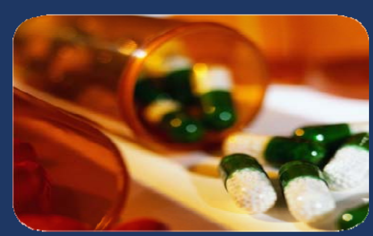
Sixth Annual National ACO Summit



June 17-19, 2015

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Center for Health Policy at Brookings | The Dartmouth Institute

THE SIXTH NATIONAL **Accountable Care Organization Summit**

Opening Plenary Session

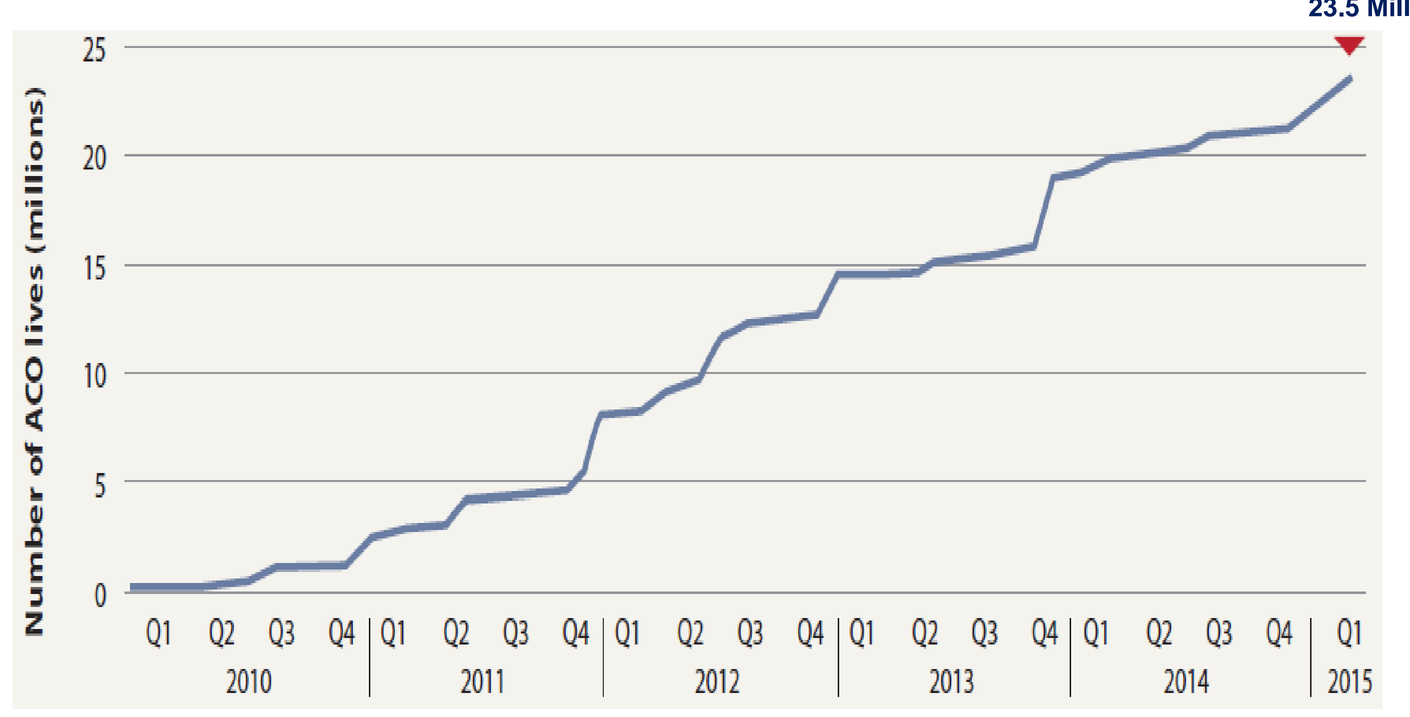
Summit Opening

Mark McClellan, MD, PhD
Senior Fellow and Director, Health Care Innovation and Value Initiative, The Brookings Institution; Former CMS Administrator and FDA Commissioner

Elliott S. Fisher, MD, MPH
Director, Dartmouth Institute for Health Policy and Clinical Practice; John E Wennberg Distinguished Professor of Health Policy, Medicine and Community and Family Medicine, Geisel School of Medicine at Dartmouth; Co-Director, Dartmouth Atlas of Health Care

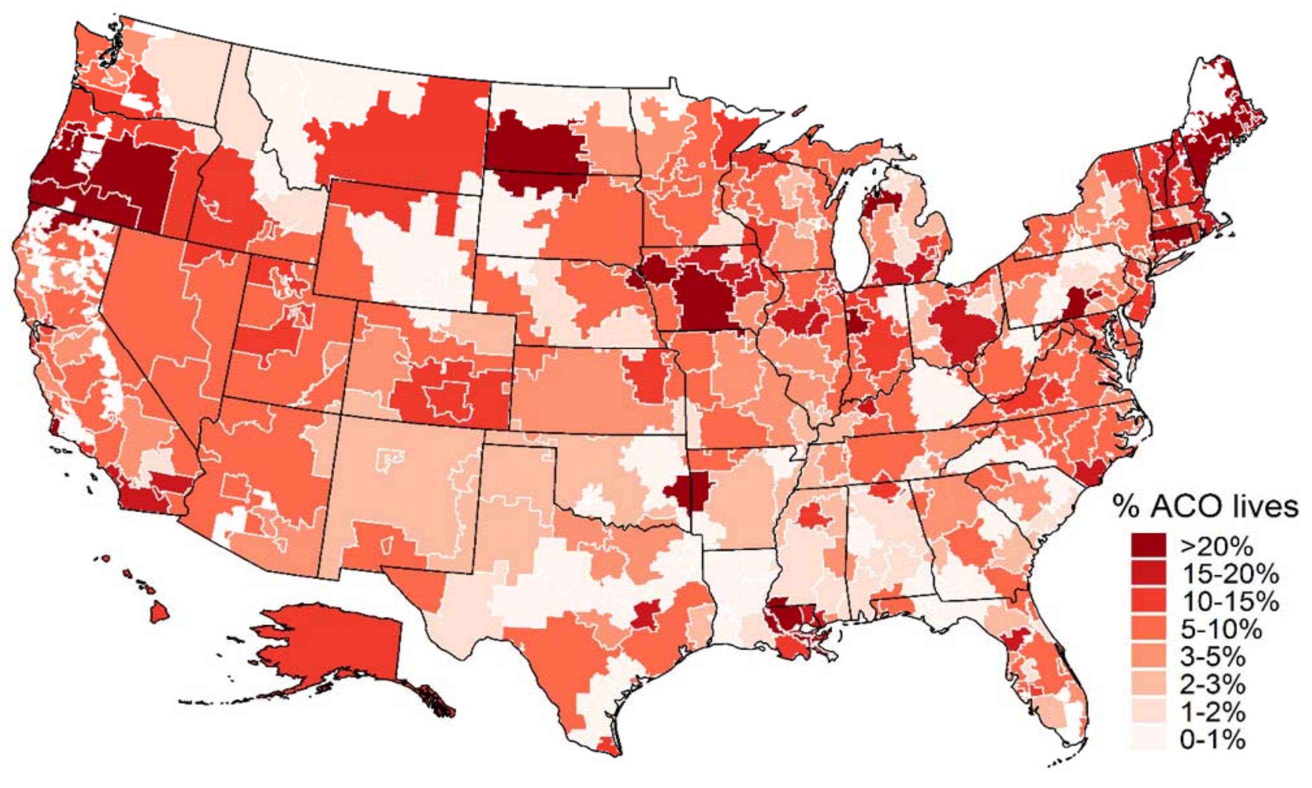
Growth of ACOs Over Time: Medicare vs. Non-Medicare

Covered ACO Lives – Medicare and Commercial



Source: The Impact of Accountable Care: Origins and Future of Accountable Care Organizations, Leavitt Partners; 2015

Population Covered by Hospital Referral Region

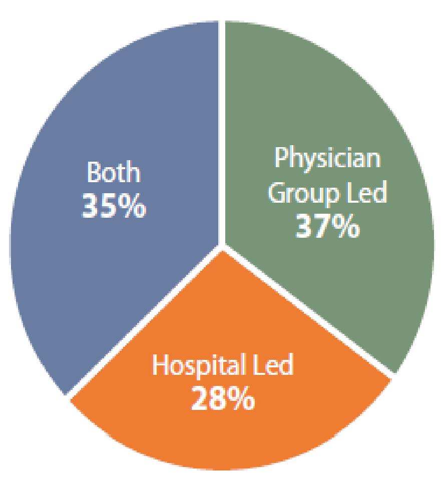


Source: Growth and Dispersion of Accountable Care Organizations in 2015, *Health Affairs* Blog; 2015

ACO Enrollment Continues to Grow

Total Number of ACOs

Share of ACOs by Provider Type

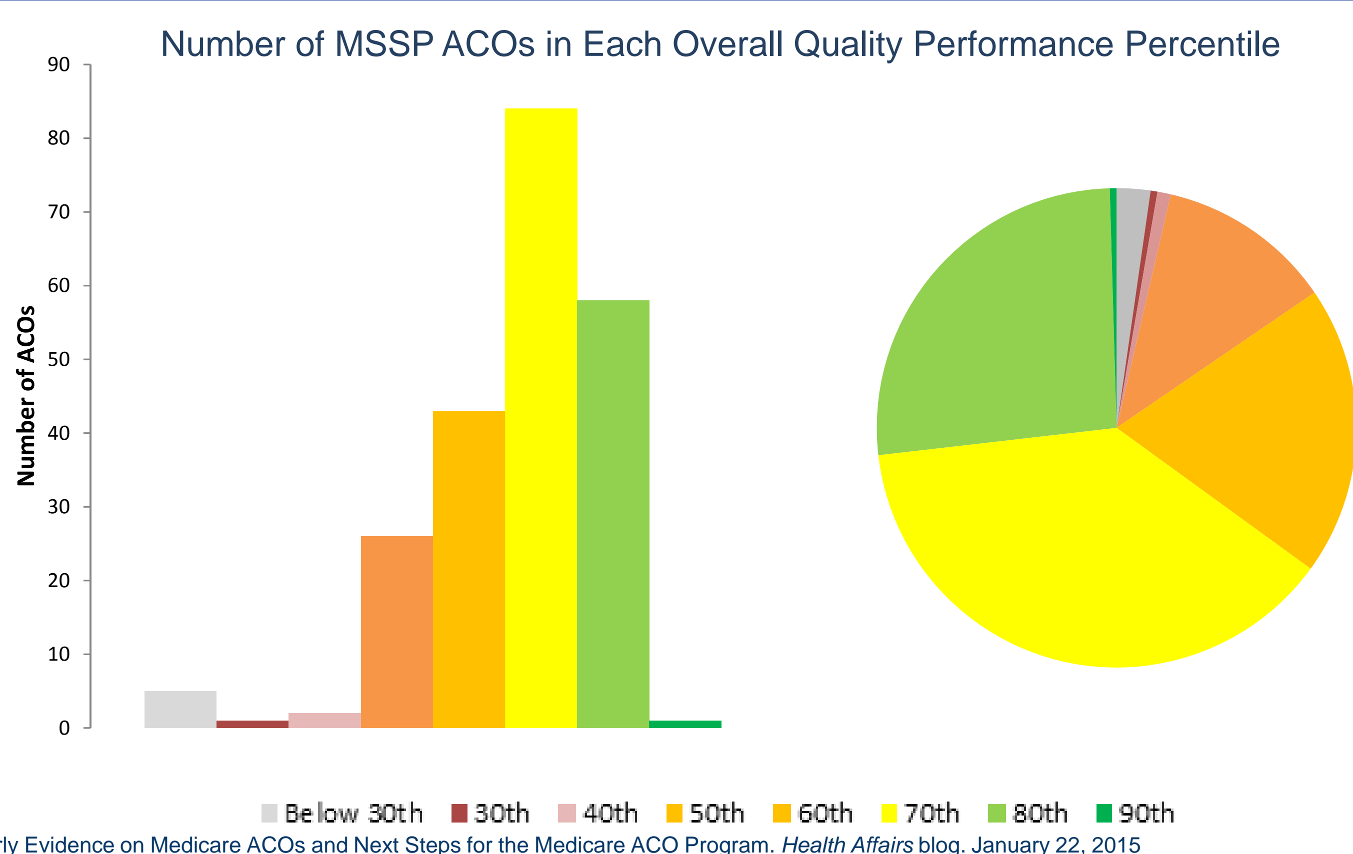


Source: The Impact of Accountable Care: Origins and Future of Accountable Care Organizations, Leavitt Partners; 2015

Growing Commercial ACO Experience

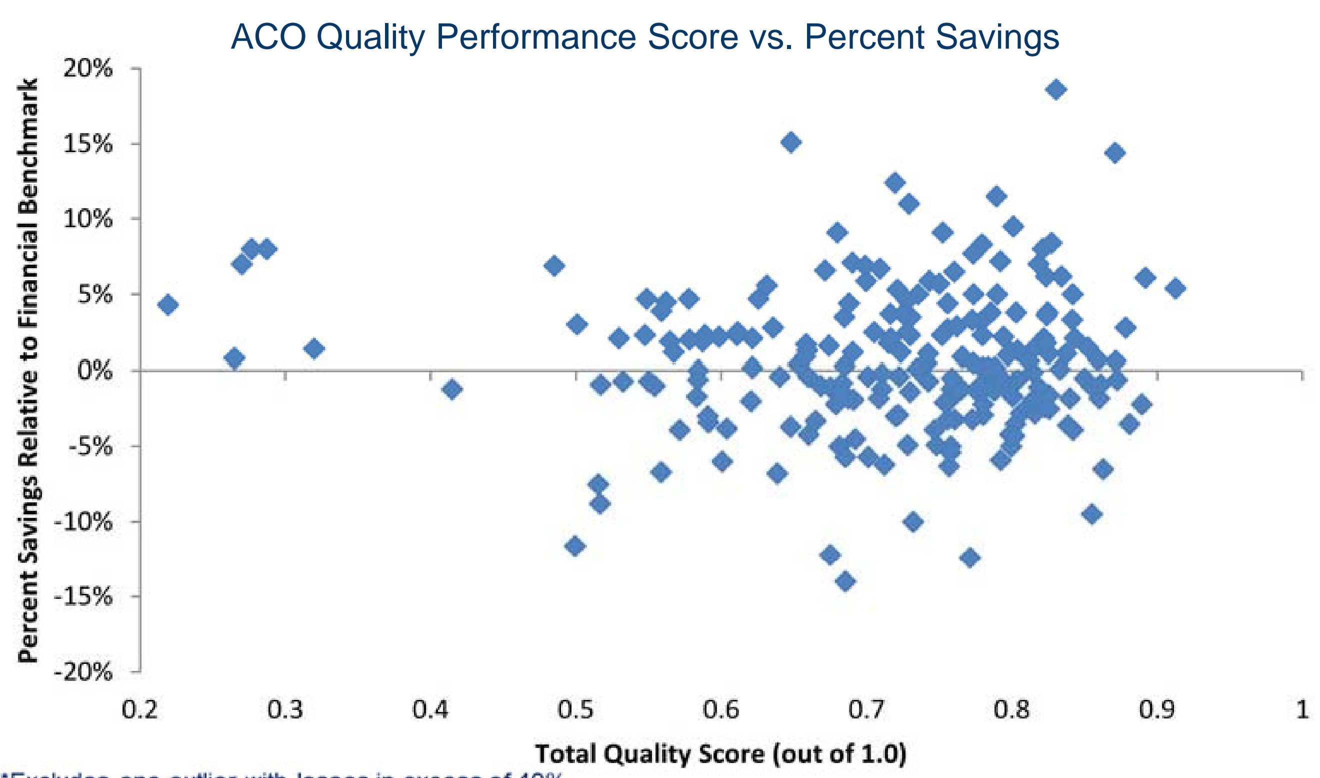
	Aetna	Cigna	United Healthcare	Blues Plans
# ACOs	60 across 18 states	122 across 29 states	520 across 48 states	450 across 32 states
Covered Lives	750,000	1.3 million	11 million	25 million (including ACOs, PCMHs, P4P)
Quality Performance	---	+2% better than market trend	-11% reduction in hospital admissions	BCBSMA's AQC: 12% above national average by year 4
Cost Performance	On average, 10% savings	+3% savings for physician-led ACOs	---	CalPERs/HPMG/Dignity ACO: saved $85 million

MSSP ACOs First and Second Year Results: Quality



McClellan et al. Early Evidence on Medicare ACOs and Next Steps for the Medicare ACO Program. *Health Affairs* blog. January 22, 2015

MSSP Performance on Cost & Quality



McClellan et al. Early Evidence on Medicare ACOs and Next Steps for the Medicare ACO Program. *Health Affairs* blog. January 22, 2015

Performance Differences in Year 1 of Pioneer Accountable Care Organizations

J. Michael McWilliams, et al., *NEJM*, April 2015

Key Findings:

- In 2012, the ACO group yielded a 1.2% savings in per-beneficiary spending
- Savings were significantly greater for ACOs with baseline spending above the local average (vs. below) and ACOs serving high-spending areas (vs. low-spending areas)
- Savings were similar in ACOs with financial integration between hospitals and physician groups and those without, as well as in ACOs that withdrew from the program and those that did not

Association of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service With Spending, Utilization, and Patient Experience

David J. Nyweide et al., *JAMA,* May 2015

Key Findings:

- Total spending for beneficiaries aligned with Pioneer ACOs in 2012 or 2013 increased from baseline to a lesser degree relative to comparison populations
- Spending reduced by approximately $280 million in 2012 and $105 million in 2013
- Inpatient spending showed the largest differential change of any spending category
- Changes in utilization of physician services, ED, and post-acute care
- ACO-aligned beneficiaries reported higher mean scores for timely care and for clinician communication

Pioneer ACO Evaluation Findings from Performance Years One and Two

L&M Policy Research, LLC, March 10, 2015

Key Findings:

- Savings in Pioneer Program translates to $35.62 PBPM in 2012 and $11.18 PBPM in 2013
- Total spending relative to local markets varied for the 32 individual Pioneer ACOs:
  - 10 had statistically significant savings in both performance years
  - 10 had statistically significant savings in only one year; 2 of these had significant losses the other year
  - 12 had no statistically distinguishable savings or losses
- Most features explored (hospital relationships, care continuum capabilities, leadership, market factors) do not explain differences in Pioneer spending performance in Yr 1 or 2
  - Provider engagement activities suggest some relationship with Pioneer performance
- Scant evidence of systemic spillover in care delivery Spending performance accompanied by utilization reductions in acute inpatient settings
- Claims-based quality measures compared to near market trends showed Pioneers had
  - Statistically significant reductions in acute hospital admissions for COPD, older adult asthma, or heart failure in 2013
  - Significantly increased rates of post-discharge physician follow-up after discharge

Certification of Pioneer Model Savings

CMS Office of the Actuary

- **Expansion of the Pioneer Model would reduce net program spending, as specified in CMMI statutory language**

Key Findings of Existing Analysis

- The program has generated gross savings on expected claims cost between 3.7 and 4.8 percent in Yr 1 (2012) and 1.1 and 1.8 percent in Yr 2 (2013)
- Majority of Pioneer ACOs were estimated to have produced statistically significant savings in 1st performance year
  - Only 11 (near-market) or 12 (far-market) ACOs were estimated to have shown statistically significant savings in Yr 2
- Annual cost trends for MSSP and Pioneer groupings are generally equal to or below those for the comparison markets for each of the 3 years of the two programs
- Pioneer ACOs were likely to have generated greater relative savings than MSSP ACOs in the first 3 years of the two programs

MSSP Final Rule

- Affects participants joining or renewing their agreement for the performance period beginning January 1, 2016
- Spending benchmark equally weights three years preceding start of performance period
- Shared savings are included in benchmark
- Track 1 ACOs can remain in one-sided risk for additional performance cycle, up to 6 years total
  - Continue at 50% shared savings rate
- New Track 3 option
  - Higher level of risk sharing (up to 5-15%)
  - Upwards of 75% shared savings and loss, depending on quality performance
  - Prospective attribution and option of patient attestation beginning in 2017
  - Option to elect for waiver of 3-day SNF rule
  - Possible phase-in of broader telehealth coverage beginning in 2017, depending on Next Gen experience
- Track 2 and Track 3 now have 3 different symmetric MSR/MLR options
  1) no MSR/MLR
  2) 0.5% increments: 0.5%, 1.0%, 1.5%, 2.0%
  3) Rate based on number of assigned beneficiaries, like Track 1

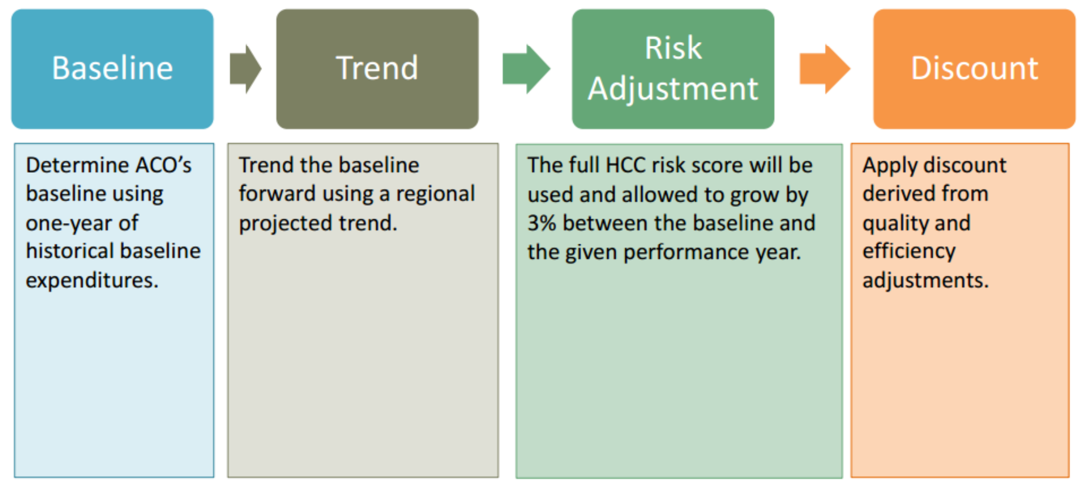
Next Generation ACO Model Moves Away From FFS With More Flexibility and More Beneficiary Engagement

- CMS announced the Next Generation Model on 3/10 and expects 15-20 participants
- ACOs must have at least 10,000 aligned Medicare beneficiaries (or at least 7,500 aligned Medicare beneficiaries if "rural" ACO) and will use a prospective benchmark
- Payment mechanisms:
  - **Normal FFS Payment**: same as original Medicare
  - **Normal FFS Payment + Monthly Infrastructure Payment**: receive normal FFS reimbursement, plus a PBPM payment unrelated to claims
  - **Population-Based Payment**: a monthly payment to ACOs taken out of a % of their Next Generation Provider/Supplier payments
  - **Capitation**: monthly PBPM payment based on an estimated total annual expenditures for the ACO
- Downside risk sharing with a 15% savings/losses cap and discount, and can either be:
  - A: 80% sharing rate for PY1-PY3 and 85% for PY4-PY5
  - B: 100% risk for Part A and B

Next Generation ACO Model Moves Away From FFS With More Flexibility and More Beneficiary Engagement

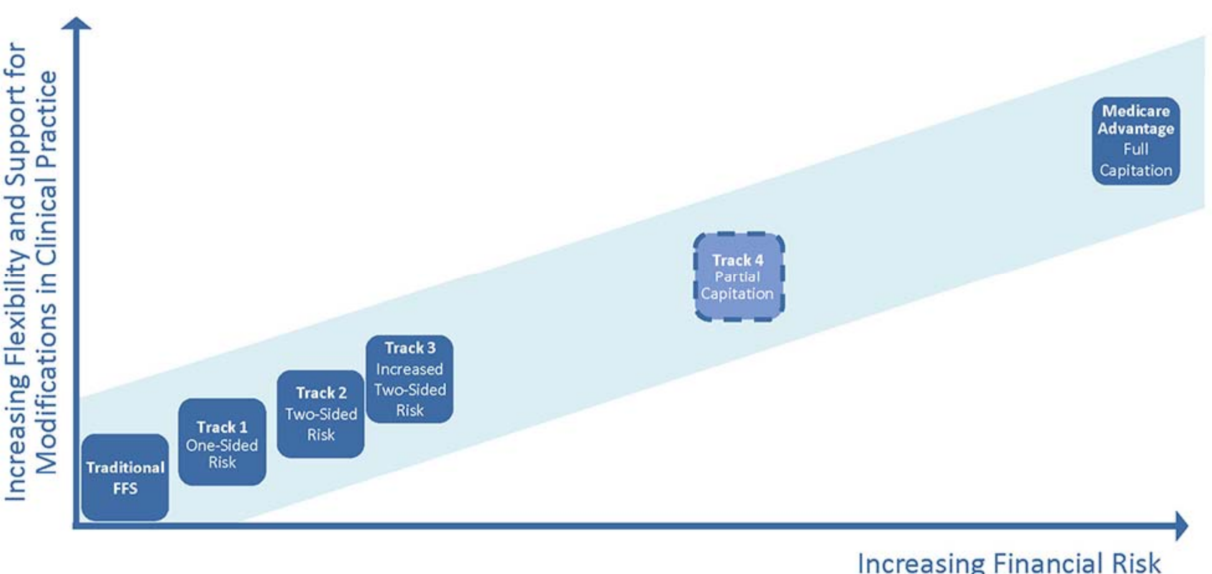
- Benefit enhancements available once the ACO is approved by CMS:
  - CMS is considering Waiving of Deductibles and Coinsurance
  - Beneficiary Coordinated Care Reward: *estimated $50 per-beneficiary per-year paid semiannually, which is not included in the ACO's benchmark*
  - 3-Day SNF Rule Waiver
  - Telehealth Expansion
  - Post-Discharge Home Visits
- Next Generation Model participants can designate:
  - **Preferred providers**: not direct providers/suppliers, but contributors to the ACO network
  - **Capitation affiliates**: Medicare providers/suppliers contracting with the ACO to participate in capitation
  - **SNF affiliates**: SNFs to which ACO providers/preferred providers may admit beneficiaries (according to the 3-Day SNF Rule benefit)

Next Generation ACO Model
Prospective Benchmark Methodology



CMS, Next Generation ACO Model, First Open Door Forum

Medicare Shared Savings Program: Work in Progress



- Most Medicare ACOs expected to stay in Track 1 (shared savings)
- Some attractive features for two-sided risk ACOs available only in Track 3: prospective attribution, patient attestation, waivers from 3-day hospital stay requirement for SNF coverage
- No option for ACOs besides Next Gen ACO to shift further than than two-sided shared savings – though partial capitation models in commercial ACOs are becoming more common
- Rulemaking coming on including regional costs trends in financial benchmark
- No changes to risk adjustment methodology
- Limited opportunities so far for more meaningful patient engagement: patient attestation in Track 3 only, financial incentives to seek care within ACO in Next Gen only
- These features are likely to continue to evolve

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: Patrick Conway**, Deputy Administrator for Innovation and Quality, Chief Medical Officer, Director, Center for Medicare and Medicaid Innovation Center for Medicare and Medicaid Services (CMS)
- **Panel: Aligning Goals on Payment Reform**
  - John Bertko, Chief Actuary, Covered California
  - Robert S. Galvin, CEO, Equity Healthcare; Chair, Catalyst for Payment Reform
  - Carmella Bocchino, Executive Vice President, Clinical Affairs, America's Health Insurance Plans (AHIP)
  - Robert C. Sehring, Chief Executive Officer, Central Region, OSF Healthcare System
- **Panel: Future Directions for Transforming Health Care Delivery through ACOs**
  - Andrew Dreyfus, President and CEO, Blue Cross Blue Shield of Massachusetts
  - Thomas Malone, President and CEO, Summa Health System
  - Richard Merkin, President and CEO, Heritage Medical Systems

Thursday Afternoon Plenary Session

- **Keynote Discussion: Michael Leavitt**, Founder and Chairman, Leavitt Partners; Former Governor of Utah; Former US Secretary of Health and Human Services

ACO Summit Plenary Session Highlights

Friday Opening Plenary Session

- **Keynote Discussion: Glenn D. Steele Jr.,** Former President and Chief Executive Officer, Geisinger Health System; Former Richard T. Crane Professor in the Department of Surgery, Vice President for Medical Affairs and Dean, Division of Biological Sciences Division and Pritzker School of Medicine, University of Chicago

Friday Closing Plenary Session

- **Transforming Health Care Delivery: The Cleveland Clinic Experience: Delos M. "Toby" Cosgrove,** President and Chief Executive Officer, Cleveland Clinic, Cleveland, OH
- **Panel: ACO Next Steps – Proposed Rule and Beyond**
  - Mark McClellan, Senior Fellow and Director, Health Care Innovation and Value Initiative, The Brookings Institution; Former CMS Administrator and FDA Commissioner
  - Elliott S. Fisher, Director, Dartmouth Institute for Health Policy and Clinical Practice; John E Wennberg Distinguished Professor of Health Policy, Medicine and Community and Family Medicine, Geisel School of Medicine at Dartmouth; Co-Director, Dartmouth Atlas of Health Care
  - Stephen Shortell, Blue Cross of California Distinguished Professor of Health Policy and Management, University of California, Berkeley

ACO Summit Tracks: Addressing Implementation Challenges

Summit Day 1

- **Track 1:** Alternative Approaches to Meaningful Quality Improvement and Measurement
- **Track 2:** Commercial ACO Innovation and Growth
- **Track 3:** Variation and Financial Performance Metrics
- **Track 4: E**mployer-Led Accountable Care Innovations
- **Track 5:** State Innovations in Accountable Care
- **Track 6:** Strategies for Managing Vulnerable Populations

Summit Day 2

- **Track 7:** Data Management/Health IT Issues
- **Track 8:** Opportunities to Maximize the Value of Supply Chain Innovation
- **Track 9:** Specialty Care Challenges and Approaches
- **Track 10:** Advancing Primary Care and Delivery Design
- **Track 11:** Clinical Leadership and Engagement
- **Track 12:** Patient Engagement

THE SIXTH NATIONAL

Accountable Care Organization Summit

Opening Plenary Session

Keynote Address

Patrick Conway
Deputy Administrator for Innovation and Quality, Chief Medical Officer, Director, Center for Medicare and Medicaid Innovation and Director, Office of Clinical Standards and Quality, Center for Medicare and Medicaid Services

CMS Innovation and Health Care Delivery System Reform

Patrick Conway, M.D., MSc

Acting Principal Deputy Administrator, Deputy Administrator for Innovation and Quality and Chief Medical Officer

Center for Medicare and Medicaid

June 18, 2015

Better. **Smarter.** ***Healthier.***

So we will continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

Delivery System Reform requires focusing on the way we pay providers, deliver care, and distribute information

Source: Burwell SM. Setting Value-Based Payment Goals – HHS Efforts to Improve U.S. Health Care. NEJM 2015 Jan 26; published online first.

During January 2015, HHS announced goals for value-based payments within the Medicare FFS system

Medicare Fee-for-Service

GOAL 1: 30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2: 85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

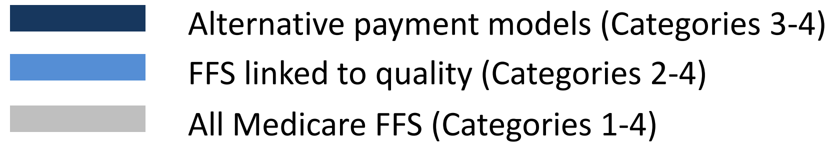
Consumers | Businesses
Payers | Providers
State Partners

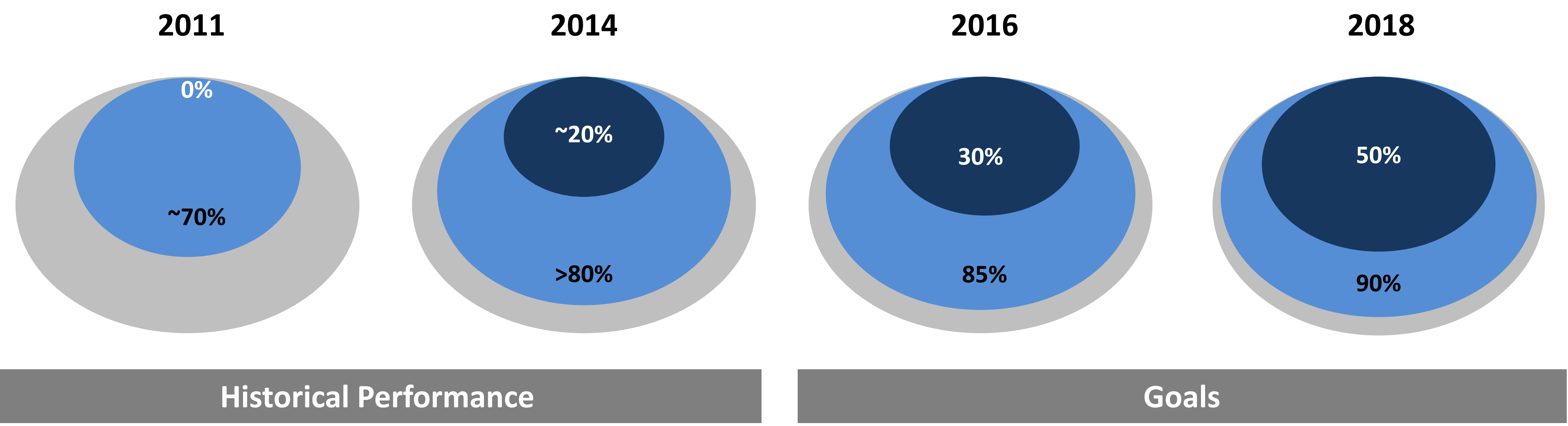
NEXT STEPS:

Testing of new models and expansion of existing models will be critical to reaching incentive goals

Creation of a Health Care Payment **Learning and Action Network** to align incentives for payers

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018





Achieving the Goals

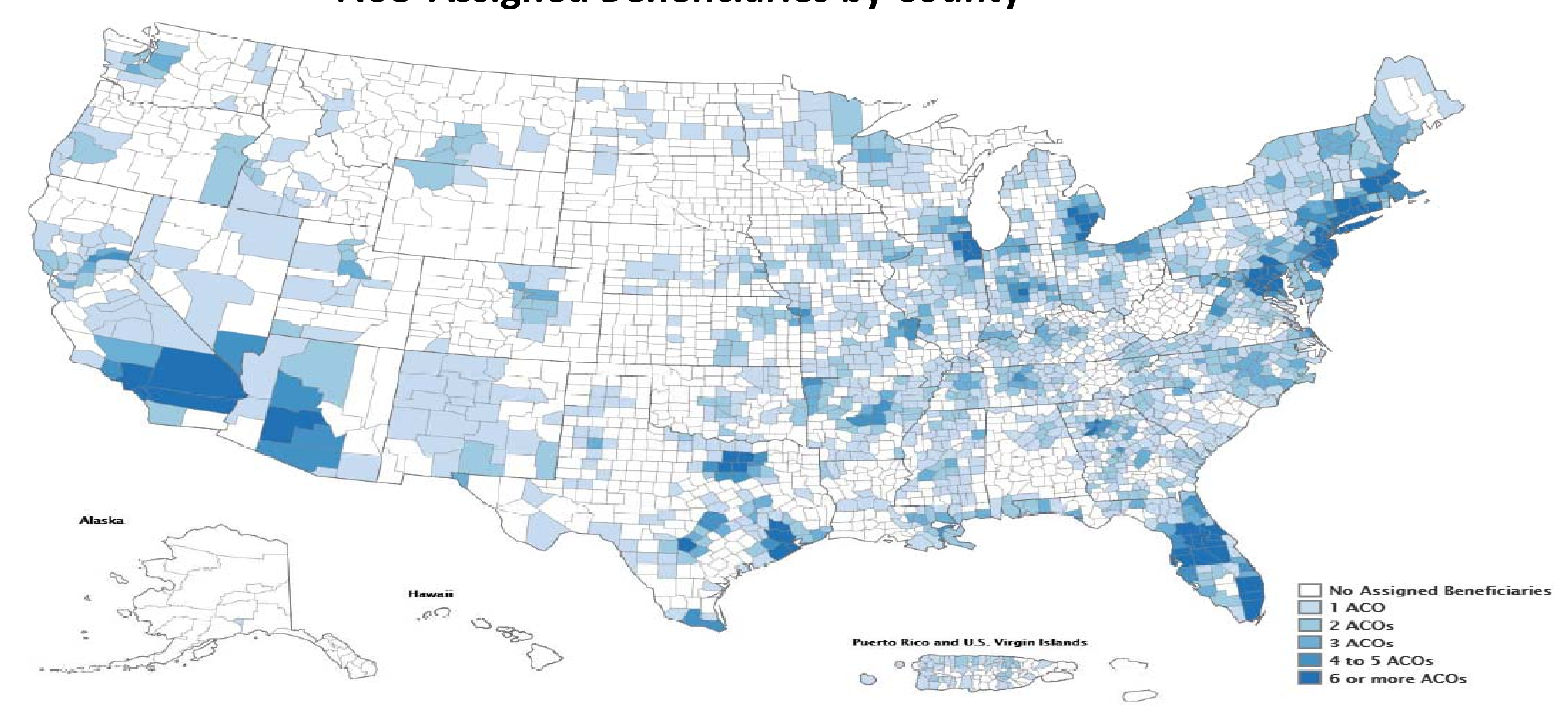
- Accountable Care Organizations (ACO)
  - Pioneer ACO Model
  - Next Generation ACO Model
  - ESRD ACO Initiative
  - Advance Payment Model
  - ACO Investment Model
  - Medicare Shared Savings Program – 3 Tracks
- Value-Based Purchasing / Value-Based Modifier
- Medicare Advantage / Medicare Part D

ACOs - Participation is Growing Rapidly

- More than 400 ACOs participating in the Medicare Shared Savings Program
- Almost 8 million assigned beneficiaries in 49 states, plus D.C. and Puerto Rico
- Proposed MSSP rule seeks to build on this momentum.

ACO Participation

ACO-Assigned Beneficiaries by County

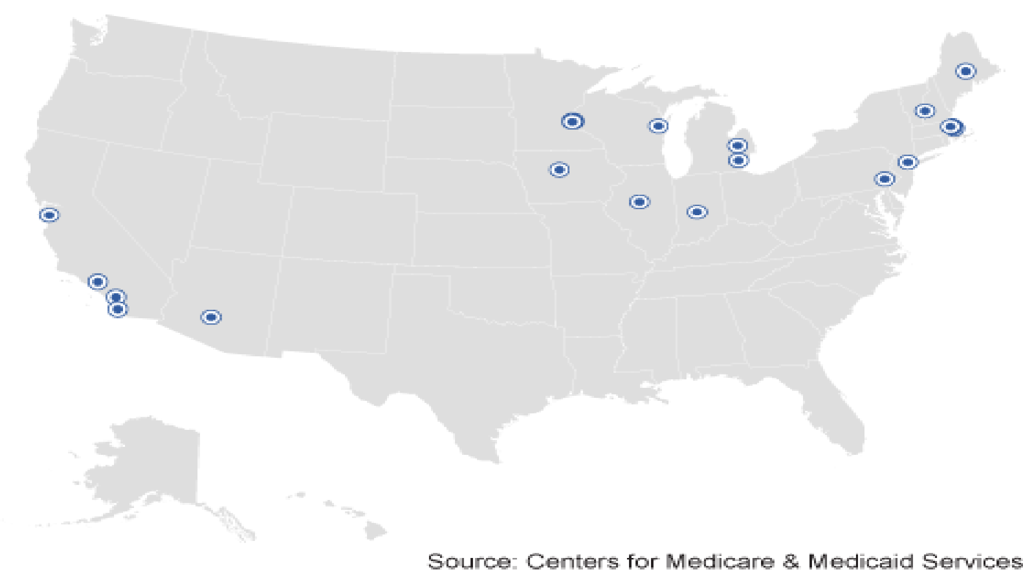


Pioneer ACO Model

- Among CMMI's first demonstrations – began January 2012
- Prospectively aligns beneficiaries
- PY1 and PY2 - Shared savings payment arrangement with higher levels of savings and risk than in the Shared Savings Program.
- PY3 - Organizations that earned savings in past 2 years were eligible to move to a population-based payment arrangement and full risk arrangements
- Benefit Enhancements:
  1) 3-day Skilled Nursing Facility Rule Waiver
  2) Voluntary Alignment - A process that allows beneficiaries to confirm their care relationship with ACO providers

Pioneer ACO Model

- 19 ACOs currently participating
- Model in its 4th of 5 performance years
- $400M saved in first two performance years
- OACT Certification



Pioneer ACO Quality Results

- The mean quality score among Pioneer ACOs increased from 71.8 percent in 2012 to 85.2 percent in 2013.
- The organizations showed improvements in 28 of the 33 quality measures, including 6 of 7 patient experience measures
- High level of baseline quality that improved

Next Generation ACO Model

- Protect Medicare FFS beneficiaries' freedom of choice
- Create a financial model with long-term sustainability
- Use a prospectively-set benchmark that:
  - Rewards quality;
  - Rewards both attainment of and improvement in efficiency; and
  - Ultimately transitions away from updating benchmarks based on ACO's recent expenditures

Next Generation ACO Model

- Offer benefit enhancements that directly improve the patient experience and support coordinated care
- Allow beneficiaries a choice to remain aligned to the ACO
  - Mitigates fluctuations in aligned beneficiary populations
  - Respects beneficiary preferences
- Smooth ACO cash flow and improve investment capabilities through alternative payment mechanisms
- Focus on quality indicators across the spectrum of care

Financial Goals and Opportunities

Goals:

- Increased ACO financial risk
- Long-term fiscal sustainability
- Benchmark predictability and stability

ACO Opportunities:

1) Greater financial risk coupled with a greater portion of savings; and
2) Flexible payment options that support ACO investments in care improvement infrastructure to provide high quality care to patients.

Beneficiary Engagement Overview

- **Encourage greater care coordination and closer care relationships between the ACO and beneficiaries by:**
  - **Supporting meaningful discussions and considerations about care through the voluntary alignment process**
  - **Enhancing services beneficiaries can receive from ACOs.**
  - **Offering a coordinated care reward directly from CMS for beneficiaries seeking care from Next Generation Providers/Suppliers, Preferred Providers, and Affiliates**

Advance Payment Model

Provides participants in the Shared Savings Program (SSP) with advance payments that will be recouped from the shared savings they earn

- **Supports infrastructure investments**
- **Focus is on physician-led ACOs and smaller, rural providers**

Vision for Future

- Tracks of ACOs that allow providers to migrate based on tolerance for risk and model design features
- Increased direct engagement of beneficiaries
- Continued exploration of waivers that enable higher quality and lower costs
- ACO model grows over time, delivers results, and we continue to learn
- Multi-payer alignment
- Participation in ACOs and alternative payment models are key to provider success and better outcomes for patients

Contact Information

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THE SIXTH NATIONAL **Accountable Care Organization Summit**

Opening Plenary Session

Aligning Goals on Payment Reform

Robert S. Galvin, MD, MBA
Chief Executive Officer, Equity Healthcare; Operating Partner, Blackstone; Chair, Catalyst for Payment Reform

Karen Ignagni, MBA
President and Chief Executive Officer, America's Health Insurance Plans

Robert C. Sehring
Chief Executive Officer - Central Region, OSF Healthcare System

Mark B. McClellan, MD, PhD (Moderator)
Senior Fellow and Director, Health Care Innovation and Value Initiative, The Brookings Institution

Break

THE SIXTH NATIONAL Accountable Care Organization Summit

Opening Plenary Session

Future Directions for Transforming Health Care Delivery through ACOs

Andrew Dreyfus
President and Chief Executive Officer, Blue Cross Blue Shield of Massachusetts

Thomas Malone, MD, MBA
President and Chief Executive Officer, Summa Health System
General Partner, Welsh, Carson, Anderson & Stowe; Senior Counsel, Alston & Bird LLP

Richard Merkin, MD
President and Chief Executive Officer, Heritage Medical System

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

THE SIXTH NATIONAL Accountable Care Organization Summit

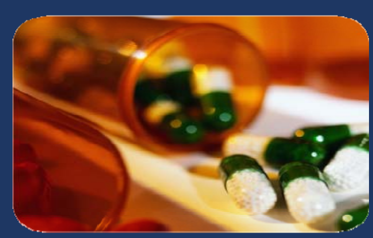
Afternoon Plenary Session

Keynote Discussion

Michael Leavitt
Founder and Chairman, Leavitt Partners;
Former Governor of Utah;
Former US Secretary of Health and Human Services

Break and
Afternoon Track Sessions

Sixth Annual
National ACO Summit



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