,

**Jeffrey Kang, MD, MPH,** Senior Vice President of Health and Wellness Services and Solutions, Walgreen Co.

**Jonathan Gavras, MD, FCCP,** Senior Vice President, Delivery System, Chief Medical Officer, Florida Blue
### Why Oncology?

<table>
<thead>
<tr>
<th>Diagnosis Group</th>
<th>% Medical Spend</th>
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<tbody>
<tr>
<td>Neoplasms</td>
<td>16%</td>
</tr>
<tr>
<td>Musculoskeletal System</td>
<td>13%</td>
</tr>
<tr>
<td>Circulatory System</td>
<td>10%</td>
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</table>
Program Partners

The Miami-Dade Accountable Oncology Program involves three parties.
Program Highlights

Florida Blue, AMS, and BHSF agreed to focus the program on six cancer types:

- Breast
- Digestive System and Peritoneum
- Female Reproductive Organs
- Lymphatic and Hematopoietic Tissue
- Male Reproductive Organs
- Respiratory and Intrathoracic Organs

The parties agreed upon:

- Attribution methodology to establish the cost baseline
- Calculation of average member per year expense for AMS members
  - Financial targets for attributed members
    - Progressively reach medical CPI, then overall CPI
- Shared savings percentages for each party
- Effective date for the agreement
Progress

- Program implemented May 1, 2012
- Completed third quarter review
  - The program continues to run favorable to target
    - Decrease in trend better than targets
      - Reduced admissions
      - Reduced ER use
      - Better adherence to clinical and Oncology drug pathways

- Added clinical capabilities to fill identified gaps in care
  - Onsite dedicated Clinical Coordinator
  - Increased connectivity among the partners
    - Streamlining UM, Pharmacy, and Care Management functions
  - Expanding relationship to total cost of care value based model
The Florida Blue Delivery System is becoming a Mosaic of Value Models

**ACO Models**
1. Baptist/AMS
2. Naples Community
3. BayCare
4. Holy Cross
5. Moffitt
6. Cleveland Clinic
7. HMA Brevard ACO

**Physician Groups / Clinics**
1. Diagnostic Clinic - Largo
2. Florida Blue Retail Center - Pensacola
3. Florida Blue Retail Center - Winter Haven

**Bundled Payment Pilots**
1. Mobile Surgical Inc.
2. Florida Ortho Institute
3. Mayo Clinic

**Staff Model HMOs**
1. Capital Health Plan
2. Florida Health Care Plan

**Patient Centered Medical Homes**
>240 groups and growing

**Medicare Collaborative Care Models**

**Hospital P4P**
>30% of our contracts and growing
Emerging Models of Accountable Care

Dr. Jeff Kang, Senior Vice President
Health and Wellness Division
6.13.13
Walgreens is Well-Positioned to Partner with Physicians & Health Systems as A Total Population Health Solution

Strategic Considerations

- Traditional focus of US healthcare delivery system
- System is focused on providing sick care

- Focus of population health solution companies
- System is focused on keeping people and preventing hospitalizations

WAG's Role

- Home Infusion
- Medication Reconciliation and Adherence (Well Transitions)
- Medication Reconciliation and Adherence
- Medication Counseling
- Biometric monitoring
- Chronic Condition Management
- Acute Episodic
- H&W counseling
- Health Testing
- Immunizations
Walgreens Population Health Solution

Health Plan Population Health

- Telephonic
- Inaccessible
- Outside of Physician Care Team

Community–Based Population Health

- Face-to-Face
- Convenient
- Part of Physician Care Team

TRIPLE AIM™
- Lower total medical costs
- Improved health
- Improved experience
- PLUS – Helping physicians fill gaps in care

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Our integrated services help identify, manage and control acute health issues and chronic conditions through affordable and convenient access to health care services.
## Walgreens Three ACO Partnerships (MSSP1)

**Dynamic and trusted community leaders positioned to deliver high quality care**

### 31,000 Lives - Temple, Texas
- 65 physicians’ offices
- 12 current hospital sites/ 29,000 square miles
- 112 Walgreens Pharmacies

### 7,600 Lives – Largo, Florida
- 100 provider multi-specialty practice
- Largo location contains a Walgreens Health System Pharmacy
- 156 WAG Pharmacies and 9 Take Care Clinics

### 10,000 Lives – Marlton, N.J.
- 350 multi-specialty physicians and 70 physician extenders
- Over 110 locations throughout NJ and Southeastern PA
- 208 WAG Pharmacies and 8 Take Care Clinics

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Opening Plenary Session

Emerging Models of Accountable Care

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