The Medicare Shared Savings Program

Overview

- CMS vision and goals
- Major changes in final rule
- Next steps
ACO Vision

- An ACO promotes seamless coordinated care
  - Puts the beneficiary and family at the center
  - Remembers patients over time and place
  - Attends carefully to care transitions
  - Manages resources carefully and respectfully
  - Proactively manages the beneficiary’s care
  - Evaluates data to improve care and patient outcomes
  - Innovates around better health, better care and lower growth in costs through improvement
  - Invests in team-based care and workforce

CMS’s ACO Strategy: Creating Multiple Pathways with Constant Learning and Improving
Operating Principles

- Creating multiple pathways and on-ramps for organizations to participate
- Strong data partnership
- Beneficiary notification and engagement
- Maintain strong partnership with federal anti-trust agencies
- Robust quality measurement and performance monitoring
- Stronger business case to participate
- Excitement and momentum

Shared Savings Program ACO Structure

- **ACO**
  - **Legal Entity**
  - **ACO Participants** Ex: Acute Care Hospitals, Group Practice, Individual Practice, FQHC, RHC, CAH, Pharmacy, LTCH, SNF, etc
  - **ACO provider/suppliers** that bill through ACO participants (e.g. physicians, NPs, PAs, CNSs, pharmacists, chiropractors, etc)
Eligible Organizations

- Physicians and professionals in group practice arrangements
- Networks of individual practices of physicians and other professionals
- Joint ventures/partnerships of hospitals and physicians and professionals
- Hospitals employing physicians and professionals
- Critical Access Hospitals (CAHs) that bill under Method II
- Other providers/suppliers may participate in an ACO but would not be used to directly assign patients

Assignment of Patient Population

- ACO accepts responsibility for an “assigned” Medicare patient population
- Assigned patient population is the basis for establishing and updating the financial benchmark, quality measurement and performance, and focus of the ACO’s efforts to improve care and reduce costs
- Patients assigned to ACOs using a two-step method based on plurality of primary care services rendered by ACO physicians and other professionals
- Assignment will not affect beneficiaries’ Medicare benefits or choice of physician or any other provider
- Assignment of beneficiaries based on preliminary prospective assignment with retrospective reconciliation.
Quality Measurement & Performance

- Quality measures separated into four domains:
  1. Patient/Caregiver Experience
  2. Care Coordination/Patient Safety
  3. Preventive Health
  4. At-Risk Population/Frail Elderly Health
- ACOs that score higher will be eligible for greater savings
- Measures aligned with current CMS measurement efforts and incentive programs

Financial Performance

- Performance year expenditures are calculated and risk adjusted.
  - Account for health status and demographic changes during each performance year
  - Use an ACO’s HCC prospective risk score to take into account changes in severity and case mix for beneficiaries who are newly assigned and for beneficiaries who drop out of an ACO’s assigned population
  - Use patient demographic factors only to account for changes in the beneficiaries continuously assigned to the ACO’s population
Two-Track Payment Approach

• ACOs may choose to participate in one of two tracks:
  1. Initial agreement of shared savings only
  2. An initial agreement of two-sided shared savings/losses

• All ACOs who elect to continue in the program after the first agreement period must continue in the two-sided model
• Provides an "on-ramp" for organizations to gain population management experience and transition to risk arrangements

One-Sided and Two-Sided Risk Models

• One-sided risk model has a maximum share of savings of 50% for quality performance with a cap on shared savings
  – Cap on shared savings (10% of benchmark)
• Two-sided risk model has a maximum share of savings of 60% for quality performance with a cap on shared savings
  – Higher cap on shared savings (15% of benchmark)
  – Shared loss calculation is 1 minus final sharing rate as a function of quality performance (not to exceed 60%)
    • ACOs which meet or exceed the minimum loss rate will share in losses on a first dollar basis
• All ACOs share in first dollar saved once they meet or exceed MSR
Data Sharing

• Aggregate data reports provided at the start of the agreement period, quarterly aggregate data reports thereafter and in conjunction with year end performance reports.
• Aggregate data reports will contain a list of the beneficiaries used to generate the report.
• Beneficiary identifiable claims data provided for patients seen by ACO primary care providers who have been notified and not declined to have data shared.

Intra-agency Coordination

The Center for Medicare and Medicaid Innovation Initiatives:
• Pioneer ACO Model
• Accelerated Development Learning Sessions
• Advance Payment

For more information: http://innovations.cms.gov/
Interagency Coordination

Antitrust Agencies (FTC/DOJ): Antitrust Policy Statement
www.ftc.gov/opp/aco/


OIG/CMS: Interim Final with Comment

Questions?


Contact: ACO@cms.hhs.gov
### Proposed vs. Final Rule

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Modifications in Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition to risk in Track 1</td>
<td>Choose from two 3-year tracks. Track 1 would comprise 2 years of one-sided shared savings with a mandatory transition in year 3 to two-sided risk model of shared savings and losses. Track 2 would comprise 3 years all under the two-sided model.</td>
<td>Remove two-sided risk from Track 1. Two tracks would still be offered for ACOs at different levels of readiness, with one providing higher sharing rates for ACOs willing to also share in losses.</td>
</tr>
<tr>
<td>Prospective vs. Retrospective assignment</td>
<td>Retrospective assignment based on utilization of primary care services, with prospective identification of a benchmark population.</td>
<td>A preliminary prospective-assignment method with beneficiaries identified quarterly; final reconciliation after each performance year, made on the basis of patients served by the ACO.</td>
</tr>
</tbody>
</table>

### Proposed vs. Final Rule

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<tr>
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</thead>
<tbody>
<tr>
<td>Proposed measures to assess quality</td>
<td>65 measures in 5 domains, including patient experience of care, utilization claims–based measures, and measures assessing process and outcomes. Pay for full and accurate reporting first year, pay for performance in subsequent years.</td>
<td>33 measures in 4 domains. (Note: Claims-based measures not finalized to be used for ACO-monitoring purposes.) Longer phase-in of measures over course of agreement: first year, pay for reporting; second and third years, pay for reporting and performance.</td>
</tr>
<tr>
<td>Sharing savings</td>
<td>One-sided risk model: sharing beginning at savings of 2%, with some exceptions for small, physician-only, and rural ACOs. Two-sided risk model: sharing from first dollar.</td>
<td>Share on first dollar for all ACOs in both models once minimum savings rate has been achieved.</td>
</tr>
</tbody>
</table>
## Proposed vs. Final Rule

<table>
<thead>
<tr>
<th>Topic</th>
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</thead>
<tbody>
<tr>
<td>Sharing beneficiary identification claims data</td>
<td>Claims data shared only for patients seen by ACO primary care physician during performance year; beneficiaries given opportunity to decline at the point of care.</td>
<td>The ACO may contact beneficiaries from provided quarterly lists to notify them of data sharing and opportunity to decline.</td>
</tr>
<tr>
<td>Eligible entities</td>
<td>The four groups specified by the Affordable Care Act, as well as critical access hospitals paid through Method II, are eligible to form an ACO. ACOs can be established with broad collaboration beyond these providers.</td>
<td>In addition to groups included in the proposed rule, Federally Qualified Health Centers and Rural Health Clinics are also eligible to both form and participate in an ACO.</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Start date</td>
<td>Agreement for 3 years with uniform annual start date; performance years based on calendar years.</td>
<td>Program established by January 1, 2012; first round of applications are due in early 2012. First ACO agreements start April 1, 2012, and July 1, 2012.</td>
</tr>
<tr>
<td>Aggregate reports and preliminary prospective list</td>
<td>Reports will be provided at the beginning of each performance year and include: name, date of birth, sex, and health insurance claim number.</td>
<td>Additional reports will be provided quarterly.</td>
</tr>
</tbody>
</table>
## Proposed vs. Final Rule

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<tr>
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<th>Modifications in Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic health</td>
<td>50% of primary care physicians must be defined as meaningful users by start</td>
<td>No longer a condition of participation. Retained EHR as quality measure but weighted higher than any other measure for quality-scoring purposes.</td>
</tr>
<tr>
<td>record (EHR) use</td>
<td>of second performance year.</td>
<td></td>
</tr>
</tbody>
</table>
| Assignment process     | One-step assignment process: beneficiaries assigned on the basis of a plurality | Two-step assignment process:  
  of allowed charges for primary care services rendered by primary care physicians  
  Step 1: for beneficiaries who have received at least one primary care service from a physician, use plurality of allowed charges for primary care services  
  Step 2: for beneficiaries who have not received any primary care services from a physician, use plurality of allowed charges for primary care services rendered by any other ACO professional. |
| Marketing guidelines   | All marketing materials must be approved by the Centers for Medicare and Medicaid Services. | “File and use” 5 days after submission and after certifying compliance with marketing guidelines; CMS to provide approved language. |

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Proposed vs. Final Rule

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Coordination with Antitrust Agencies (DOJ/FTC)</td>
<td>Proposed that the ACO meet certain clinical integration criteria in order to be eligible for participation. Also proposed ACOs undergo review by an Antitrust Agency if certain market power thresholds are met.</td>
<td>Maintain policy goal, but modify the process to address legal concerns. Provide for a voluntary review process and clinical integration criteria. Worked with FTC/DOJ to streamline our requirements while ensuring ACOs can participate without running afoul of antitrust laws.</td>
</tr>
</tbody>
</table>

Questions?

For more information:
www.cms.gov/sharesavingsprogram/
aco@cms.hhs.gov
410-786-8084
### Appendix: Financial Model

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposed Rule</th>
<th>Final Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sharing Rate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>One-Sided Risk Model</td>
<td>Two-Sided Risk Model</td>
</tr>
<tr>
<td></td>
<td>Up to 52.5%, sliding scale based on quality</td>
<td>Finalize our proposal for establishing the MSR which protects the trust fund</td>
</tr>
<tr>
<td></td>
<td>performance and inclusion of FQHC/RHCs</td>
<td>from paying out incentives for normal variations in cost rather than for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>real improvements made by the ACO.</td>
</tr>
<tr>
<td><strong>Minimum Savings Rate (MSR)</strong></td>
<td></td>
<td>Modify our proposals to:</td>
</tr>
<tr>
<td></td>
<td>One-Sided Model</td>
<td>• Eliminate the 2.5% and 5% FQHC/RHC add on but continue to make the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>two-sided model more attractive for organizations willing to take on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>performance-based risk.</td>
</tr>
<tr>
<td></td>
<td>Vanes according to number assigned</td>
<td>• Increase the cap on shared savings (to 10% and 15%, respectively).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Share on first dollar for all ACOs in both models once the MSR has been</td>
</tr>
<tr>
<td><strong>Performance Payment Cap</strong></td>
<td>One-Sided Model</td>
<td>overcome.</td>
</tr>
<tr>
<td></td>
<td>7.5%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Two-Sided Model</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td><strong>Sharing from 2%</strong></td>
<td>One-Sided Model</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sharing from 2% with some exceptions for small,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>physician only, and rural ACOs</td>
</tr>
<tr>
<td></td>
<td>Two-Sided Model</td>
<td>Sharing from first dollar</td>
</tr>
</tbody>
</table>

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<tr>
<th>Topic</th>
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<th>Final Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCC Risk Adjustment and Cap</strong></td>
<td>Proposed using prospective HCC risk scores to</td>
<td>Modify recommendation to use prospective HCC risk scores to allow for</td>
</tr>
<tr>
<td></td>
<td>adjust for beneficiary characteristics in both</td>
<td>increases in risk scores for newly assigned beneficiaries each year. For</td>
</tr>
<tr>
<td></td>
<td>benchmark and performance years.  We further</td>
<td>beneficiaries that are continuously assigned, demographic factors only will</td>
</tr>
<tr>
<td></td>
<td>proposed to cap the risk adjuster at zero growth.</td>
<td>be used to adjust risk scores - unless the HCC risk score declines for the</td>
</tr>
<tr>
<td><strong>IME/DSH Adjustments</strong></td>
<td>Proposed not to adjust the benchmark for IME/DSH</td>
<td>group, in which case it will be reset at the lower score.</td>
</tr>
<tr>
<td></td>
<td>or any other payments.</td>
<td>Modify recommendation to adjust both the benchmark and performance year</td>
</tr>
<tr>
<td><strong>Benchmarking methodology</strong></td>
<td>Proposed setting a benchmark based on the</td>
<td>expenditures for IME/DSH payments.</td>
</tr>
<tr>
<td></td>
<td>expenditures of beneficiaries who would have</td>
<td>Finalize our proposal to set a benchmark based on the expenditures of</td>
</tr>
<tr>
<td></td>
<td>been assigned to the ACO in each of the 3 years</td>
<td>beneficiaries who would have been assigned to the ACO in each of the 3</td>
</tr>
<tr>
<td></td>
<td>prior to the start of an agreement period.</td>
<td>years prior to the start of an agreement period.</td>
</tr>
</tbody>
</table>
Advancing Accountable Care

February 23, 2012

S. Lawrence Kocot, JD, LLM, MPA
Deputy Director, Engelberg Center for Health Care Reform;
Senior Counsel, SNR Denton

Sean McBride
Project Manager, Engelberg Center for Health Care Reform;
Project Manager, ACO Learning Network

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
1. Overview of national ACO Implementation: growing private and public sector activity

2. Discovering the unicorn: ACO fundamentals

3. Role of Pharmacists: Services that Drive Value

4. Implementation through collaboration: Brookings-Dartmouth ACO Learning Network
Little formal ACO activity just two years ago

Private Sector
★ = Brookings-Dartmouth

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

{Not exhaustive}
PGP demo informs Medicare accountable care pathway

- Increase in quality scores from baseline to PY5 an average of:
  - 11% points on diabetes measures
  - 12% points on heart failure measures
  - 6% points on coronary artery disease measures
  - 4% points on hypertension measures
  - 9% points on cancer screening measures
- Four physician groups earned $36.2 million in shared savings in PY5

<table>
<thead>
<tr>
<th></th>
<th>Quality Percentage</th>
<th>Shared Savings Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PY1</td>
<td>PY2</td>
</tr>
<tr>
<td>Billings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dartmouth</td>
<td>90.91%</td>
<td>97.78%</td>
</tr>
<tr>
<td>Everett</td>
<td>95.45%</td>
<td>97.78%</td>
</tr>
<tr>
<td>Forsyth</td>
<td>86.36%</td>
<td>95.56%</td>
</tr>
<tr>
<td>Geisinger</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Marshfield</td>
<td>72.73%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Middlesex</td>
<td>81.82%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Park Nicollet</td>
<td>86.36%</td>
<td>95.56%</td>
</tr>
<tr>
<td>St. John's</td>
<td>95.45%</td>
<td>97.78%</td>
</tr>
<tr>
<td>Michigan</td>
<td>95.45%</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
Early private-sector effort: Brookings-Dartmouth ACO pilot sites

<table>
<thead>
<tr>
<th>Payer partners</th>
<th>Perf. measures</th>
<th>Downside risk?</th>
<th>Other clinical transformation &amp; reform efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norton Healthcare</td>
<td>B-D</td>
<td>Yr 1</td>
<td>• Electronic data feeds and dashboards; ambulatory access pilots; CER pilots</td>
</tr>
<tr>
<td>Humana</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HealthCare Partners</td>
<td>B-D</td>
<td></td>
<td>• Homebound program; disease mgmt programs; MD incentives; care reminders</td>
</tr>
<tr>
<td>Medical Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealth Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMC Healthcare</td>
<td>B-D</td>
<td></td>
<td>• Level 6 (of 7) EHR capacity; 3rd party analytics and HIE platform; medical home</td>
</tr>
<tr>
<td>TMC Healthcare</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>TMC Healthcare</td>
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<tr>
<td>Monarch HealthCare</td>
<td>IHA</td>
<td></td>
<td>• EHR deployment in process; patient registries</td>
</tr>
<tr>
<td>A Medical Group, Inc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carilion Clinic</td>
<td>TBD</td>
<td></td>
<td>• Enterprise-wide EHR; P4P; outcome reporting; physician compensation</td>
</tr>
<tr>
<td>TBD</td>
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</table>

*All pilots plan to introduce downside risk within five years*
New momentum from the ACA Passage
With the MSSP and ACO Pioneer Model

Medicare Shared Savings Program

- Two tracks offering shared savings to ACOs if cost and quality targets are met
- 33 quality measures spread over four domains
  - Patient/Caregiver Experience; Care Coordination/Patient Safety; Preventive Health; and, At-Risk Populations
- CMS estimates up to 270 ACOs will participate between 2012 – 2015 resulting in $1.3 billion in shared savings payments to ACOs
  - First round of applications submitted

Pioneer ACO Model

- 32 provider organizations across the country participating in the ACO Pioneer Model, offering accelerated tracks to more financial risk
  - Five different financial models all moving to population-based payments in year 3
- Pioneer Model is meant to inform future changes to the MSSP
Commercial insurers also moving to Accountable care arrangements

<table>
<thead>
<tr>
<th>Payers</th>
<th>Examples of Accountable Care Initiative</th>
<th>Early Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIGNA</td>
<td>• <strong>Cigna Collaborative Accountable Care Initiatives:</strong> Engaged in nine accountable care programs including with a primary care practice, a multi-specialty group, and an IDS. Cigna plans to have approximately 30 ACOs launched by the end of 2011.</td>
<td>Downward trends in unnecessary visits and an improving medical cost trend</td>
</tr>
<tr>
<td>Blue Cross Blue Shield</td>
<td>• <strong>BCBS of MA AQC:</strong> Twelve provider groups are replacing the FFS model with a modified global payment model tied to nationally-endorsed quality metrics.</td>
<td>Reductions in readmission rates while the rates for the rest of the network have increased</td>
</tr>
<tr>
<td></td>
<td>• <strong>BCBS of MN Aligned Incentive Contracting:</strong> Partnering with largest healthcare systems in MN in three contracts that tie provider payments increases to their ability to improve quality and lower costs.</td>
<td>Findings indicate that the cost trend is below the national average while quality has remained high</td>
</tr>
<tr>
<td></td>
<td>• <strong>Blue Shield of California:</strong> Participating in three ACOs in Sacramento and San Francisco covering 70,000 lives with two additional collaborations planned.</td>
<td>Blue Shield, Catholic Health Care West, and Hill Physicians Group saved $15.5 million last year</td>
</tr>
<tr>
<td></td>
<td>• <strong>Brookings-Dartmouth ACO Pilot:</strong> Working with Tucson Medical Center and the newly created Southern Arizona ACO on a shared savings model.</td>
<td>In progress</td>
</tr>
<tr>
<td></td>
<td>• <strong>Aetna ACOs:</strong> Implemented its ACO model in 36 primary care practices across the nation that focus on realigning incentives through shared savings and employing a care management process.</td>
<td>Net decrease in utilization decreased across the board by 11% - most effective partnerships resulting in a 50% drop.</td>
</tr>
</tbody>
</table>

*Not exhaustive*
Most states passed or considering passing ACO legislation

- 12 states passed accountable care legislation in 2011
ACO implementation is now accelerating across the country

*Upwards of 150 self-identified ACOs*

Private Sector
- ★ = Brookings-Dartmouth
- ★ = Premier
- ★ = CIGNA
- ★★ = AQC (9 organizations in MA)
- ★ = Other private-sector ACOs

Public Sector
- ★★★ = Beacon Communities
- ★★★★ = PGP, MHCQ
- ★★★★★ = Pioneer

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1. Overview of national ACO Implementation: growing private and public sector activity

2. Discovering the unicorn: ACO fundamentals

3. Role of Pharmacists: Services that Drive Value

4. Implementation through collaboration: Brookings-Dartmouth ACO Learning Network
Progression to more accountable payment: Pioneer ACO core payment model

Start with shared savings dependent on quality scores

Progressively implement a blend of FFS and partial capitation

Benchmark based on trend in per capita expenditures for aligned FFS beneficiaries

Population-based payment of up to 50% of ACO's expected part A & B revenue

Less a guaranteed discount for Medicare ranging from 3% to 6% based on the ACO's quality score
### Core measures
- **Overview:** Easily calculable through administrative data or existing patient survey systems
- **Health IT:** Implementable without fully functioning and integrated EHRs (e.g. internal web portals, patient registries)
- **Sample Measures:** breast cancer screening, hemoglobin A1c testing in patients with diabetes, patient and care giver experience of care, and total per-capita expenditures

### Interim process measures
- **Overview:** Require clinical data on evidence-based care processes
- **Health IT:** Expanded health IT capabilities from investments in electronic data systems and better access to clinical data
- **Sample Measures:** drug therapy for lowering LDL cholesterol, beta-blocker therapy for left ventricular systolic dysfunction, and childhood immunization status

### Longitudinal & Advanced measures
- **Overview:** Advanced, patient-reported measures that include functional outcomes and health risk assessment
- **Health IT:** Advanced health IT capabilities that likely include an integrated and fully-functioning EHR system
- **Sample Measures:** self-reported physical functioning in patients with heart failure, 10-year risk of developing hard CHD, and condition-specific outcome measures

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**Increasingly Sophisticated Measures Over Time**

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
## Measuring and supporting better performance

<table>
<thead>
<tr>
<th>Integrated Delivery System</th>
<th>Multispecialty Group Practice</th>
<th>Physician-Hospital Organization</th>
<th>Independent Practice Association</th>
<th>Regional Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more hospitals &amp; large group of employed physicians</td>
<td>Strong physician leadership</td>
<td>Joint venture between one or more hospitals &amp; physician group</td>
<td>Small physician practices working together as a corp., partnership, professional corporation or foundation</td>
<td>Independent or small providers</td>
</tr>
<tr>
<td>Insurance plans (some cases)</td>
<td>Contract with multiple health plans</td>
<td>Vary from focusing contracting with payers to functioning like multi specialty group practices</td>
<td>Often contract with health plans in managed care setting</td>
<td>Leadership may come from providers, medical foundations, non-profit entities or state government</td>
</tr>
<tr>
<td>Aligned financial incentives, advanced health IT, EHRs, &amp; well-coordinated team-based care</td>
<td>Developed mechanisms for coordinated care (sometimes arranged through another partner)</td>
<td>Many require strong management focused on clinical integration &amp; care management</td>
<td>Individual practices typically serve non-HMO clients on a standalone basis</td>
<td>Sometimes in conjunction with health information exchanges or public reporting</td>
</tr>
<tr>
<td>E.g., Dartmouth Hitchcock</td>
<td>E.g., Marshfield Clinic</td>
<td>E.g., Tucson Medical Center</td>
<td>E.g., Mount Auburn IPA</td>
<td>E.g., NC-CCN</td>
</tr>
</tbody>
</table>
Glide path towards payment reforms that reward value

Supporting Better Performance
- Pay for Reporting
  - HOPQDRP
- PQRI
- Stage 1 Meaningful Use

Paying for Better Performance
- Payment for Coordination
  - Medical Home
- Pay for Performance
  - Never Events
  - Future Stages of Meaningful Use

Paying for Higher Value
- Episode-Based Payments
  - Bundled Payments
  - Readmissions
- Shared Savings with Quality Improvement
  - One- or Two-sided ACO Risk Model (individual or regional)
- Partial or Full Capitation with Quality Improvement

Payment reforms progressively move away from FFS & support sustainable health care reform.
Multi-payer efforts critical to successful ACO formation

Successful ACOs should build support from private payers, states, and CMS
### Arizona Connected Care (Tucson, AZ)

<table>
<thead>
<tr>
<th><strong>Commercial Payer-Partner:</strong> United Healthcare (Also has applied to the Medicare Shared Savings Program)</th>
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</thead>
<tbody>
<tr>
<td><strong>Legal entity:</strong> LLC</td>
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<tr>
<td><strong>Governance:</strong> Hospital will have 20% representation and physicians will have 80%</td>
</tr>
<tr>
<td><strong>Payment model:</strong> shared savings, no risk in years 1 &amp; 2; transition to risk-bearing in year 3</td>
</tr>
<tr>
<td><strong>Patient attribution model:</strong> Brookings-Dartmouth prospective method and United Healthcare PCMH Method</td>
</tr>
<tr>
<td><strong>Performance measures:</strong> Brookings-Dartmouth 35 measures of quality and efficiency</td>
</tr>
<tr>
<td><strong>ACO patient population:</strong> 23,000 PPO patients and 8,000 MA beneficiaries</td>
</tr>
<tr>
<td><strong>ACO physician population:</strong> 55 PCPs, 35 specialists</td>
</tr>
</tbody>
</table>

### Success factors:
1. Capability to care for a population
2. Effective health information technology
3. Performance Measurement Infrastructure
4. Ongoing learning: “It’s a process not a destination”

### Core challenges:
1. Developing a care management infrastructure
2. Adjusting to a new paradigm for hospital care
3. Overcoming legal barriers
4. Engaging physicians

Steward Health Care System (MA): “Value (quality, access, cost) is the new paradigm”

- **Population Identification and Stratification**: Analyze population to identify patients' health status and drive the most appropriate and effective care interventions.

- **Deliver Care Interventions**: Evidence based clinical pathways and protocols to define and deliver the most appropriate intervention for all patients based on their identified health status.

- **Measure & Track Performance**: Improve ability to measure population health to the patient level, disease/condition level and physician level.

- **Optimize Care & Physician Communication**: IT and communication infrastructure to enable improved care delivery.

- **Patient Engagement**: Primary prevention initiatives including cultural compatibility and community education outreach.

Source: Presentation by Steward Health Care System’s Medical Network President, Dr. Mark Girard, to the ACO Learning Network on 23 Jan 2012.
### Key challenges for successful ACO implementation

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Potential solutions</th>
<th>Required ACO Competencies</th>
</tr>
</thead>
</table>
| Aligning multi-payer ACOs with other reform initiatives | • Develop a common set of performance measures with a pathway for more sophistication over time  
• Create harmony between other payment and delivery system reforms  
• Commit sufficient leadership support towards shared goals between payers and providers  
• Develop a health IT plan to identify costs and quality improvement opportunities  
• Develop common framework and contract templates to reduce costs and uncertainty  
• Analyze data to understand organizational performance and develop realistic start-up costs  
• Promote transparency to accelerate learning | 1. Governance and leadership focused on the resources and project management required to implement new models of care  
2. Health IT that supports measurement for improvement and accountability  
3. Care coordination especially for the frail elderly or for those with multiple chronic conditions – across clinicians and sites of care  
4. Care improvement programs allowing teams comprised of providers to maintain health and prevent costly complications of chronic diseases and major procedures |
1. Overview of national ACO Implementation: growing private and public sector activity

2. Discovering the unicorn: ACO fundamentals

3. Role of Pharmacists: Services that Drive Value

4. Implementation through collaboration: Brookings-Dartmouth ACO Learning Network
Savings opportunities for pharmacists in ACOs

1. **Poor patient adherence to recommended care**¹
   - Patients adhere to medication regimens about 50% of the time due lack of belief in benefits of the treatment, treatment complexity, treatment costs, side effects of the medication
   - Pharmacists can play a key role in facilitating better adherence

2. **Poor care coordination across providers**²
   - Fewer than half of primary care physicians are provided information about patient discharge or medication plans of their recently hospitalized patients
   - Pharmacists can help coordinate care by reconciling medication histories across settings and making them electronically available to providers

3. **Avoidable complications**
   - Patients visit pharmacies more than any other health-care setting
   - Pharmacies are well-placed to reinforce and maintain educational interventions

Core focus and a caveat

• **Studies suggest that pharmacists are well equipped to manage diseases that:**¹
  
  – Are chronic
  – Can benefit from routine monitoring and coaching
  – Can be treated or managed through medications but are prone to medication mismanagement (e.g., medications not prescribed/taken appropriately)
  – Have measureable results (e.g., glucose test for diabetes, blood pressure cuffs, peak flow meters for asthma, finger stick test for cholesterol) that can be rewarded

• **Pharmacists will play a critical role if they engage with ACOs in new ways that drive value**

Agenda

1. Overview of national ACO Implementation: growing private and public sector activity

2. Discovering the unicorn: ACO fundamentals

3. Role of Pharmacists: Services that Drive Value

4. Implementation through collaboration: Brookings-Dartmouth ACO Learning Network
ACO Learning Network: implementation through collaboration

**2009-2010 ACO Learning Network**
- Focused on defining core ACO concepts
- Included webinars, ACO materials, and conference discounts
- Included the release of our ACO Toolkit

**2010-2011 ACO Learning Network**
- Shared lessons learned from ongoing examples of ACO implementation
- Identified best practices and strategies from ongoing ACO implementation efforts
- Provided in-depth analysis of emerging Federal and State regulation

**2011-2012 ACO Learning Network**
- Focused peer-led work groups on key ACO challenges guided by technical experts and resulting in real actionable ACO implementation tools
- Continued analysis of emerging Federal and State regulation and National ACO trends

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
Accountable Care Core Design Elements

1. Overview and Key Principles of ACOs
2. Organization and Governance
3. Accountability for Performance (e.g. patient attribution, payment models, performance measurement)
4. ACO Infrastructure
5. Health Care Delivery Transformations for Achieving High-Value Health Care
6. Legal Issues for ACOs

Available at: [http://www.acolearningnetwork.org/request-aco-toolkit](http://www.acolearningnetwork.org/request-aco-toolkit)
Overview of the 2011-12 Brookings-Dartmouth ACO Learning Network

Brookings-Dartmouth ACO Learning Network Services

- Enhanced ACO Implementation Webinars
- Member-Driven Conferences
- Implementation Work Groups
- Online Tools and Resources
Clinician-led implementation work groups to address core ACO challenges

**Implementing Performance Measures**
- Shared learning on how to leverage data collection and acquisition across payers to support both internal feedback to clinicians and external reporting to payers.

**Accountable Care Payment Strategies**
- Shared learning on how to align quality with payment and effectively match payments to staff alignment.

**Clinical Transformation**
- From Leadership to Quality Improvement: shared learning on how to engage clinicians in leading quality and process improvement efforts.

**High-Risk and Vulnerable Populations**
- Shared learning on how to identify and care for high risk and vulnerable populations.

Member informed decision-making tools to help ACOs make strategic investments to improve care & lower costs
2011-12 ACO Learning Network members helping drive accountable care and innovation

www.ACOLearningNetwork.org

The Engelberg Center for Health Care Reform at Brookings | The Dartmouth Institute
Thank you

For more information:
smcbride@brookings.edu

February 23, 2012
CHANGING PHARMACY PRACTICE MODELS
FOR A NEW DAY IN HEALTH CARE

KATE GAINER, PHARMD
CEO - IOWA PHARMACY ASSOCIATION

UP FRONT

Key Assumptions

• We don’t have all the answers ...
• Not here to sell a particular model
• Our principle focus is on changing the community pharmacy practice model ...
• We need collaboration from others ...

“A MIDWEST COLLABORATION”
INTERNAL FORCES DRIVING CHANGE

- “Buy Low, Sell High” ... is failing
- JCPP 2015 Vision for Pharmacy Practice
  “Pharmacists ... health care professionals responsible for providing patient care that ensures optimal medication therapy outcomes”
- Embraced by all practitioner organizations – APhA, ASHP, ACCP, NCPA, AMCP, ACA, NASPA
- Endorsed by Education (ACCP), Regulators (NABP) and standard setting bodies (ACPE).
- Medication Management – Declared As Our “Reason for Being”

INTERNAL FORCES DRIVING CHANGE

- Elevation of pharmacy technicians – certification, training, utilization
- PharmD programs – emphasis on clinical practice
- Twenty Five (25) year effort to implement pharmaceutical care based practice and medication management
INTERNAL FORCES DRIVING CHANGE

- Success of MTM Initiative and Programs – Best Practices Documented
- Part D Recognition of Medication Management
- Recognition by others – IOM, AMA, (CDTM, MTM), JAMA, Annals of Internal Medicine, Health Affairs … “Pharmacists are Integral”.
- HCR-Med Management Initiatives, Interdisciplinary Teams, Pilots for ACOs/Heath Homes, Center for Innovation

SOCIETAL RECOGNIZED NEED

New England Health Care Institute

Consequences of Medication Misuse:
- 125,000 preventable deaths/yr
- $100 billion in excess hospitalizations
- $290 billion (13% of total health care costs)
- 75% of US spending – chronic disease

Institute of Medicine

Adverse Drug Events:
- More than 1.5 million preventable ADEs/yr
- $887 million/yr to treat preventable ADE in Medicare
WHAT CHANGES ARE NECESSARY

1. Reengineer our practices ... recognizing that we are in the patient care business not the drug dispensing business
2. Change our practice acts to eliminate legal barriers and allow for greater use of technology and technicians in the dispensing end of our practice
3. Prepared to assume risk for performance
4. Establish connectivity with other members of the health care team

COMMUNITY PHARMACY
NEW PRACTICE MODEL

- Officially created the Community Pharmacy New Practice Model Task Force .. April 2010
- Task Force Membership: community practitioners, family practice clinical pharmacists, pharmacy management, academia, hospital practitioners
- Focus – Restructuring the dispensing workflow to increase the pharmacists capacity to provide direct patient care to entire spectrum of patient population
MISSION
To create a community pharmacy practice model that fully utilizes the knowledge and expertise of pharmacists to improve patient’s health outcomes and provide a safer, more efficient and cost effective medication use system.

VISION
To prepare community pharmacy practice sites to fully integrate with emerging health care delivery and payment systems (i.e. ACOs, PCMHs)

To create a collaboration with patients, health care providers, and payers to share responsibility for improving patient outcomes by retaining technical excellence while expanding and integrating clinical pharmacy functions, currently under utilized in the health care system.
COMMUNITY PHARMACY
NEW PRACTICE MODEL TASK FORCE

GOALS

• Enhance patient safety
• Establish a unique practice model that is recognized for value by physicians, patients and payers
• Improve patient outcomes that are measurable and reproducible
• Establish professionally rewarding practice that is aligned with current pharmacy education experiences
• Create a financially stable model that decreases overall health care costs and improves quality of care

% Pharmacist Time – Dispensing Activity
% Pharmacist Time – Clinical Activity
THE LOOK
• Pharmacist physically located and principally engaged in patient care activities
• Environment conducive to efficient patient interaction
• Pharmacy staffed with certified and trained technicians supported by automation and patient safety technology
• Tech-check-Tech processes in place for refill prescriptions. New prescriptions trigger different process with pharmacist involvement on MTM side of process/verification of accuracy
• Medication counseling by pharmacist provided in association with distribution, but may also occur outside of dispensing
• Pharmacists available for consultation with patients, prescribers, and others as an integral member of the health care team

ESSENTIAL PRACTICE ELEMENTS
• Pharmacist integrated into health care system with access to information – HIT connectivity essential
• Pharmacist-symbiotic relationship with prescribers/patients
• Payment based on “risk of performance” and shared with physicians and others … driven by quality and economic measures
• Pharmacy accreditation and pharmacist credentialing may be useful for patient safeguard and necessary element for payment
• Regulatory change may be necessary for BOP approval of pilots
ACO PROJECT

- Iowa Health System
  - 14 Senior Affiliate Hospitals
  - 63 Communities Served by 160 Physician Clinics
  - 11 Community Hospitals

- Multidisciplinary Team Based Care
  "Working at the Top of Their License"
  Physician, Nurse, Pharmacist

- IHS/IPA Vision: “Best Outcome Every Patient Every Time”

ACO PROJECT

- CMMI Proposal

- 8-County Service Area

- Payers-Medicare, Medicaid, BC/BS

- > 50,000 Patients

- Approved as Pioneer ACO Model
ACO PROJECT-QUALITY INITIATIVES

• Risk Stratification Process for Complex Patients
• Integrated Palliative Care
• Enhanced Patient Engagement
• Medication Therapy Management

ACO PROJECT

• Pharmacy's Role
  ▪ Ensuring Appropriate Medication Use
  ▪ Reducing Medication Related Adverse Events
  ▪ Preventing Hospital Readmissions
  ▪ Helping Patients Manage Chronic conditions
  ▪ Helping Reduce the Cost of End-of-Life Care
ACO PROJECT
Possible Duties Placed Upon Pharmacists by Collaborating Physicians

- MTM Services
- Chronic Disease Medication Management
- Collecting and Reviewing Drug Histories
- Ordering & Evaluating Lab Results
- Hospital Discharge Medication Management

ACO PROJECT
Structure

IHS Hospitals  ---  IHS ACO  ---  IHS Physicians

IHS Clinic Pharmacy Team  ---  IHS Pharmacist Coordinator  ---  IHS Hospital Pharmacy Team

Network of Community Pharmacies
ACO PROJECT

Payment for Pharmacy Services

- Initially FFS Payments to Community Pharmacies
- Shared Savings Model in Development
- Metrics in Development

QUESTION

Can pharmacy achieve its rightful and valued place on the Health Care Team
- without changing its current practice and business model?