



Fifth Annual National ACO Summit

June 18-20, 2014

Follow us on Twitter at [@ACO_LN](https://twitter.com/ACO_LN) and use [#ACOSummit](https://twitter.com/hashtag/ACOSummit)

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Opening Plenary Session

Summit Opening

Mark McClellan, MD, PhD

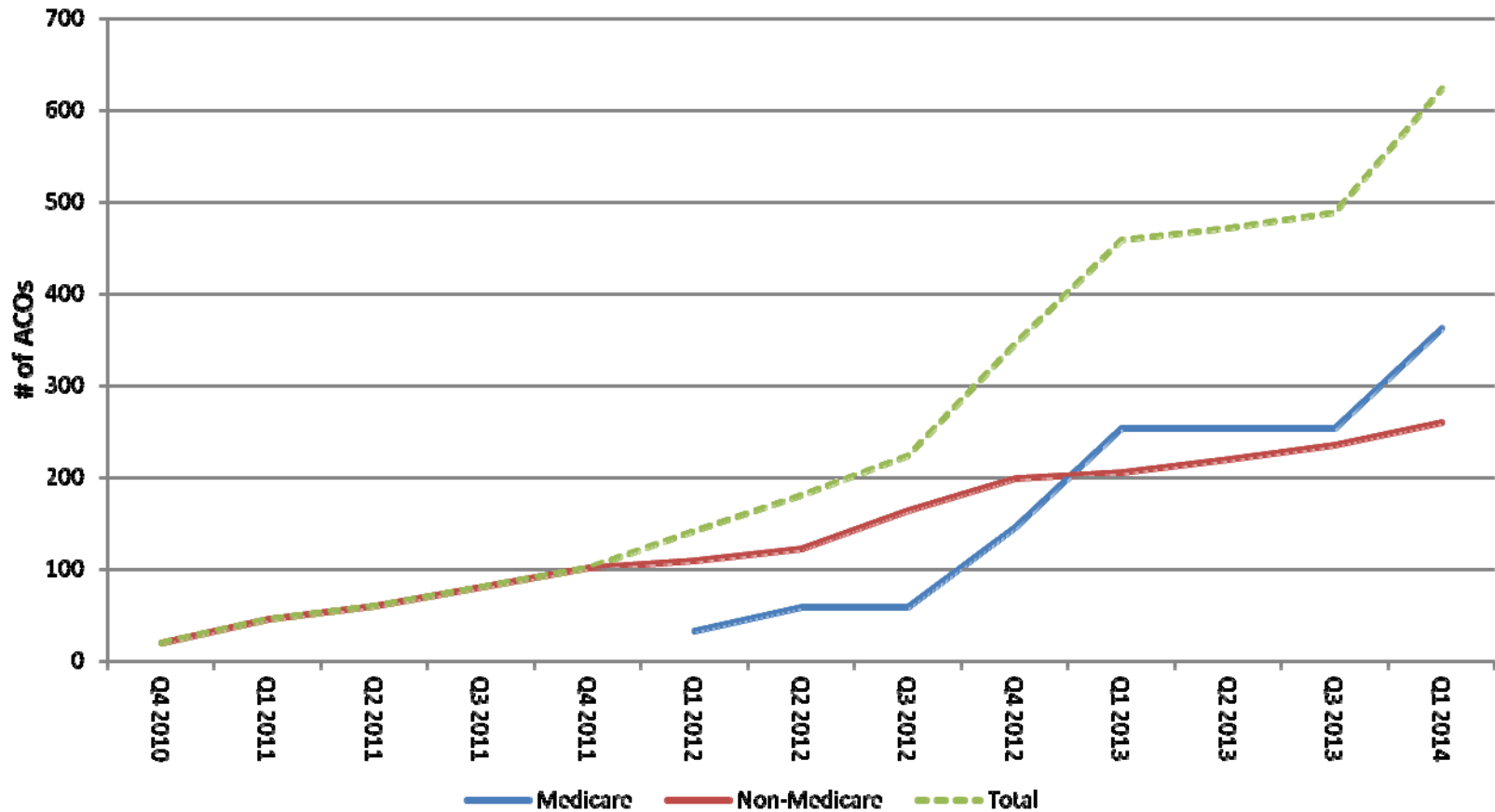
Senior Fellow and Director, Health Care Innovation and Value Initiative, The Brookings Institution; Former CMS Administrator and FDA Commissioner, Washington, DC

Elliott Fisher, MD, MPH

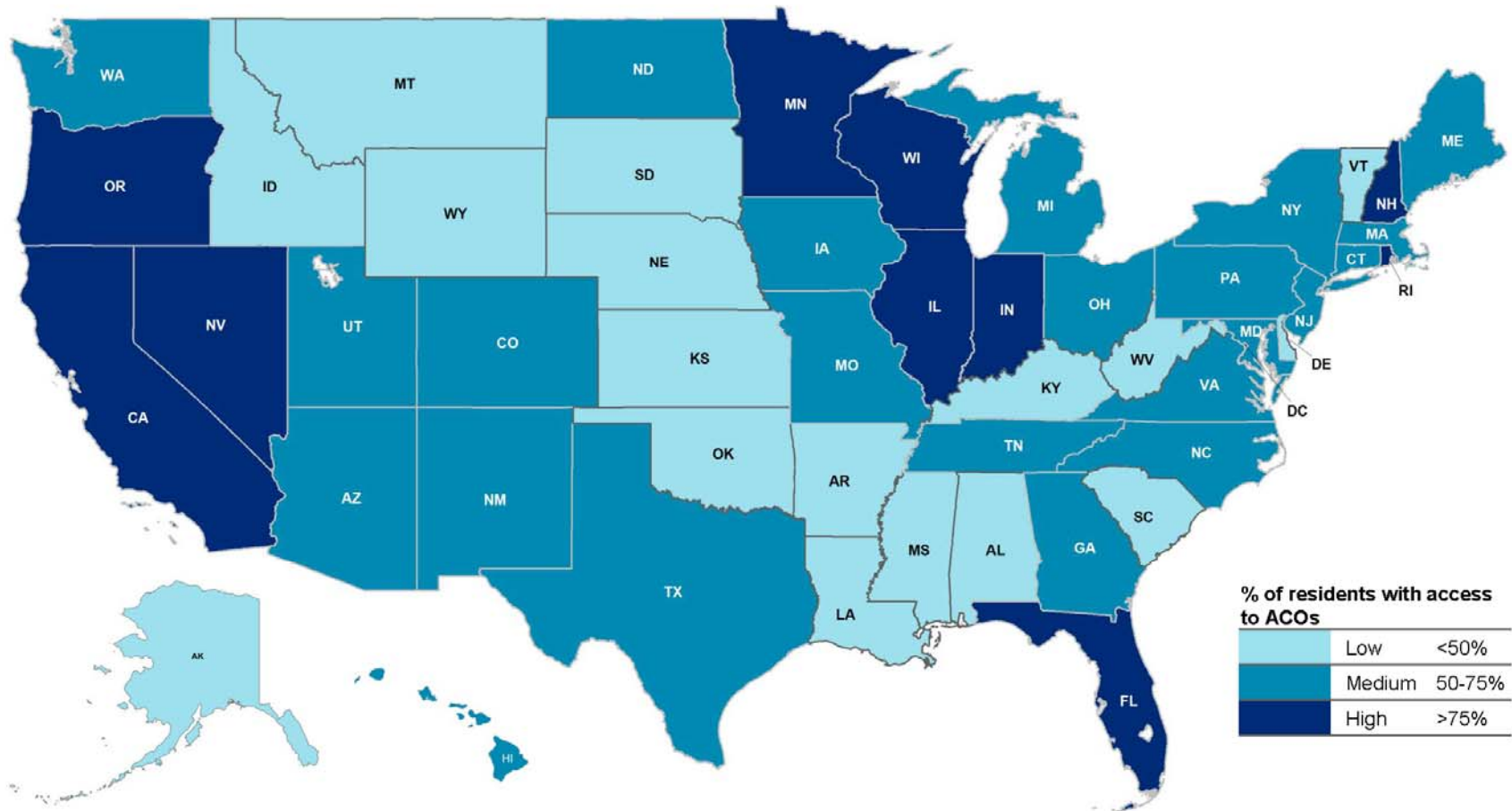
Director, The Dartmouth Institute for Health Policy and Clinical Practice; James W. Squires Professor of Medicine, Geisel School of Medicine at Dartmouth

Growth of ACOs Over Time

Medicare vs. Non-Medicare ACOs



Current Access to ACOs



% of residents with access to ACOs		
Light Blue	Low	<50%
Medium Blue	Medium	50-75%
Dark Blue	High	>75%

Updated as of January 2014. Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis

ACO Enrollment Continues to Grow



Medicare ACO Beneficiaries	5.6 Million
Non-Medicare Patients Served by Medicare ACO	>33 Million
Medicaid ACOs	34 across 19 states
Commercial ACO Contracts	287
Private Sector ACOs Beneficiaries	9 to 16 Million

Sources: “Fast Facts- All Medicare Shared Savings Program and Medicare Pioneer ACOs” May 2014; State “Accountable Care” Activity Map, National Academy for State Health Policy; “ACO Results: What We Know So Far” Leavitt Partners April 25, 2014; “ACO Update: Accountable Care at a Tipping Point Oliver Wyman April 2014

MSSP and Pioneer ACO First-Year Results: Quality



- 109/114 Medicare Shared Savings Program (MSSP) ACOs and all 32 Pioneer ACOs successfully reported quality measures
- Similar average quality performance but considerable variation in reported quality
- Better performance than quality benchmarks (now set based on performance data)
- Better performance than Medicare FFS on measures with FFS data (colorectal cancer screening, tobacco cessation, depression screening)
- Higher CAHPS patient experience survey scores than Medicare FFS

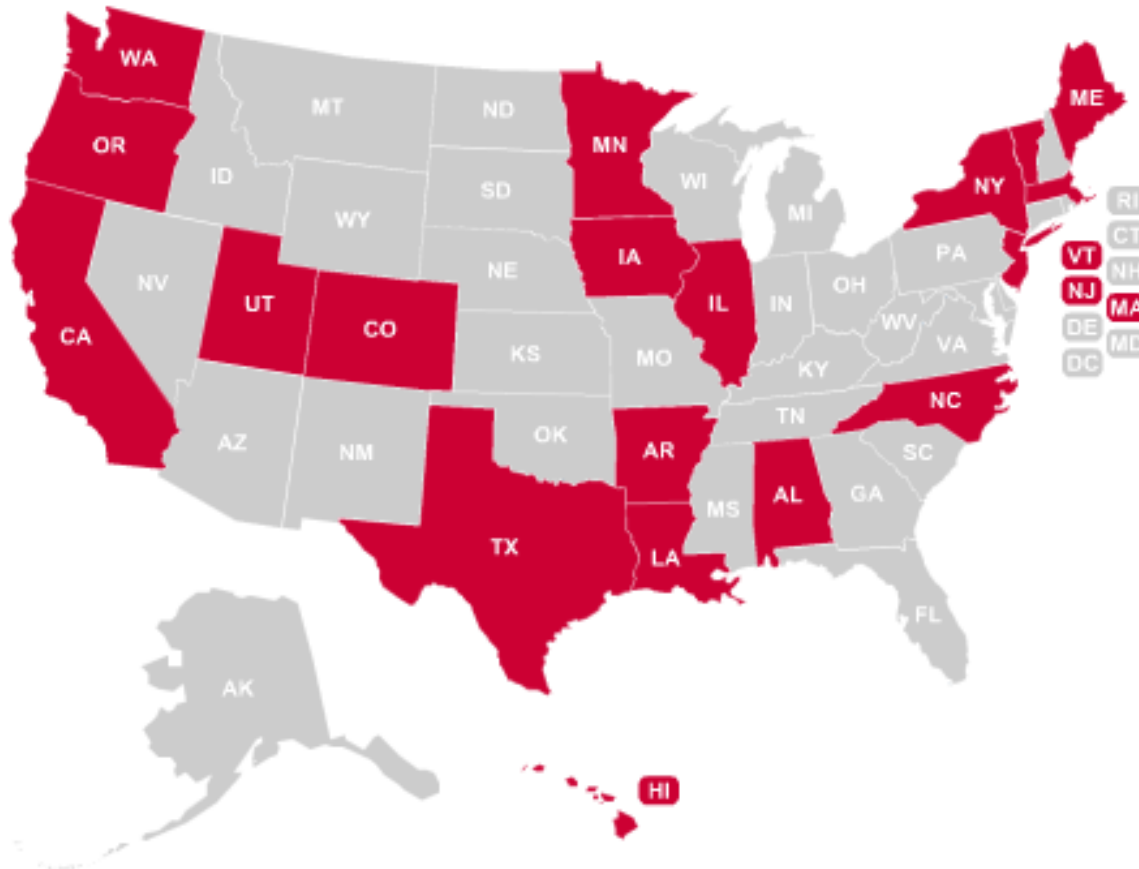
MSSP and Pioneer ACO First-Year Results: Financial



- MSSP: Medicare spending growth benchmark 0.8%
 - 54/114 MSSP ACOs had lower spending than benchmarks, and 29 reduced spending growth enough to share in savings
 - 21 of 29 successful MSSP ACOs were physician-led
 - Two MSSPs had shared losses
 - Total shared savings to MSSP ACOs of \$126 million; \$128 million in Medicare savings (approx 1% overall savings)

- Pioneer: Medicare spending growth benchmark 0.3%
 - 13/32 Pioneer ACOs reduced spending growth enough to share in savings
 - One Pioneer ACO had shared losses of approx. \$2 million
 - Total shared savings of \$76 million; \$71 million in Medicare savings (approx 2% overall savings)

Medicaid ACO Activity



Source: "State Accountable Care Activity" Map National Academy for State Health Policy

Medicaid ACO Examples



New Jersey: Enacted a 3 year ACO demo in 2011; final regulations released in May

- ACOs take responsibility for all Medicaid beneficiaries in a designated geographic area, with shared savings for quality and cost improvement
- Geographic focus must include 100% of the acute care hospitals, 75% of the primary care providers, two behavioral health providers, and two community residents on the board
- Program expansion will be considered depending on success reflected within 2014-2017

Colorado: Launched the Accountable Care Collaborative in 2011, with 352,000 enrollees

- Providers paid FFS with additional PMPM payments to Medical Home and RCCO (Regional Care Collaborative Organizations)
- A portion of PMPM payments are withheld in incentive quality pool and state provides data reports to support management and coordination
- **Early results:** \$6 million in net savings for FY 2012-2013 with a \$44 million in gross savings or cost avoidance, achieving more than double the savings of the prior fiscal year
 - Hospital readmissions decreased by 15-20 percent
 - High cost imaging decreased by 25 percent reduction
 - Emergency Room Utilization increased by only 1.9 percent compared to a 2.8 percent increase for those not enrolled in the program

Early Results from Private-Plan ACOs



Blue Cross Blue Shield of California

ACOs delivering care to 160,000 enrollees, with plans to have 20 ACOs by CalPERS requires contracting health plans to integrate care contracts over the next five years using ACO models

• **Early results** from first 4 years of global budget pilot for CalPERS with Dignity Health and Hill Physicians

- Costs for CalPERS population growing at a rate of ~3 percent annually compared to non-ACO annualized trend of 7.6 percent
- Total inpatient days fell by 16 percent
- Net savings of \$95 million for CalPERS members since 2010 with Gross savings approximately \$105 million and \$10,000 paid in bonuses

Massachusetts Blue Cross Blue Shield Alternative Quality Contract

11 total provider systems

• **Early results (JAMA)**

- Year 2 savings of 3.4 percent on total quarterly spending on Medicare beneficiaries primarily due to decreased spending on outpatient care procedures, imaging, and tests for beneficiaries with 5 or more conditions
- Performance improved on quality measures by 3.1 percentage points for beneficiaries with diabetes and 2.5 percentage points for those with cardiovascular disease



Early Results from Private-Plan ACOs



Cigna

- 89 ACO initiatives in 27 states serving 910,000 commercial customers, with plans to increase to 100 ACOs by the end of 2014, reaching one million customers

• Early results

- On average, 3% better-than-market quality performance
- On average, 3% better-than-market total medical cost
- 19% to 25% better compliance with diabetes measures;
- 21% more gaps in care closed
- 50% fewer emergency room visits



Aetna

- 32 ACO agreements in place serving 550,000 members, with plans to increase to 60 ACOs by the end of 2014 to cover 750,000 members, amounting to \$2.5 billion or 7% of its total revenue

- **Early results:** ACOs have generated 10% savings on average

Early Results from Private-Plan ACOs



WellPoint ACOs

- 85 ACOs, a rapid increase from the 23 ACO contracts it had in May 2013

Anthem ACOs

- 14 ACOs serving 55,000 patients in Southern California in PPO plans
- Partnerships with HealthCare Partners, Santa Clara County IPA, Sharp Community Medical Group and Sharp Rees-Stealy Medical Group
- **Early results** showed 35% year-over-year increase in the number of mammograms performed and a 44% increase in appropriate prescribing of antibiotics for bronchitis treatment by the end of 2013
- Cost savings reported in early June of 2014 by Anthem in partnership with HealthCare Partners
 - Net savings of \$4.7 million achieved in the first half of 2013, in conjunction with care coordination fee implementation
 - Overall admissions fell by 4%
 - Inpatient days fell by 18%
 - Visits for radiology and other lab tests fell by 4%



Early Results from Private-Plan ACOs



UnitedHealthcare

ACOs and Patient-Centered Medical Homes across 29 states

- Programs designed via five value levers: evolved care management programs; high-performing networks; value-based contracting; value-based benefits; and transparency and all involve shared risk and savings between both the health plan and care provider

- >\$30 billion of UnitedHealthcare's annual physician and hospital reimbursements are linked to its accountable care programs, centers of excellence and performance-based programs with the goal to reach \$65 billion by 2018

• Early results

- 4 Star HEDIS level on screenings for diabetes, cardiovascular care, colorectal cancer and rheumatoid arthritis for Medicare Advantage plan accountable care programs
- PCMH in OH, CO, RI, & AZ resulted in overshooting clinical quality targets on **95%** of measures, 2:1 medical cost savings as compared to incentive payout and reduced medical cost trend by **4% to 4.5%** points



Lessons from ACO Experience



1. Rapid and diverse growth and development of ACOs

- Commercial contracts have more than doubled in the past 2 years
- Medicare ACOs are forming in all parts of the country with different organizational models: metropolitan, rural, suburban, hospital-based, physician-led, PHOs, FQHCs
- Medicaid ACO activity is growing rapidly across the country in various stages of development: fully implemented with results (CO, OR), entering implementation (NJ, IL), proposed reforms (NC)

2. Wide variation in pace and types of ACO activity

- ACOs in both the public and private sector are in different stages of development with varying levels of risk ranging from “downside” only to full capitation
- Some organizations see ACOs as an end product; others are using ACOs as transition path to increasingly advanced payment and delivery models

3. Mixed results including some strong successes and some with little early impact

- Medicare ACOs are meeting quality benchmarks, but only a quarter have been able to reduce costs enough to qualify for shared savings
- Many commercial ACOs have been able to transform care, and in some cases bend the cost curve (ranging from 2 to 12%), but success can often be determined by market changes or factors beyond scope of ACO

Lessons from ACO Experience



4. Increasing opportunities to learn from ACO experience

- Diversity in implementation steps, with chances to learn how to innovate more effectively
- Right strategy and implementation steps depend on context

5. Progress in payment reform and implementation support

- Moving beyond shared savings: ongoing physician payment reform efforts, bundled payments, medical homes
- New mechanisms to provide capital needed to support practice change

6. Further policy reforms coming

- CMS is expected to release new proposed regulations for the Medicare ACO programs—opportunities to address existing issues and create sustainable path forward
- Further state reform initiatives
- Potential further steps on antitrust and consolidation

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 70 leading providers, payers, 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 implementation-focused Innovation Exchanges
- Online ACO resources and research, including profiles of organizations implementing ACOs, a library of ACO publications, over 50 archived webinars, and past ACO LN event materials

Learn more at www.acolearningnetwork.org or e-mail aco@brookings.edu.

ACO Learning Network Innovation Exchanges



Physician-Led ACOs Innovation Exchange

- Identifies critical areas of need and opportunities for physician-led ACOs and develops tools and resources to help these ACOs succeed. Topics include identifying and managing high-risk patients, crafting referral networks, engaging patients, and using event notifications to improve care

Optimizing the Value of Pharmaceuticals Innovation Exchange

- Examines ways to improve the use and integration of pharmaceuticals into ACOs, through novel stakeholder arrangements that consider existing challenges, structural constraints, and changing incentive landscapes

Commercial Payer-Provider ACO Forum

- Explores challenges for implementing commercial accountable care arrangements, including quality measurement alignment, and identifies key steps for effectively implementing new value-based payment and delivery models

ACO 2.0: Future Policy and Regulatory Changes

- Identifies existing barriers to effective accountable care implementation in both the private and public sector and considers potential policy and regulatory changes to help organizations of varying experience and composition to succeed as an ACO

National Survey of ACOs

Research Questions:

Who forms
ACOs?

What
strategies
are ACOs
using?

How do
ACOs
perform?

Methods: Survey, qualitative research,
claims analysis, spatial analysis

Defining the Survey Population

A group of providers collectively held accountable for the **total cost** and overall **quality of care** for a **defined patient population**

1

Federal or state Medicaid program participation

2

Public notices of ACO contracts

3

National surveys and collaboratives identifying potential ACOs

National Survey of ACOs



Longitudinal Web-based Survey

- Wave 1: October 2012 to May 2013 (N=173)
- Wave 2: October 2013 to January 2014
- Wave 3: Spring 2014

Determining Eligibility

- Public-payer ACOs were automatically considered eligible
- Eligibility of other ACOs determined via participation in survey

Response Rate

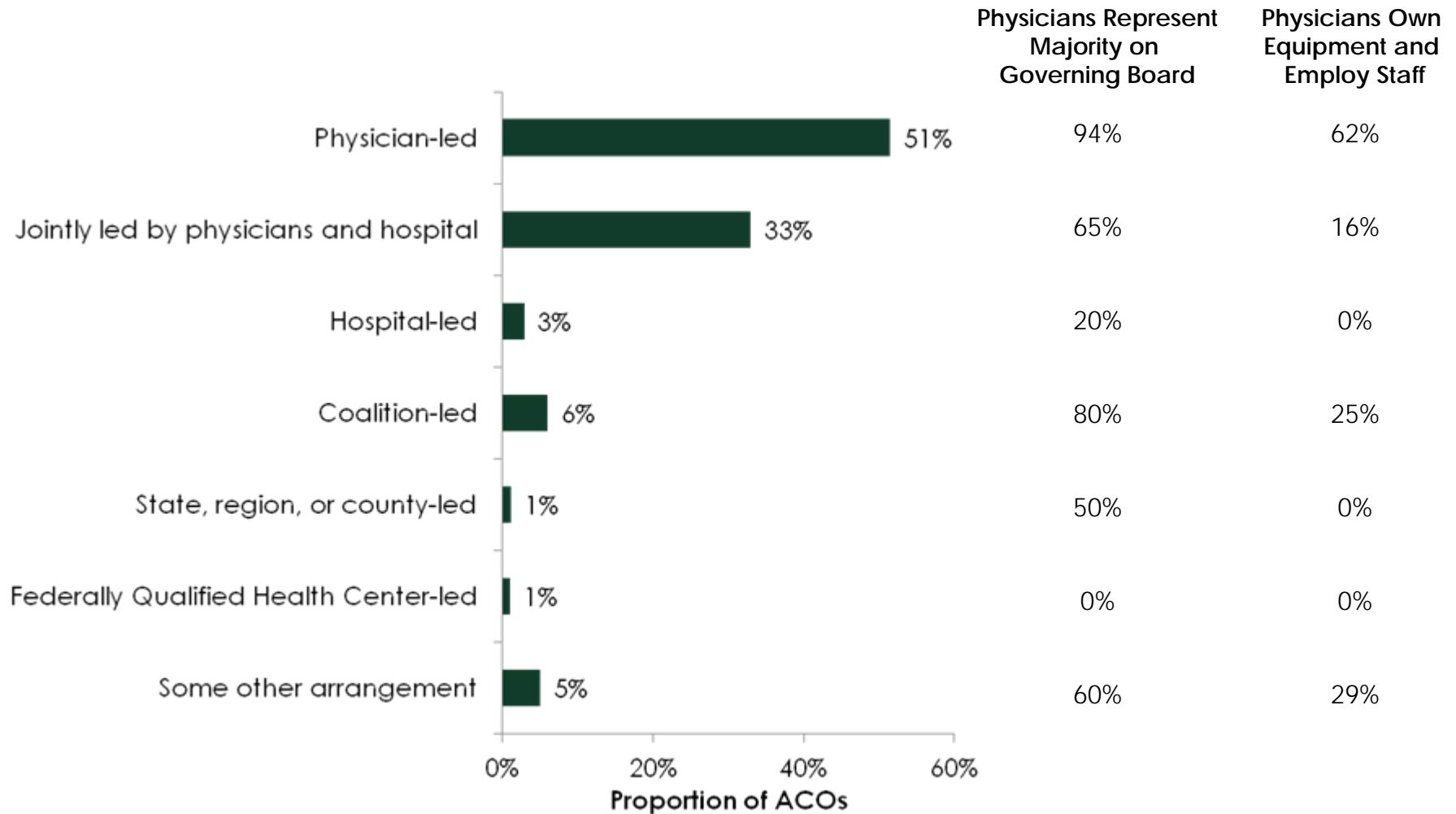
- Overall: 70%
- Medicare: 81%
- Medicaid: 41%

National Survey of ACOs: work in progress



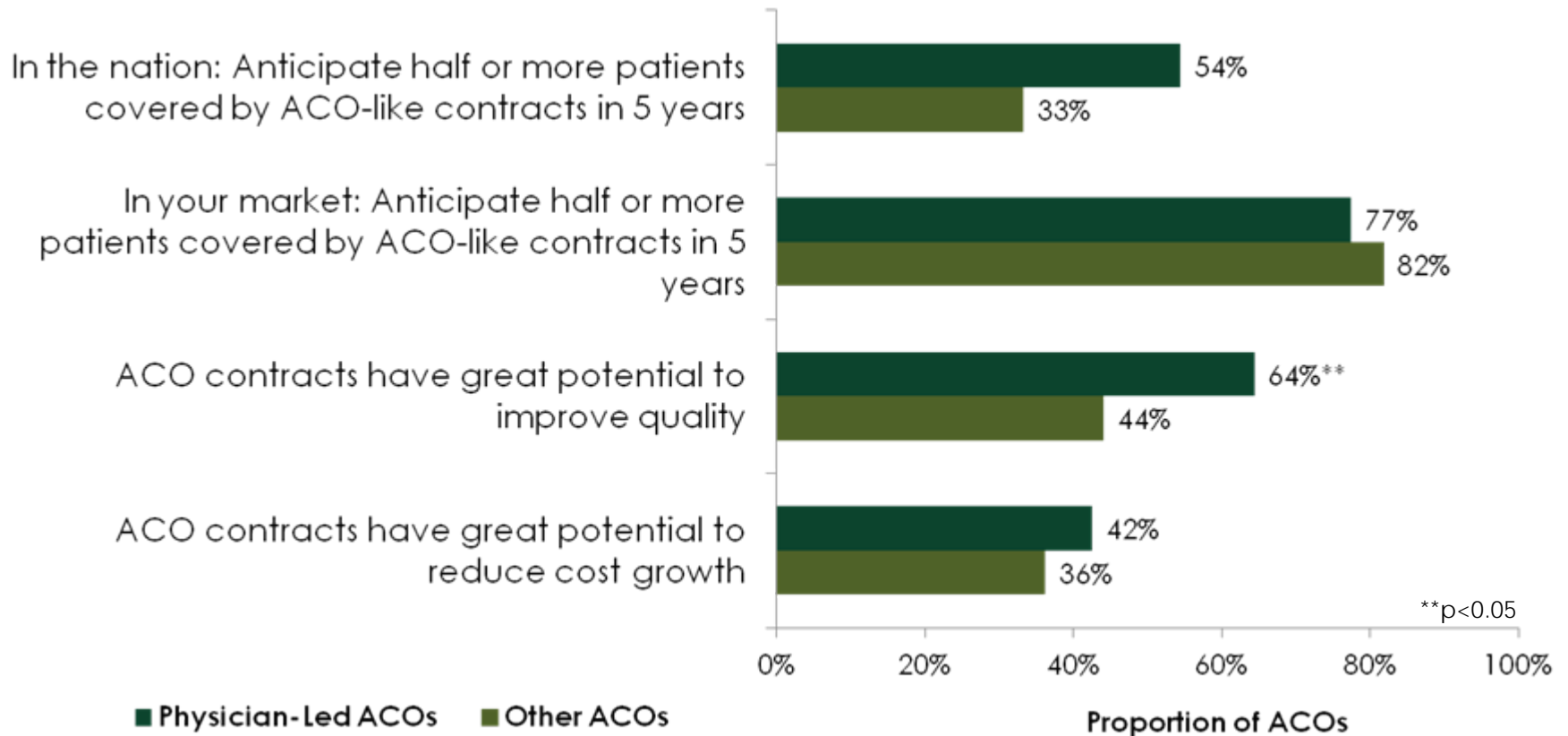
A Framework for Evaluating ACOs	Health Affairs, 2012
Promise and Perils of ACOs for Vulnerable Populations	Health Affairs, 2012
ACOs in the US: Factors associated with formation	HSR 2013
Physician Leadership in ACOs	Health Affairs, 2014
Safety net providers in ACOs	JGIM, in press
ACO Contracting with private and public payers	AJMC, in press
A taxonomy of ACOs in the United States	Submitted
Post acute care in ACOs	Submitted
Pharmacy and prescription drug management in ACOs	Submitted

National Survey of ACOs



National Survey of ACOs

Outlook on the ACO Model



ACO Structure

- 73% include a **hospital**
- 74% include **post-acute care**
- 28% include an **FQHC** or **RHC**
- Average of 179 **PCPs**, 241 **specialists** for largest ACO contract

Performance Management

- 50% reporting **physician performance measures on quality** among peers within organization
- 33% reporting **physician performance measures on cost** among peers within organization
- 46% utilize individual **financial incentives**

Health IT

- 87% attested to **Meaningful Use** at end of 2012
- 38% reported having ability to **integrate outpatient and inpatient data**
- 27% reported having system in place for **predictive risk assessment AND risk stratification**

Care Management

- 21% reported pre-visit **planning, medication management, and reminders** for preventive care
- 32% reported **chronic care mgmt.**
- 20% reported all or nearly all systems in place to ensure **smooth care transitions**

ACO Summit Objectives



- 1. Learn from early and ongoing ACO efforts to make implementation efforts more efficient and effective**
- 2. Identify key barriers to effective ACO reforms in the private and public sector, and promising steps to address them**
- 3. Collaborate to build strategies to address ACO implementation and management challenges**
- 4. Identify critical next steps for accountable care and health care reform, including policy and regulatory changes**

ACO Summit Plenary Session Highlights



Thursday Opening Plenary Session

- **Keynote Address: Sean Cavanaugh**, Center for Medicare, CMS
- **Panel: The Changing Environment of Commercial ACO Arrangements**

Thursday Afternoon Plenary Session

- **Keynote Address: Alice Rivlin**, Engelberg Center for Health Care Reform, Brookings
- **Financial, Implementation, and Policy Considerations in Advancing Accountable Care: A Roundtable with Former Medicare and Medicaid Administrators**
 - **Leonard Schaeffer**, Senior Advisor, TPG Capital; Judge Robert Maclay Widney Chair, USC; Founding Chairman and CEO, WellPoint Inc.; Former Administrator, HCFA (now CMS)
 - **Thomas Scully**, General Partner, Welsh, Carson, Anderson & Stowe; Senior Counsel, Alston & Bird LLP; Former Administrator, CMS;

Friday Closing Plenary Session

- **Keynote Address: Michael Leavitt**, Founder and Chairman, Leavitt Partners; Former Governor of Utah; Former US Secretary of Health and Human Services
- **The Future of ACOs: Anticipated Regulatory and Policy Changes**
 - **John Pilotte**, Director, Performance-Based Payment Policy Group, Center for Medicare, Centers for Medicare and Medicaid Services

ACO Summit Tracks: Addressing Implementation Challenges



Summit Day 1

- **Track 1:** Performance Measurement for Accountable Care: Challenges and Solutions
- **Track 2:** Innovations in Contract and Payment Incentives
- **Track 3:** Emerging Payer-Provider Accountable Care Models
- **Track 4:** Opportunities and Challenges for Physician-Led ACOs
- **Track 5:** Engaging Patients in Accountable Care
- **Track 6:** Consolidation and Competition in Health Care Markets: Implications of ACOs

Summit Day 2

- **Track 7:** Coordinating Care for High-Risk and Vulnerable Populations
- **Track 8:** Innovations in Data Management
- **Track 9:** Clinical Leadership in ACOs
- **Track 10:** Optimizing the Value of Pharmaceuticals in New Care Models
- **Track 11:** Caring for and Meeting the Needs of Frail and Elderly Patients
- **Track 12:** Community Based Accountable Care Organizations

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Opening Plenary Session

Keynote Address

Sean Cavanaugh

Deputy Administrator and Director, Center for Medicare,
Centers for Medicare and Medicaid Services

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Opening Plenary Session

The Changing Environment of Commercial ACO Arrangements

Samuel W. Ho, MD

Executive Vice President and Chief Medical Officer, UnitedHealthcare; President, UnitedHealthcare Clinical Services

Samuel R. Nussbaum, MD

Executive Vice President, Clinical Health Policy and Chief Medical Officer, WellPoint; Former President, Disease Management Association of America

Joseph M. Zubretsky

Senior Executive Vice President, National Businesses, Aetna; Former Chief Financial Officer, Aetna, Hartford, CN

Mark B. McClellan, MD, PhD (Moderator)

Senior Fellow and Director, Health Care Innovation and Value Initiative, The Brookings Institution

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Opening Plenary Session

**Break and
Morning Track Sessions**

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Afternoon Plenary Session

Keynote Remarks

ACOs: From Rationale to Reality

Alice Rivlin

Leonard D. Schaeffer Chair in Health Policy Studies and
Director, Engelberg Center for Health Care Reform, Brookings
Institution, Visiting Professor, Public Policy Institute,
Georgetown University, Founding Director, Congressional
Budget Office

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Afternoon Plenary Session

**Financial, Implementation, and Policy Considerations in Advancing Accountable
Care:**

A Roundtable with Former Medicare and Medicaid Administrators

Leonard D. Schaeffer

Senior Advisor, TPG Capital, Judge Robert Maclay Widney Chair, USC,
Founding Chairman and CEO, WellPoint Inc.,

Thomas A. Scully, Esq.

General Partner, Welsh, Carson, Anderson & Stowe; Senior Counsel, Alston &
Bird LLP; Former Administrator, Centers for Medicare and Medicaid Services

THE FIFTH
NATIONAL

Accountable Care Organization Summit

The Leading Forum on
Accountable Care Organizations
and Related Delivery System
and Payment Reform

Afternoon Plenary Session

**Break and
Afternoon Track Sessions**



Fifth Annual National ACO Summit

June 18-20, 2014

Follow us on Twitter at [@ACO_LN](https://twitter.com/ACO_LN) and use [#ACOsummit](https://twitter.com/ACOsummit)