

# Moving Toward the “Triple Aim:” The Affordable Care Act and the Implications For Payment and Quality Reform



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National Pay for Performance Summit  
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# This presentation at a glance

- **The Affordable Care Act, One Year Later**
- **Triple Aim focus as unifying strategy**
- **Innovations to contain costs; payment reform**
- **Innovations to improve quality (“Better Care”)**
- **Political considerations**
- **Implications and conclusions**

# Obama Signs Affordable Care Act into Law, White House, March 23, 2010

The bill “enshrines the core principle that everybody should have some basic security when it comes to their health care.”



# Simplified Structure of Health Reform

- **Coverage expansion** to projected 32 million more Americans from 2014-2019
  - Estimated 16 million into expanded Medicaid program
  - Estimated 16 million able to buy private insurance through state-based exchanges with government subsidies
  - Individual and employer mandates
- **Insurance Market Reforms** – broaden and stabilize private coverage
- **Financing** (taxes, slower Medicare spending and fees) to pay for above
- **Delivery/payment reforms & experiments** to slow growth rate of health care spending
  - Independent Payment Advisory Board
  - Comparative Effectiveness Research
  - Accountable Care Organizations, pilot and demonstration projects
- **Health Promotion and Prevention initiatives**, including \$15 billion prevention fund
- **Other:** Workforce provisions; CLASS ACT; follow-on biologics

# One year later...

- **The Pre-Existing Conditions Insurance Program in effect (enrollment below expectations)**
- **Small business tax credits to defray employees insurance costs in effect**
- **Early retiree reinsurance program in effect**
- **Several insurance market reforms have been put into effect – e.g., no preexisting condition restrictions on children; phased in elimination of annual and lifetime limits**
- **Grants flowing to states to plan exchanges**
- **Grants flowing to states to assist in insurance rate oversight**
- **Medical loss ratio regulation published**

# One year later...

- **Medicare Part D enrollees in donut hole received \$250 rebate, get 50% discounts on branded drugs**
- **Medicare coverage of preventive services in effect**
- **Center for Medicare and Medicaid Innovation created**
- **A number of pilots and demonstrations launched or under way**
- **CMS about to issue regulations on Accountable Care Organizations**
- **Patient Centered Outcomes Research Institute board appointed**
- **Obama has said he would support advancing state waiver authority**

# Parallels to Moon Shot?

- President John F. Kennedy announces US will go to moon on May 25, 1961
- On May 25, 1962, we were still earthbound



Apollo 11 takes off, July 16, 1969

# The Triple Aim

- **Better health**
- **Better health care**
- **Greater value for the dollars spent**
- **Core principle now at heart of major U.S. delivery system reform efforts**



**Donald Berwick, MD**  
**Administrator**  
**Centers for Medicare**  
**and Medicaid Services**

# Military Health System: variation on theme



# The National Quality Strategy

- **Mandated under ACA and released Monday, March 21, 2011**
- **Builds on Triple Aim with three goals**
- **Better Care: “Improve the overall quality, by making health care more patient-centered, reliable, accessible and safe”**
- **Healthy People/Healthy Communities: “Improve the health of the US population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering higher quality care”**
- **Affordable Care: “Reduce the cost of quality health care for individuals, families, employers and government”**
- **Source: National Quality Strategy, at <http://www.healthcare.gov/center/reports/quality03212011a.html>**

# The National Quality Strategy

- **HHS to create agency-specific plans to implement**
- **“Effort to be under way to obtain private sector input on specific goals, benchmarks, and quality metrics in 2011”**
- **National Quality Strategy to evolve and develop “a sharper focus on specific goals, measures, and additional actions to be taken by the government and private sector partners.”**

# Center for Medicare and Medicaid Services

- Charged with a number of responsibilities under ACA
- Accountable care organizations and “shared savings” program
- Medical home/health home demonstrations under Medicare and Medicaid
- Value-based purchasing
- Bundled payment
- Federal coordinated care office to better coordinate care of dual eligibles
- If any pilots or tests (including ACO program) achieves stated goals of improving or not reducing quality and reducing spending, Secretary can expand across entire Medicare program

# Center for Medicare And Medicaid Innovation

■ \$10 billion authorized  
(as mandatory spending)  
over next ten years to  
experiment

■ Seeking cost-saving  
innovation platforms in 3  
areas:

- Improving care of  
particular types of patients
- Improving care  
coordination
- Improving care for patient  
populations overall



Richard Gilfillan, MD  
Acting Director  
Center for Medicare  
And Medicaid Innovation

# **Accountable Care Organizations – Section 3022, ACA**

- Organizations that can provide (or can effectively manage) continuum of care as real or virtually integrated local delivery systems**
- Must include primary care providers who have at least 5,000 Medicare patients**
- Must have formal legal structure**
- Must have in place leadership and management structure that includes clinical and administrative systems**
- Must provide data on cost and quality**
- Must accept principles of evidence-based medicine, patient engagement and patient centeredness**

## **Accountable Care Organizations – Section 3022, ACA**

- **Must be of sufficient size to support comprehensive performance measurement, shared electronic health records, patient decision-support, care coordination**
- **Must be capable of prospectively planning budgets and resource needs**
- **Government has broad discretion to develop and set standards; set budget targets and payment rules; determine amount of shared savings; allow financial arrangements among payers that might otherwise trigger concerns about violations of “gainsharing” or antitrust rules**

# ACO's, as per CMS

## ACO Principles

- Put the patient and family at the center
- Have a memory about patients over time and place
- Attend carefully to handoffs, especially as patients journey from one part of the care system to another.
- Manage resources carefully and respectfully
- Be proactive
- Be data-rich..
- Innovate in the service of the Triple Aim: better and better patient care, better population health, and lower cost through improvement.
- Continually invest in the development and pride of its own workforce, including affiliated clinicians.

# **“Shared Savings” Program**

- **To bring together groups of providers and suppliers to deliver better quality and more cost-effective care to Medicare beneficiaries**
- **Statute requires program to be established no later than January 2012**

# Key Issues on ACOs/Shared Savings

- Regulation due out from CMS soon, most likely week of 3/28/11
- Issue: how prescriptive versus open-ended regs are likely to be
- How much will be set forth in regulation and how much will be guidance offered at “sub-regulatory” level

# Key Issues on ACOs/Shared Savings

- **“Attribution” methodology – how the primary care professional providing the largest share of “evaluation and management” services would have patients assigned to him or her**
- **Budget targets and how they will be calculated**
- **Precise financial arrangements behind “shared savings”**
- **Relationship with private ACOs, or “all payer” ACO arrangements**
- **FTC/DOJ pre-clearance?**

# **Multi-Payer Advanced Primary Care Practice Demonstration**

- **8 states now participating**
- **Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota**
- **Demonstration will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries**
- **Health professionals to receive “more coordinated” payment from Medicare, Medicaid and private health plans**

# Medicaid “Health Homes”

- **New State plan option allows patients enrolled in Medicaid with at least two chronic conditions to designate a provider as a “health home” to help coordinate treatments for the patient**
- **States that implement will receive enhanced financial resources from the federal government to support “health homes” in their Medicaid programs**
- **The Innovation Center to assist with learning, technical assistance and evaluation activities**

# **State Demonstrations to Integrate Care for Dual Eligible Individuals**

- **States can apply for contracts to support development of new integrated care models that can be rapidly tested and, upon successful demonstration, replicated in other states.**
- **Aimed at improving care quality, care coordination, cost-effectiveness and overall experience of beneficiaries eligible for both Medicare and Medicaid and CHIP**
- **CMS plans to award contracts to up to 15 states of up to \$1 million each.**
- **Applications were due February 1, 2011 for proposals as to how states would structure, implement, and evaluate models**

# **“Leading Causes of Mortality Initiatives”**

- **Quality/prevention focus**
- **Begin with cardiovascular disease; move on to others**

■ **Source: National Quality Strategy, <http://www.healthcare.gov/center/reports/quality/03212011a.html>**

# Quality: Cardiovascular disease focus

- CVD accounts for 1 in 3 deaths
- More than \$500 billion spent annually on CVD
- 75 million Americans have high blood pressure
- 18 million have history of heart attack or angina
- 6 million have history of heart failure
- 6 million have history of stroke
- Source: National Quality Strategy, <http://www.healthcare.gov/center/reports/quality/03212011a.html>

# CVD goals

- **Increase blood pressure control in adults**
- **Reduce high cholesterol levels in adults**
- **Increase use of aspirin to prevent CVD**
- **Decrease smoking among adults and adolescents**

# Reducing avoidable readmissions

- In an analysis of 2003–2004 Medicare claims data, 20% of hospitalized patients were rehospitalized within 30 days after discharge.
- 34% readmitted within 90 days
- Nearly half of the Medicare patients who are rehospitalized within 30 days did not have a physician visit between the time of discharge and readmission.

■ Source: Jencks S.F., Williams M.V., Coleman E.A.  
N Engl J Med 2009; 360:1418 - 1428

# Reducing avoidable readmissions

- Under Affordable Care Act, beginning in FY 2013, PPS hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments
- In FY 2013, the reduction cannot be greater than 1 percent. In FY 2014, it cannot be larger than 2 percent, and in FY 2015 and beyond, it cannot be greater than 3 percent.
- Hospital performance will be evaluated based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare
- The ACA requires the Centers for Medicare & Medicaid Services to modify the measures to exclude planned readmissions, as well readmissions that are unrelated to the first admission
- CMS Office of the Actuary (OAct) projects that this provision, when fully implemented, will reduce Medicare costs by \$8.2 billion from implementation through 2019.
- CMS has not indicated when it will publish proposed rule

# Value-based Payment and Purchasing

- CMS will expand payments for value—in 2013—by rewarding better care for five of the most prevalent conditions.
- Physician payments will also become more closely linked to value with the launch of a physician value-based payment system and the implementation of a “value-modifier” that rewards physicians who deliver better care.
- ACA charts path for value-based payment strategies for additional providers in Medicare, including skilled nursing facilities, home health care providers, hospice care, rehabilitation hospitals, and ambulatory surgery facilities.
- CMS Office of the Actuary estimates that the provisions to improve Medicare’s physician payment methodology will reduce Medicare costs by over \$1.9 billion over the next 10 years.

# Value-based Purchasing-Hospitals

- Required by Congress under Section 1886(o) of the Social Security Act
- Would apply beginning in FY 2013 to payments for discharges occurring on or after October 1, 2012
- Would make value-based incentive payments to acute care hospitals, based either on how well the hospitals perform on certain quality measures or how much the hospitals' performance improves on certain quality measures from their performance during a baseline period
- 70% of Total Performance Score based on Clinical Process of Care measures; 30% of Total Performance Score based on Patient Experience of Care measures
- CMS issued a notice of proposed rulemaking on January 13, 2011; accepted public comments on the proposed rule through March 8, 2011
- For more information, see [http://www.cms.gov/HospitalQualityInits/downloads/0210\\_Slides.pdf](http://www.cms.gov/HospitalQualityInits/downloads/0210_Slides.pdf)

# Bundled Payment

- CMS recently finalized a new “bundled payment” system for serving patients with End Stage Renal Disease (ESRD)
- Complements quality improvement and delivery reform activities from the Affordable Care Act
- Combines payment for dialysis related services and supplies that is projected to reduce Medicare spending by \$1.7 billion over ten years

# Bundled Payment Pilots

- Section 3023 of ACA requires establishment of a national, voluntary, 5-year pilot program on payment bundling for Medicare by January 1, 2013
- To bundle payments to providers around 10 conditions
- Bundled payments would cover the costs of acute care inpatient services; physicians services delivered in and outside of an acute care hospital setting; outpatient hospital services including emergency department services; post-acute care services, skilled nursing services, inpatient rehabilitation services; inpatient hospital services furnished by a long term care hospital; among others.
- Payment methodology would also include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient centered activities.
- Separate Medicaid bundling demonstration program to be in place by 2012

## Other key initiatives

- **American Reinvestment and Recovery Act/HITECH incentives for adoption of electronic health records; “meaningful use” criteria**
- **Patient registries**
- **Care/disease management**
- **Performance reporting and improvement**
- **E-health, telemedicine, m-health**
- **Shared decision-making**

By Glenn D. Steele, Jean A. Haynes, Duane E. Davis, Janet Tomcavage, Walter F. Stewart, Tom R. Graf, Ronald A. Paulus, Karena Weikel, and Janet Shikles

## ANALYSIS & COMMENTARY

# How Geisinger's Advanced Medical Home Model Argues The Case For Rapid-Cycle Innovation

**ABSTRACT** The Patient Protection and Affordable Care Act of 2010 provides for a number of major payment and delivery system initiatives. These potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services. We discuss lessons learned from our iterative tests of care reengineering at Geisinger—specifically, through our advanced medical home model, ProvenHealth Navigator<sup>SM</sup>, and the way we continuously modified the model to improve quality and value. We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.

**T**he Patient Protection and Affordable Care Act of 2010 contains a large portfolio of major payment and delivery system reengineering initiatives recently summarized by Stuart Guterman and colleagues at the Common-

care shared savings program or accountable care organization provisions of the Affordable Care Act in January 2012 (personal communication from Stuart Guterman to Glenn D. Steele, July 7, 2010).

The nation simply cannot afford another

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**“Potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services.”**

**Source:**  
*Health Affairs*,  
2010 Nov; 29(11):2047-53.

# **“A Model For Integrating Independent Physicians Into Accountable Care Organizations”**

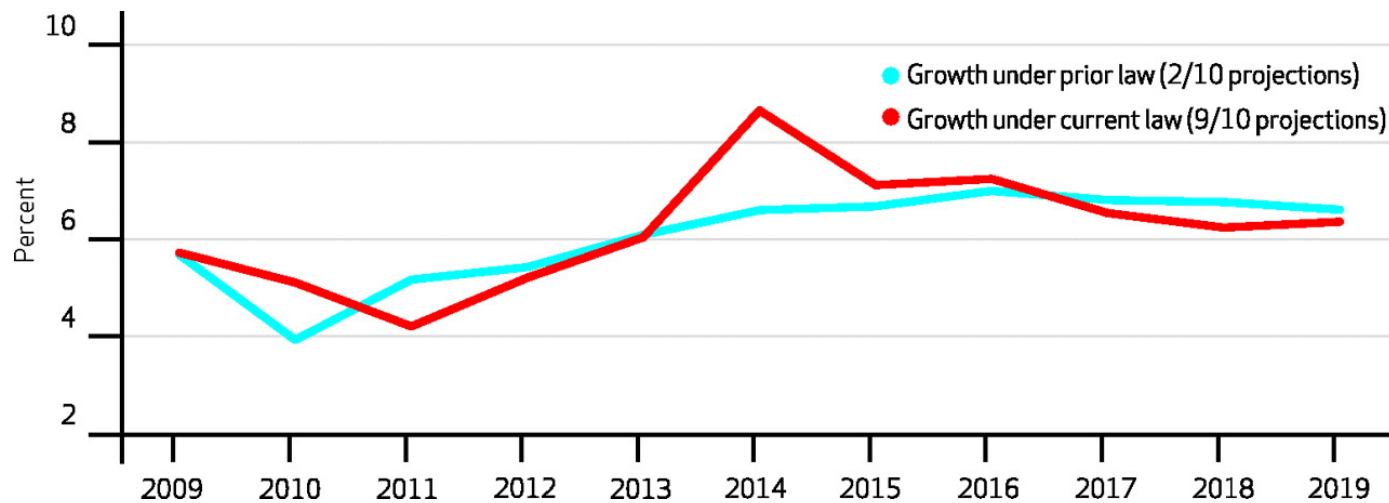
- **Advocate Physician Partners, affiliated organization to Advocate Health System, largest hospital system in Illinois**
- **Author Mark C. Shields, vice president for medical management of Advocate Health Care and senior medical director of Advocate Physician Partners, in Mt. Prospect, Illinois; et al.**
- **Model for organizing independent physicians into partnerships with hospitals to improve care, cut costs, and be held accountable for the results.**
- **Signed its first commercial ACO contract effective January 1, 2011, with the largest insurer in Illinois, Blue Cross Blue Shield**
- **Other commercial contracts are expected to follow**

# “AdvocateCare”

- **Launched January 1, 2010**
- **Features of contract:**
  - **Shared Savings model**
  - **Pledge to grow costs of system only at rate of consumer price index**
  - **Attribution methodology agreed upon**
  - **Requirements for safety, outcomes, and service**



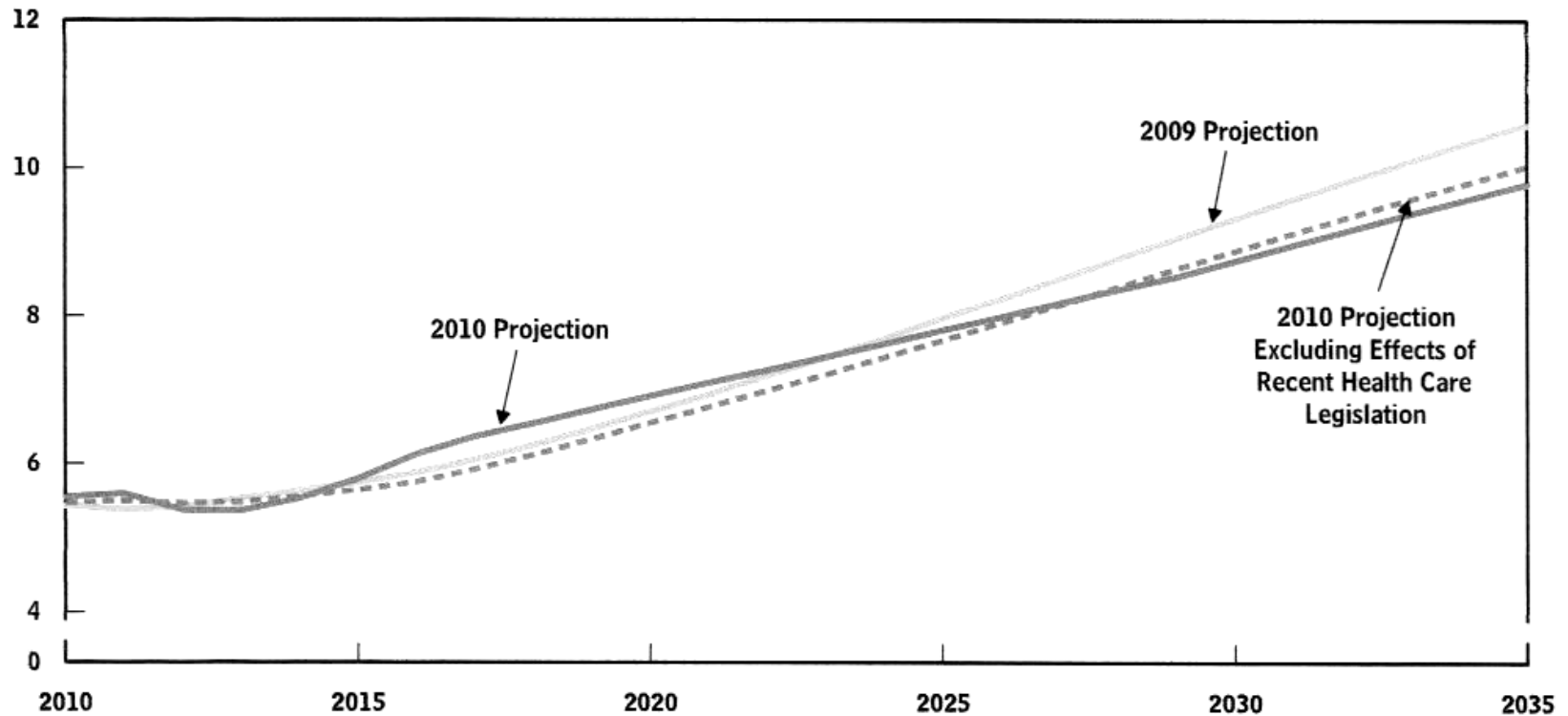
# CMS Projections, National Health Spending In Light of Health Reform



Andrea M. Sisko, Christopher J. Truffer, Sean P. Keehan, John A. Poisal, M. Kent Clemens, and Andrew J. Madison,  
National Health Spending Projections: The Estimated Impact Of Reform Through 2019,  
Health Affairs, Vol 0, Issue 2010, hlthaff.2010.0788v1-101377201

## Comparison of CBO's 2009 and 2010 Projections of Mandatory Federal Spending on Health Care Under the Extended-Baseline Scenario

(Percentage of gross domestic product)



Source: Congressional Budget Office.

Source: Congressional Budget Office, The Long-Term Budget Outlook, June 2010  
<http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf>

# Health reform: The Next Wave?

- **“Health care reform is part of deficit reform.”**
- **“We know that health care costs, including programs like Medicare and Medicaid, are the biggest contributors to our long-term deficit. Nobody disputes this.”**



President Obama at Families USA  
Conference, Washington, DC, Jan. 28, 2011

# Overlapping Fights: Fiscal 2011 (current year) budget

- **The federal government continues to operate at fiscal year 2010 levels under the fifth Continuing Resolution – soon to be the sixth (until April 8)**
- **Negotiations on spending for rest of fiscal year**
- **House has voted to deny any ACA implementation funds; unlikely to survive final bill**
- **Collision looming over 2012 budget**

# Where We Are Now: The “Known Unknowns”

- **Outcome of congressional efforts to defund/repeal/replace individual provisions of ACA or entire law**
- **Outcome of President’s new proposal to allow states to set up own plan provided it can meet objectives of Affordable Care Act**
- **Outcome of federal lawsuits challenging individual mandate or entirety of law**

# Best Guess Scenario

- **ACA stays largely intact, at least until January 2013**
- **Delivery system/payment reform provisions have at least lukewarm support from Senate Republicans**
- **ACA remains key issue in November 2012 elections**

**Who will it be  
In 2012?**



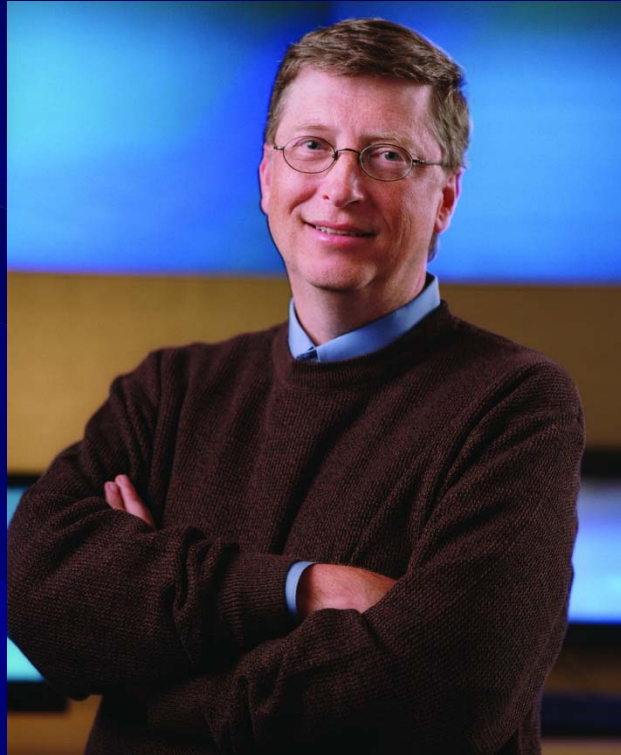
# Challenges and Opportunities

To large degree, health care reform in US = delivery system reform

“Bending the curve” – what opportunities exist for achieving greater value in care, lowering costs/prices

Bottom line: It will all be in the implementation, but the potential is enormous

Coupled with other provisions, real potential exists to create a true “health care” rather than a “sick care” system



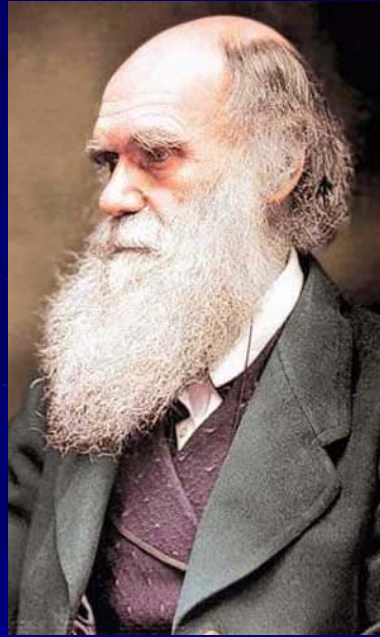
**“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”**

**--Bill Gates Jr.**



**“There has never been a better time to be an  
Innovator in health care.”**

**--Don Berwick, administrator, CMS  
Military Health System conference  
January 2011**



**“In the long history of humankind...those who learned to collaborate and improvise most effectively have prevailed.”**

**--Charles Darwin**



**“We always need to remember that behind almost every great moment in history, there are heroic people doing really boring and frustrating things for a prolonged period of time.”**

**– Gail Collins, *The New York Times*, August 13, 2010**

Good luck!

The End