



Brandeis University

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BRANDEIS UNIVERSITY // THE HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT

THE HEALTH INDUSTRY FORUM

**BUILDING ACCOUNTABLE CARE
ORGANIZATIONS**

CO-SPONSORED BY THE AETNA FOUNDATION AND

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The Health Industry Forum is based at Brandeis University, chaired by Professor Stuart Altman, and directed by Robert Mechanic. The Forum brings together public policy experts and senior executives from leading healthcare organizations to address challenging health policy issues. The Forum conducts independent, objective policy analysis and provides neutral venues where stakeholders work together to develop practical, actionable strategies to improve the quality and value of the US healthcare system.

Conference presentations and other background materials are available at <http://healthforum.brandeis.edu/>

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Key Themes

Overview

With the passage of federal health reform legislation, the next phase is implementation. A key aspect of health reform is the establishment of Accountable Care Organizations (ACOs).

This Forum examined potential ACO structures and alternatives for building ACOs. Participants shared case studies of current organizations and described challenges in further developing their models. Most participants agreed that there is no one-size-fits-all approach. Becoming an effective ACO will require a combination of leadership, physician commitment, infrastructure, financial management, and patient engagement.

Context

On April 16, 2010, the Health Industry Forum brought together leading experts and representations from health care delivery organizations to discuss policy options for building Accountable Care Organizations (ACOs). This Forum examined different approaches to forming ACOs, and reviewed case studies of different ACO models. Federal and state-level policy considerations were also discussed.

Key Themes

- **Participants agreed on key characteristics needed for ACOs to function effectively**

The primary objective of ACOs will be improving the quality of health care they deliver while controlling the rate of growth in health spending. Other goals include increasing the capacity and effectiveness of primary care, coordinating medical services for high risk patients more effectively, and improving population health.

Participants agreed on several aspects of ACOs:

- *Primary care-centric.* Patient-centered primary and preventive care is a core competency of ACOs, which can be achieved through medical-home models and other primary care-focused management strategies.
- *Different levels of ACOs.* There is no unitary model for ACOs. They can range from medical groups that primarily serve as medical homes to integrated delivery systems.
- *Better care coordination.* ACOs must improve the coordination of care and implement processes to help monitor patients and manage care.
- *Information infrastructure.* To exchange information among physicians, coordinate care and measure quality, ACOs require a viable IT infrastructure, including electronic medical records.
- *Risk contracting.* Most participants agreed that the preferred financial model would be some form of global risk contracting, with rewards for quality and efficiency. In the near term, however, a transition plan

is needed as many potential ACOs are not capable of risk contracting.

- **But they offered alternative approaches to building ACOs.**

One view promotes a “bottom-up” approach where primary care practices add capabilities (through partnerships or contractual relationships) to become ACOs. Another view argues that a “top-down” approach is more feasible, where hospitals add new services to become ACOs. One important factor is that hospitals have significantly more capital and management infrastructure to form the foundation of an ACO. However, most hospitals now operate as revenue centers and the prevailing philosophy of “heads in beds” will likely conflict with ACOs’ mandate to control spending.

Ultimately, there is not a one-size-fits-all approach; ACOs will evolve differently depending on the structure of their local market environment. Participants agreed that collaboration among regional stakeholders will be an important ingredient in ACO development.

The case studies illustrate a variety of different replicable ACO models including an independent physician IPA, collaboration between a community hospital and a physician group, and a large integrated network.

- **Among the most important aspects of becoming a successful ACO will be cultural change.**

One of the most important challenges facing organizations with experience in risk contracting is establishing an organizational culture that supports integrated care. Developing a collaborative team approach; care is often delivered by care managers and nurse practitioners; treatment decisions are based on standards; results are closely measured; and providers are held more accountable. Decreasing unnecessary utilization and producing value represent a significant shift in mindset and behavior, which can take years. Organizational and cultural issues can’t be underestimated.

- **New payment models are essential for encouraging delivery system reform.**

Multiple presenters mentioned the need for payment reform. In the absence of payment reform, hospitals will continue to be driven by the fee-for-service mindset of “heads in beds.” To align incentives, bundled payments, episode payments, or full-risk contracts are needed.

- **Federal and state policy will significantly influence ACO developments.**

In addition to payment reform, there are other important regulatory considerations. These include support for innovative payment pilots and new processes for quickly scaling what works. Other important areas include developing clear quality measures, aggregating data, creating greater transparency, and oversight of ACO financial condition including potential reserve requirements and risk adjustment mechanisms.

Essential Building Blocks for ACO Development

Presenter: **Harold D. Miller**, President and CEO, Network for Regional Healthcare Improvement

Overview

Accountable Care Organizations (ACOs) can be an essential component to transforming health care delivery, but experts disagree on the “best” way to encourage their development. One view is a “bottom-up” approach in which primary care providers add capabilities needed to manage a defined population of patients. Another view presents a “top-down” approach in which hospitals and integrated delivery systems evolve towards prevention-oriented clinical coordination.

In practice, there is not a one-size-fits-all approach; different models will be adopted in different markets. Regardless of the specific model, the transformation will require physicians and hospitals to take accountability for both cost and quality of services. Doing so effectively will require changes in benefit design and payment policies to support changes in care delivery. Unprecedented collaboration in local markets is needed to ensure these changes are made in a coordinated way.

“To me, the core of an Accountable Care Organization is effective primary care.”

— Harold D. Miller

To be successful, PCPs must be able to deliver services differently. First, PCPs need adequate time to do effective diagnosis, treatment planning, and coordination. They need the ability to be proactive about helping patients understand and manage health conditions, they need tools to help them identify and focus on high-risk patients, and they need coordinated relationships with specialists and hospitals. They also need utilization and quality so they can track and improve their performance.

Currently, these capabilities usually reside in health plans or disease management vendors, not primary care practices, and they are often directed at patients without coordination with their PCPs. Medical home initiatives have helped PCPs build some of these capabilities, but most have not gone far enough to enable PCPs to accept accountability. These capabilities are essential and must be developed either as part of the PCP’s organization or through partnerships with other organizations. By forming IPAs or virtual physician organizations, even small practices can develop the capabilities needed to successfully function as ACOs.

Context

Mr. Miller shared his perspective about requirements for developing ACOs, and key steps in the development process and Stuart Altman presented an alternative view.

Key Takeaways (Miller)

- **Primary care providers (PCPs) represent the core of ACOs but must strengthen key capabilities in order to deliver coordinated, efficient care.**

The goal of ACOs should be to reduce healthcare costs without rationing care. This can be achieved by:

- Keeping people healthy.* Helping people stay healthy – a principal role of primary care – avoids the need for expensive treatments.
- Avoiding hospitalization.* When people do develop chronic diseases and other health conditions, costs can be reduced by helping them manage their own conditions so they are hospitalized less frequently. This is also a key role of primary care, with support from specialists.
- Efficient, high-quality outcomes in acute care.* When a patient needs hospital care, costs can be reduced by providing treatment in the most efficient way and by improving outcomes through eliminating complications, infections, and readmissions. The principal responsibility for this resides with hospitals and specialists, but a patient’s primary care provider also has influence over the selection of the most appropriate treatment and the provider who will deliver it.

- **Policies that support different levels of ACOs, will allow a broader range of providers to participate.**

In a nation where most physicians are in small, independent practices and have been paid for decades based on the quantity rather than quality of services, it is unrealistic to expect them to take accountability for the total cost of care without a multi-year transition. One approach is allowing different providers to accept different “levels” of accountability, based on the types of services they can control:

- Level 1: PCPs Only.* Primary care group practices and IPAs can take accountability for reducing costs through improved prevention and screening, more appropriate utilization of testing and specialists, and reductions in preventable ER visits and hospital admissions.
- Level 2: PCPs + Key Specialists.* Multi-specialty group practices and IPAs could also take accountability for costs and quality in major specialty areas.
- Level 3: PCPs + Specialists + Hospitals.* Integrated delivery systems or physician-hospital organizations can take accountability for reducing costs and improving quality across a broad continuum of health services.
- Level 4: Integrated Medical and Social Services.* Some organizations, like Denver Health, have a sufficiently

broad array of services that they can not only improve outcomes for traditional populations, but also provide a wide range of public health and community health improvement activities.

In each of these structures, clinical integration, not corporate structure, is the key. In fact, consumers and employers will likely be unwilling to support ACOs that try to limit a patient's care to hospitals and specialists within the ACO if the care offered in that ACO is not uniformly of high quality and low cost. Conversely, consumers may well be attracted to ACOs where a patient-centered primary care medical home helps coordinate their care and helps identify the highest-quality/lowest-cost providers for their particular condition; that, in turn, will help stimulate competition among hospitals and specialists to improve outcomes and lower costs.

- **ACO development must be accompanied by changes in payment policies and benefit design to truly control costs.**

Current fee-for-service (FFS) payment models do not enable or incentivize providers to form or support ACOs. Providers are often penalized financially for improving quality and avoiding unnecessary services, and no payment at all is made for certain services that have been shown to prevent hospitalizations.

In the long term, the most appropriate payment model for ACOs is a global payment where ACOs are paid a risk-adjusted capitated rate with quality incentives to care for a defined population. This approach gives providers flexibility to determine which services are most appropriate and incentives to deliver high-quality, efficient care. For most providers, however, going in one step from FFS to global payment is too much of a jump. An interim or transitional payment structure will be needed. That structure could include:

- Add-on payments to primary care practices for care management services, combined with pay-for-performance based on utilization of high-cost services, which would simulate the flexibility and incentives of global payment.*
- Episode payments with warranties to acute care providers which bundle payments for all professional and facility costs associated with a defined acute care event.*

It's not enough for *healthcare providers* to take greater accountability for costs and outcomes; *patients* also need to take greater accountability. Most health insurance benefit designs provide few incentives for consumers to choose lower-cost providers and services, and may create barriers to obtaining preventive care. Instead, health benefits must give patients and providers incentives to make decisions that improve outcomes and reduce costs. Global payments and episode payments will enable consumers to compare costs across providers, and if consumers are also

required to pay the "last dollar" of costs (the difference between more and less expensive services), healthcare providers will have the incentive to compete on value. But this can only happen if purchasers (government and employers) and payers change their payment and benefit systems, and if the definition of ACOs is flexible enough to ensure there are multiple, competitive healthcare providers.

"We have to make consumers sensitive to price differences among providers and services to encourage more value-based choices."

— Harold D. Miller

- **Healthcare reform requires stakeholder collaboration at the regional level.**

Many changes need to happen simultaneously in a region for health reform to take place. These changes include:

- Value-driven payment systems and benefit designs.* This requires support from the purchasers in the community, and alignment of all payers.
- Value-driven delivery systems.* Many providers will need technical assistance in restructuring the way care is delivered and coordinated to achieve better outcomes and lower costs.
- Quality/cost reporting.* Transparency of both cost and quality are necessary so that consumers, payers, and providers can make informed decisions about value and ensure lower costs are not achieved at the expense of quality.
- Consumer education/engagement.* Consumers have to support efforts by providers to deliver higher-value care and also work to improve their own health.

All local/regional stakeholders need to work collaboratively to design and implement these changes in a coordinated way; neutral facilitation and technical assistance will be needed from organizations such as regional health improvement collaboratives.

Key Takeaways (Altman)

Stuart Altman agreed that ACOs should have PCPs at their core, and that the FFS payment system must be changed. His perspective differed in two major areas:

- **Changes in benefit design.**

Dr. Altman is skeptical about potential changes in benefit design, particularly for Medicare and Medicaid beneficiaries. Employers are reluctant to push for drastic modifications and it is unlikely that Congress will enact large changes in benefit design for Medicare beneficiaries. (Mr. Miller was more optimistic about potential changes, particularly in commercial insurance.)

- **ACO development from a “top-down” approach seems more practical.**

The reality of the U.S. health care system is that hospitals and hospital-centric delivery systems have tremendous power and resources. A successful ACO will require managerial expertise and access to capital to build its population-health functions, including health information technology and disease management capabilities. Many large community hospitals across the country have the resources and desire to become ACOs. Because of these relative strengths, hospitals seem like likely players for the role of coordinating ACOs. (Mr. Miller doesn't see a one-size-fits-all solution. He believes that in different markets, ACOs will come about in different ways, including both “bottom up” and “top down.”)

Participant Discussion

- **Hospital incentives.** Several participants expressed concern about the “top-down” model for hospitals to oversee ACOs. While hospitals have capital and resources, historically, their focus has been “heads in beds” with a CEO's job performance evaluated based on the hospital's daily census. In the absence of payment reform, participants fear that hospitals will simply view an ACO as a referral channel.

“I am nervous about turning over health care delivery to people who are focused on filling up [hospital] beds.”

— Participant

- **Primary care shortage.** Because the ACO model relies so heavily on primary care, some participants expressed concern about lack of PCPs. This remark elicited two responses: 1) incentives should rapidly be put in place to encourage medical students to become PCPs; and 2) the PCP shortage assumes current practice patterns. If

payment systems become more supportive, and if PCPs are supplemented by nurse practitioners and other clinical resources—enabling them to care for 6,000 patients instead of 2,000—there may not be a primary care shortage.

- **Local collaboration required.** No employer or health plan wants to stick their neck out, or to go first in making benefit design or payment changes for fear of losing healthy employees/members, attracting a disproportionately sick patient population, or incurring administrative costs that others avoid. Therefore, within regional markets, purchasers and health plans need to collaborate to make changes.
- **Changes must be made in parallel, not sequentially.** Multiple changes must be made at the same time, since each depends on the other for success. The transitional process requires foresight, with a defined and agreed-upon end state.
- **Local measures.** Different communities will likely tackle different cost and quality improvement opportunities, so data on quality and utilization will need to be analyzed at a local/regional level.
- **Lessons from Massachusetts.** In Massachusetts, where 97% of the population is insured, providers now realize that there is a defined and limited pool of money. The state hospital association and medical societies now seem willing to support global capitation, if it is appropriately structured. They recognize the need to rationalize and optimize. This is likely to play out elsewhere as financial realities set in. Additionally, Massachusetts' providers and insurers have discovered that contract negotiations need to change from being purely a price negotiation to more of a collaborative conversation that includes benefit design changes.

How Will ACOs Evolve?

Moderator: **Robert Mechanic, M.B.A.**, Executive Director, Health Industry Forum

Presenters: **Patricia Briggs**, CEO, Northwest Physicians Network, Tacoma, Washington
Barbara Spivak, M.D., President, Mount Auburn Hospital Cambridge IPA, Cambridge, Massachusetts
Kathryn Burke, Vice President of Contracting & Business Development, Mount Auburn Hospital Cambridge IPA, Cambridge, Massachusetts
Terry Carroll, Ph.D., Senior Vice President, Fairview Health Services, Minneapolis, Minnesota

Overview

Case studies presented by this panel show that ACOs can evolve in many different ways—from a physician-based primary care network, to a community hospital working in collaboration with an IPA, to a large integrated delivery system. In all models, physician commitment and leadership are instrumental in driving clinical and organizational changes.

By improving the coordination of care, creating a more sophisticated information infrastructure, and assuming greater financial risk, these organizations are successfully changing their organizational cultures in order to focusing care delivery on improving quality and value.

Context

This session examined three provider organizations that illustrate potential ACO structures: 1) a physician-based model; 2) a close partnership between a community hospital and a physician group; and 3) a large integrated network. Representatives from each shared lessons learned and described some of the challenges they faced.

Key Takeaways (Across all models)

- **Experience with full-risk contracts has forced these organizations to change how they deliver care by developing care processes, management capabilities, and an HIT infrastructure.**

Across all models, several common elements were mentioned, including:

—*Delivering programs that add value and increase capacity.* Programs, such as care and disease management play an important role in improving outcomes, lowering utilization, and increasing physician capacity. Speakers emphasized the need to integrate such programs into care delivery.

—*Building an information infrastructure.* ACOs must manage populations and lower utilization. This requires an ability to track performance, share clinical information, and coordinate care across different providers and locations.

—*Undergoing cultural change.* ACO clinicians must practice as a team, use evidence, refer to standards, analyze data on variation, and be conscious of quality. This requires tools, leadership, and a modified

approach to how care is delivered; all of which can take considerable time.

—*An ability to live in two worlds.* While capitated- and other risk-based contracts will become increasingly prevalent, they will not cover all patients. For the foreseeable future, providers will have to accept both fee-for-service and risk contracts. Simultaneously navigating across both worlds will be a difficult necessity.

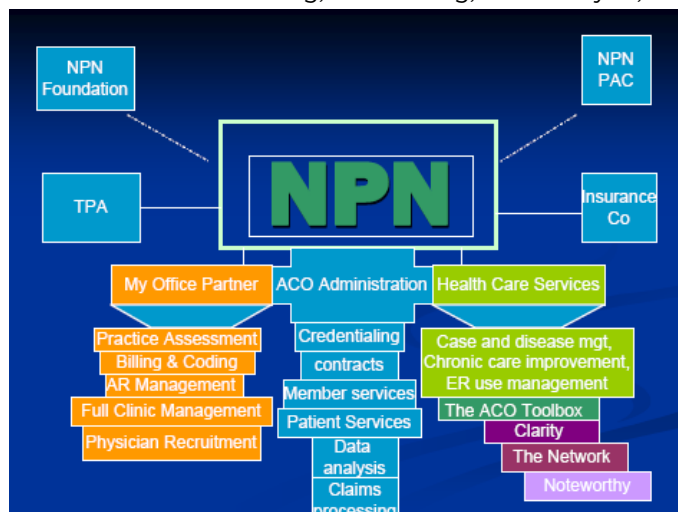
Key Takeaways (Physician-based model)

Patricia Briggs, from Northwest Physicians Network (NPN) in Tacoma, Washington, described how her organization is working to become an ACO. NRN has 450 providers, one-third of which are primary care providers (PCPs). NRN is owned by 250 of the physicians; the rest are contracted. NRN's philosophy is based on collaboration and coordination of patient services throughout their network.

NPN's 15 years of full-risk contracts have prepared it to become an ACO. During that time NPN developed the systems, processes, and technological infrastructure that is needed, and developed competencies in administration, clinical coordination, and web-based IT. These capabilities have enabled NPN to improve its outcomes and utilization compared with averages in the state of Washington.

The important components of NPN include:

—*ACO Administration.* This has existed for 15 years. It deals with credentialing, contracting, data analysis,



claims processing, and other financial and administrative services.

- Clinical Management.* The Health Care Services Arm of NPN focuses on care and disease management, as well as services for patients with chronic diseases. This area of NPN also contains a range of tools and technologies, including a care coordination system, a web-based electronic medical record, e-prescribing, a data warehouse, and a practice management system.
- Workflow Consulting.* For the last three years, NPN has offered consulting and administrative services to their small practices, seeking to help the physician offices run their business more effectively and efficiently by reviewing their billing and managerial functions. These services help practices increase revenue, decrease costs, and spend more time caring for patients.

NPN's other components include an insurance company (for Medicare Advantage patients), a political action committee (to get the message out about small practices), a third-party administrator (which pays claims better and less expensively than other options), and a foundation (that provides visibility for NPN physicians who are involved in various community-oriented activities).

The keys to NPN's evolution to an ACO include physician commitment, and further use of technology to link NPN's independent practices. Early IPAs lacked the infrastructure to manage populations, and lacked the reserves to manage risk. Now, IPAs have better tools, and can serve as a viable core for an accountable care organization. NPN finds that primary care physicians are excited about delivering better, more integrated care.

NPN reports several potential barriers to generalizing their model, including:

- Relationships with hospitals.* NPN contracts with local medical centers for inpatient services. Because the vast majority of hospital revenue is still based on FFS payments, local hospitals have been reluctant to collaborate with NPN in discharge planning or disease management programs. NPN has a history of contentious contracting relationships with these hospitals because of conflicting financial incentives.
- Reimbursement for care management services.* Presently, most disease management services are provided by health plans. These services, however, can be delivered much more effectively if embedded at the provider level. NPN offers such programs to manage the limited funds it receives, improve outcomes, and increase physician capacity. But it questions whether other IPAs and physician groups can develop such programs without additional compensation or pay-for-performance bonuses.
- Lack of payment reform.* Despite NPN's desire to be collaborative, the environment in Washington State has not been conducive to payment reform. The state

has yet to reach a critical mass of interest parties dedicated to changing the way care is delivered.

Key Takeaways (Collaboration between a community hospital and a physician group)

Kathryn Burke from Mount Auburn Hospital and Dr. Barbara Spivak of Mount Auburn Cambridge IPA (MACIPA) described the way their community hospital and IPA work closely together. Mt. Auburn is a full-service community hospital with 203 beds and outpatient services at 25 offsite locations. MACIPA has 513 physician members, 94 of whom are PCPs. In addition to contracting, the 46 staff of MACIPA provide case management, medical management, referral management, pharmacy management, and data and reporting.

Despite being independent, these organizations have long partnered together in a "win-win" relationship. They each value quality and safety, have invested in programs to manage costs, and have collaborated on risk-sharing and service agreements. (The hospital and IPA present a unified front when dealing with health plans, although each signs the contract individually.) Other important issues for the viability of this structure include: ensuring stable cash flow, joint program planning, and convincing private physicians to set aside reserve funds.

MACIPA has learned that cultural change takes years and requires strong leadership and mechanisms for engaging practicing physicians. Within MACIPA, PCPs are organized into pods and participate in monthly pod meetings where physicians go over performance reports, review cases, and develop strategies for quality improvement. MACIPA pay physicians for the time they spend in pod meetings and other quality improvement activities. Policy changes are based on consensus among physicians and data is used to show variation and comparison. The group is working on implementing a consistent electronic health record across all physicians.

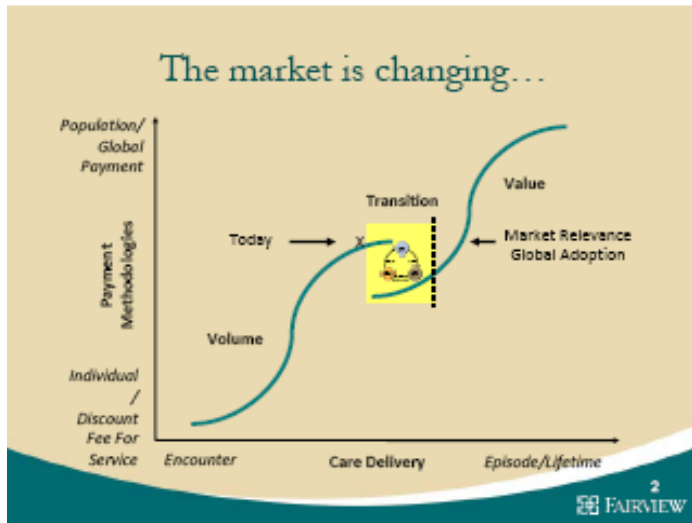
Mt. Auburn and MACIPA were the first group in Massachusetts to sign up for a new Blue Cross and Blue Shield payment pilot that compensates the group in two ways: 1) based on a traditional budget-based risk program; and 2) incentive payments of up to 10% of the budget are offered as a reward for achieving certain quality performance thresholds. The hospital and physicians are each measured on approximately 30 metrics. To earn any bonus, the group must meet minimum aggregate performance thresholds.

Like the other models, Mt. Auburn/MACIPA faces challenges working within a fee-for-service model for some patients, and a risk-based model for others. At Mt. Auburn Hospital, where 75% to 80% of their revenue is still FFS-based, their strategy may limit admissions. But the hospital has adopted a philosophy to focus on quality, safety, and cost effectiveness, believing this is the right

long-term approach as an ACO which will attract other local physicians to refer to the hospital.

Key Takeaways (Large network model)

Terry Carroll described how Fairview is transforming its business model to accept risk, provide value, and manage the health of populations. Fairview, located in Minneapolis, has nine hospitals. One is an academic teaching hospital, and the others are community-based, suburban, and rural hospitals. Fairview employs 500 PCPs with another 1300 physicians tightly affiliated.



Fairview recognizes that the market is changing, and the health systems that will be rewarded are those that deliver value. Fairview sees a new value chain that:

- Changes care.* Fairview has reorganized its medical group, and is redesigning its clinical model. It is moving to team-based care, developing ten specific care packages, (e.g. migraine care, which could be offered as a “product”) as well as offering virtual care.
- Changes the experience.* This includes net-based care, patient activation, and panel management techniques.
- Changes payment.* This entails developing different relationships and models with payers, such as revenue at risk, gain sharing, and rewards for quality.

The changes initiated at Fairview have resulted in improved quality, access, clinic throughput, and patient satisfaction. They have been able to increase the capacity in a number of outpatient clinics without increasing the number of physicians by adopting standard care processes, implementing patient portals that support virtual care, and training other types of clinicians to provide primary care. Pilot data at Fairview shows that physician capacity can be increased by 25-30%. In many instances, care is being shifted to lower-cost and more patient-friendly interactions.

Shifting the business model to emphasize value and improve the care for populations requires organizational change. It also requires the collaboration of key stakeholders—providers, payers, employers, and individuals. One of the key challenges is that innovation in care delivery is occurring faster than payment reform.

Federal and State Policy Considerations for Encouraging ACO Development

Moderator: **Murray Ross, Ph.D.**, Vice President and Director, Kaiser Permanente Institute for Health Policy

Panel: **Carol Backstrom**, Assistant to the Commissioner for Health Reform, Minnesota Dept. of Health
Anthony Rodgers, Deputy Administrator, Centers for Innovation and Strategic Planning, CMS
Steve Tringale, Managing Partner, Hinckley, Allen & Tringale, Boston, Massachusetts
Jay Want, M.D., President & CEO, Physician Health Partners, Denver, Colorado

Overview

Policymakers, in both state and federal governments are trying to create environments where care delivery innovations can flourish. Some states are trying to create common approaches to quality measurement and mechanisms for provider cost and quality transparency to support private sector innovation.

There is also significant interest in support for pilots of innovative programs and mechanisms for scaling successful approaches. Regulators will face new challenges as ACOs take on risk and lines between insurers and providers become blurred. In this environment regulatory attention to provider financial reserves and risk adjustment mechanisms will become more important.

Context

Panelists offered perspectives on federal and state policy considerations for encouraging innovation in care delivery.

Key Takeaways (CMS)

Mr. Rodgers, who is leading the CMS Centers for Innovation and Strategic Planning, described what CMS is doing to drive innovation in health care delivery.

- **CMS seeks to spark innovation and scale innovations.**

CMS is creating a process based on successful innovation models in industries such as high-tech and financial services, with the following stages:

- *Collaboration.* Through collaborative innovation, multiple stakeholders within laboratories will join to analyze trends and best practices and design prototypes.
- *Demonstration.* Through program trials, innovations can be tested and evaluated. Findings and recommendations will be published.
- *Translation.* Following successful demonstrations, policies will be developed and programs brought to scale.

Historically, there have been innovations and demonstrations supported by CMS, but these demonstrations are often not translated or scaled. In

addition, the timeline for the entire process has been too slow. Through innovation labs and well-defined innovation processes, CMS aims to increase the amount of innovation that takes place, improve cycle times, and translate these innovations into scalable programs, fundamentally changing how the health care system operates.

Key Takeaways (State of Minnesota)

Ms. Backstrom outlined the healthcare reforms that are taking place in Minnesota.

- **The State of Minnesota wants to foster further healthcare innovation.**

There is already much private sector healthcare innovation in Minnesota. The state does not want to hamper this innovation but rather find ways to encourage it further. With this in mind, in 2008, the Minnesota legislature passed comprehensive health reform legislation that included:

- *An investment in public health.* This legislation was not just about health insurance reform, but improving the health of the population. It included \$47 million in grants for communities to promote healthy behaviors.
- *Greater transparency.* The state is establishing a system for establishing provider “peer groups” based on cost and quality that could be used as the basis for new benefit models with consumer incentives for selecting efficient, high quality providers. Physician groups, hospitals, and other providers are intimately involved in determining the measures to be used. A statewide quality reporting system will serve as an umbrella for pulling together quality reporting information.
- *Care redesign and payment reform.* The Minnesota legislation includes “health care homes,” similar to patient-centered medical homes, but with required outcome reporting. The intent is that health care homes will improve population health. Payment reform includes development of defined “baskets” or episodes of care. While there are payment reform pilots, the 2008 legislation did not include significant government-driven payment reform, as the state’s key stakeholders were not ready for it yet.

The State of Minnesota intends to keep the momentum going by publishing discussion papers on ACOs, and through a Payment Reform Summit that will bring the key stakeholders together. The state recognizes that there may not be a “one-size fits all” solution, but is pressing the agenda in light of real pressures in the state budget.

Key Takeaways (State of Colorado)

In addition to serving as president and CEO of Physician Health Partners, Dr. Want is also the chairman of the Colorado Center for Improving Value in Health Care (CIVHC). His presentation focused on CIVHC’s role in reforming health care in Colorado.

- **CIVHC’s multi-stakeholder board seeks to improve the value of care delivered in Colorado through a defined number of actionable projects.**

In 2006, Colorado formed a bipartisan commission to make recommendations about improving health care and lowering costs. CIVHC was established as one of 70 separate recommendations by the commission. The Center is currently working to pass legislation that establishes an all-payer claims database, creates payment reform pilots, addresses palliative care, and reduces hospital readmissions.

The group faced early challenges when it tried to do too much and created high expectations with a very limited budget rather than focusing on execution. After a difficult start, CIVHC refocused on establishing an end vision of reform and selecting a narrow set of projects to help achieve that within a defined timeline. The board was reduced to 15 active members (from 30 to 40).

Dr. Want stresses several key lessons for policymakers. First, government can help create a space where constituents can openly talk to each other, forming trust through honest conversations. Experience has also shown that having a common vision with clear goals, and structures, which value progress and transparency, are needed.

Key Takeaways (State oversight)

As a consultant and ex-regulator in Massachusetts, Mr. Tringale shared his thoughts on oversight issues related to ACOs, and a performance-based payment system.

- **State and federal regulators must consider practical oversight issues.**

—*Timing and expectations around endpoints.* Policy-makers would be making a mistake if they based policies (related to ACO timing and outcomes) on the experience and capabilities of the early ACO adopters. The readiness to change, and the ability to achieve predetermined outcomes, is much better for early adopters, which are not representative of all possible ACOs.

Mr. Tringale suggested that different timing and credentials may be needed for different levels of ACOs. The amount of time and credentialing required to become a medical home, would be less than for an ACO that wanted to take full risk.

—*Exclusion of “knowledge generators.”* Academic medical centers that truly generate important new knowledge may not fit as part of a performance-based system. Careful consideration is needed to determine whether AMCs truly belong in this model?

—*Redefinition of “insurer” and “risk.”* As providers take on risk and reserve requirements, regulators will be forced to redefine what an insurer is. Undoubtedly, some ACOs will take risks beyond their means. As part of their oversight function, state policymakers will need to consider developing policies for residual risk facilities.

—*Risk adjustment.* To measure performance there must be mechanisms to adjust risk, particularly based on a population’s clinical and social/demographic factors. A standardized risk-adjustment methodology would eliminate the need for each ACO-payer negotiation to re-invent new metrics and methods.

—*Minimum benefit design.* In a performance-based system, there will need to be oversight provided for the clear definition of a minimum benefit design.

Participant Discussion

- **Guidance vs. flexibility.** Participants requested that the state and federal representatives help guide the process, but allow providers and payers to determine the specific route to achieve reform. In essence, government should provide guardrails, and then allow for flexibility and local innovation.

- **Demonstrations vs. pilots.** Medicare demonstrations are often ill-suited to test innovative concepts, especially with the requirement of showing budget neutrality in a fixed time frame. Further, the ability to generalize and develop large-scale change from demonstration projects has been mixed. Participants suggested more flexibility in designing and implementing pilot or prototype programs, including possibilities for public/private collaborations.