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Second National Accountable Care Organization Summit:
The Leading Forum on Accountable Care Organizations and Related Delivery System and Payment Reform

June 27th – June 28th, 2011
Omni Shoreham Hotel, Washington, DC

ACO Summit Panel Briefs

The National ACO Summit (Day 1)
Monday, June 27, 2011
Morning Plenary Session

9:15 am – 10:45 am **Core Competencies of Successful ACOs**
Elliott S. Fisher, MD, MPH, Director, Population Health and Policy, Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice *(Moderator)*

1. Debra Ness, MS, President, National Partnership for Women and Families; Leader, Campaign for Better Care
2. David Lansky, PhD, President and Chief Executive Officer, Pacific Business Group on Health
3. Jon Blum, MPP, Deputy Administrator and Director of the Center for Medicare, Centers for Medicare and Medicaid Services
4. Bob Margolis, MD, Managing Partner and Chief Executive Officer, HealthCare Partners; Chair, National Committee for Quality Assurance
5. Jeff Kang, MD, MPH, Chief Medical Officer, CIGNA

Panel Overview:
ACOs need to be a flexible model that can adapt to unique markets; however, there are certain core competencies that all ACOs will need to develop in order to successfully achieve better care, better health, and lower costs for the population it serves. Some of the core competencies that will be discussed include building a strong primary care base, successfully reporting on and being held accountable for patient-centered criteria, developing structures to manage care and risk for a population of patients, aligning ACO initiatives across payers, and providing actionable information to providers.

The panelists will highlight examples of these and other core ACO competencies, as well as share examples of how existing ACOs have developed and refined these attributes. The panel will also discuss whether any competencies are unique to the public or private sector and how to align efforts within a multi-payer environment. The issues raised on this panel will be discussed in more detail in the ACO Summit's following track sessions.

Core Questions:

- What are the overarching aims for ACOs? Do these aims differ when dealing with public or private sector payers?
- What can be done to enhance ACO accountability for the triple aim? What strategies should be pursued to most effectively inform and engage patients about these new care models?
- What do both payers and providers need to do to help achieve the aims of improved care, better health and lower costs?
- How can public and private payers most effectively align their efforts?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Morning Plenary Session

10:45 am – 12:15 pm **Models for ACO Implementation**
Mark McClellan, MD, PhD, Director, Engelberg Center for Health Care Reform, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution *(Moderator)*

1. John Friend, JD, General Counsel, Tucson Medical Center
2. Ed Miller, MD, Chief Executive Officer, Johns Hopkins Medicine; Frances Watt Baker and Lenox D. Baker Jr. Dean, School of Medicine, Johns Hopkins University
3. James Sams, MD, Medical Director, Piedmont Physicians Group
4. Steve Hester, MD, MBA, Senior Vice President and Chief Medical Officer, Norton Healthcare

Panel Overview:
By design, an ACO is meant to be a flexible model that allows networks of providers to coordinate care within diverse markets in order to improve the quality of care while reducing costs. Over the past several years, a variety of ACO models have been implemented in the private sector and CMS, through its Medicare Shared Savings Program proposed rule and ACO Pioneer model, have outlined possible parameters around the structure and composition of a Medicare ACO model.

This panel will discuss various ACO implementation models in the private sector and how CMS's proposed parameters will affect the success of these models moving forward. Different types of organizations – from physician-hospital organizations to academic medical centers to medical groups – will all require a unique ACO-design approach, with potentially different legal and governance structures, provider roles, and internal incentive structures. By describing how they led their own ACO implementation experiences, the panelists will help highlight key advantages and constraints of different ACO models.

Core Questions:

- How did you re-structure your organization to prepare for the increased accountability required by the ACO model?
- What strategies worked best in your respective organizations to effectively align independent health care providers and create real responsibility for quality outcomes and cost?
- What has been the hospitals response to the goals of decreased inpatient days and ED utilization?
- Reflecting on the core ACO competencies identified in the previous panel, do you feel that there are certain common design features that every ACO model requires?
- How did you decide whether to partner or develop new relationships with outside organizations?
- Has CMS' proposed governance and organizational requirements caused you to re-think the model you developed for ACO implementation? Is your current model sufficient to meet CMS' requirements for either the Medicare Shared Savings Program or the ACO Pioneer Model?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Track 1: Advancing Payment Models to Support Improved Performance

1:30 pm – 3:15 pm **Financial Accountability: What Providers Need to Do and How Payers Can Help**
Elliott Fisher, MD, MPH, Director, Population Health and Policy, Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice *(Moderator)*

1. Carmella Bocchino, RN, MBA, Executive Vice President, Clinical Affairs and Strategic Planning, America's Health Insurance Plans
2. Jay Cohen, MD, MBA, Executive Chairman, Monarch Health Care
3. Steve ErkenBrack, JD, President and CEO, Rocky Mountain Health Plans
4. Gene Lindsey, MD, Chief Executive Officer, Atrius Health and Harvard Vanguard Medical Associates

Panel Overview:
A critical challenge for successful ACO implementation is effectively managing financial risk for a population of patients (e.g. achieving buy-in/support from providers participating in the ACO, identifying high-risk and high-cost users). In particular, the distinction between taking on responsibility for clinical performance (e.g. reducing avoidable emergency room and hospital visits) and taking on insurance risk is an important question for both providers and payers.

Panelists will highlight the importance of having a solid payer and provider relationship and will identify the type of information and tools that providers will need to move toward greater accountability for costs. Specifically, panelists will discuss the role of payers in facilitating data sharing and transmission and what type of data providers should receive that may help reduce financial uncertainty. Panelists will also stress the challenges many provider organizations will face as they take on increasing levels of clinical and financial risk and how providers should start to mitigate these challenges.

Core Questions:
- During the early phases of the ACO payer-provider negotiations, what key issues related to provider financial accountability need to be identified and addressed in order to advance ACO implementation?
- What core competencies does the ACO need to develop in order to be able to move successfully toward greater financial accountability?
- What are the responsibilities of payers both to support ACOs capacity to meet financial targets and to help them manage financial risk? How should risk for performance be distinguished from insurance risk?
- What information do payers need from providers to build an effective partnership?
- What issues need to be addressed as providers and payers establish data sharing agreements?
- What actionable data do providers need from payers to better impact their ability to coordinate care, reduce unnecessary utilization, manage risk, and reduce costs?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Track 1: Advancing Payment Models to Support Improved Performance

3:45 pm – 5:30 pm **Methods to Help Payers and Providers Successfully Manage Increased Risk**
Sherry Glied, MA, PhD, Assistant Secretary, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services *(Moderator)*

1. Arlene Ash, MS, PhD, Professor, Quantitive Health Sciences, UMass Medical School
2. Ed Cymerys, FSA, MAAA, Senior Vice-President and Chief Actuary, Blue Shield of California
3. Dean Farley, MPA, PhD, Vice President, PPS and Payment Accuracy Solutions, Ingenix
4. Lisa Iezzoni, MD, MSc, Professor of Medicine, Harvard University
5. Steve Lieberman, MPhil, MA, Visiting Scholar, The Brooking Institution

Panel Overview:
In order to measure financial performance ACOs will need to set an accurate financial benchmark and develop tools to measure and evaluate financial performance. There are many different methodologies to determine an ACOs financial benchmark, or spending target, which includes developing a sound and accurate risk adjustment methodology to reflect the underlying health of the population of patients for which an ACO will be held accountable.

In particular, panelists will discuss methods for determining an ACO's target spending amount and to measure an ACO's actual spending against this target. Panelists will provide perspective on the pros and cons of the CMS proposed benchmark-setting process that is stipulated in the Medicare Shared Savings Program NPRM and will describe alternatives to the proposed method. Panelists will also discuss methods for updating an ACO's benchmark as well as various methods for applying risk adjustment.

Core Questions:
- What key components and steps are needed to accurately set an ACO's benchmark?
- What are they key factors providers and payers should consider when deciding on a risk adjustment methodology?
- What potential methods could help mitigate the chances that the performance of an ACO will be judged against an inaccurate benchmark?
- What are the challenges associated with determining the risk adjustment factor that could be applied to an ACO's benchmark? How can these challenges be addressed?
- Should the methodology for setting and updating an ACOs benchmark be different for private payers, Medicaid, and Medicare?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Track 2: Multi-Payer ACOs

1:30 pm – 3:15 pm **Medicaid ACOs**

Mark McClellan, MD, PhD, Director, Engelberg Center for Health Care Reform, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution *(Moderator)*

1. Carol Backstrom, MHA, Senior Policy Advisor, Office of the Deputy Administrator/Director, Center for Medicaid, CHIP and Survey & Certification, Centers for Medicare & Medicaid Services
2. Richard Onizuka, PhD, Health Care Policy Director, Washington State Health Care Authority
3. Bruce Siegel, MD, MPH, Chief Executive Officer, National Association of Public Hospitals and Health Systems
4. Elaine Batchlor, MD, MPH, Chief Medical Officer, LA Care Health Plan; Chair-Elect, Integrated Healthcare Association
5. Colleen Kraft, MD, FAAP, Program Director, Transitional Residency, Carilion Clinic Pediatric Medicine; President, Virginia Chapter of the American Academy of Pediatrics

Panel Overview:
The Medicaid population is a unique population that tends to be sicker, to be more disabled, to include the dual eligible, and to cycle on and off of health insurance coverage. ACOs have the ability to improve the care that Medicaid patients receive by coordinating care, monitoring performance, and tying performance to shared savings. However, there a number of challenges in creating Medicaid ACOs for this high risk/high cost population, including but not limited to defining the ACO population, lack of capital for providers to create ACOs, defining states' roles, and aligning incentives for the dually eligible population.

The Affordable Care Act has outlined and proposed of Medicaid ACO activities and demonstration projects (e.g., Medicaid Pediatric ACO Demonstration). Additionally, a number of states have efforts underway to implement ACO or ACO type reforms. This session will explore legislative efforts to support the development of Medicaid ACOs, state-based and health system efforts to implement ACOs, challenges and innovative solutions in creating and improving Medicaid ACOs, and the importance of public/private collaboration for the success of Medicaid ACOs.

Core Questions:
- Will the Medicare Shared Savings Program framework work for Medicaid ACOs?
- How should Medicaid ACOs align incentives for the dually eligible population?
- Can Medicaid ACOs be implemented without including uninsured and exchange/subsidy populations?
- How can we push for alignment of measures to be used for all population-based accountable care programs?
- What are states' roles in developing ACOs, particularly in a public/private partnership? Why should the private sector be interested in states' activities in Medicaid related to ACOs?
- What challenges do states, public hospitals, health systems, and others have in the development and implementation of Medicaid ACOs? What are potential solutions to these challenges?
- What resources are needed for the effective implementation of Medicaid ACOs?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Track 2: Multi-Payer ACOs

3:45 pm – 5:30 pm **Private-Public Payer Collaboration**
Mark McClellan, MD, PhD, Director, Engelberg Center for Health Care Reform, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution *(Moderator)*

1. Aaron McKethan, PhD, Director, Beacon Communities Program, Office of the National Coordinator for Health (ONC)
2. Lew Sandy, MD, MBA, Senior Vice President for Clinical Advancement, United HealthCare; Senior Fellow, University of Minnesota School of Public Health, Department of Health Policy and Management
3. Robert Margolis, MD, Managing Partner and Chief Executive Officer, HealthCare Partners; Chair, National Committee for Quality Assurance
4. Bill Kramer, MBA, Executive Director, National Health Policy, Pacific Business Group on Health

Panel Overview:
The aim of the ACO model is to change the payment incentive system for health care providers by rewarding the value of the care delivered instead of the volume of services provided. Shifting the incentive system to enable providers to practice patient-centered, evidence-based medicine will require cooperation between both public and private payers. By developing aligned quality standards and outcome-based payment mechanisms, public and private payers can jointly encourage and support innovative new value-based practice models.

Aligning efforts between private payers and between Medicare and Medicaid and the private sector will not be easy. This panel will focus on exploring possible synergies and opportunities for payers to work together in driving value-based care. With representation from the public sector, the private sector, employers, and providers, there will be a rigorous discussion focused on practical opportunities for public/private alignment and cooperation.

Core Questions:

- What are the best examples of ongoing collaborative efforts between public and private payers and how successful have these efforts been at reducing costs while improving the quality of care?
  - Will private payers and providers respond to requirements to move to outcomes-based payments by Medicare (e.g., the ACO Pioneer Model's requirement for 50% of all reimbursements based on outcomes)?
- What challenges do/will private payers face when trying to collaborate with Medicare on multi-payer initiatives?
- What types of public-private alignment could be most helpful for provider groups looking to implement new delivery and payment system reforms?
- How will employers and consumers benefit, if at all, from public-private payer alignment?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Track 3: ACO Legal Issues

1:30 pm – 3:15 pm **Addressing ACO Legal Issues**
Larry Kocot, JD, MPA, LLM, Deputy Director, Engelberg Center for Health Care Reform; Senior Counsel, SNR Denton LLP, Washington, DC *(Moderator)*

1. James A. Cannatti III, JD, Senior Counsel, Office of Counsel to the Inspector General, Office of Inspector General, U.S. Department of Health and Human Services
2. Cathy Livingston, JD, Health Care Counsel, Office of the IRS Chief Counsel
3. Doug Hastings, JD, Chairman, Board of Directors, Epstein, Becker, Green, PC
4. Chris Janney, JD, Partner, SNR Denton
5. John Friend, JD, General Counsel, Tucson Medical Center

Panel Overview:
The integration and coordination between providers through the formation of ACOs in both the private and public sectors requires careful consideration of many legal issues, including the development of new governing bodies and boards to comply with fiduciary duties, oversight responsibility, and quality improvement and fraud and abuse laws. The Centers for Medicare & Medicaid (CMS) and the Office of the Inspector General (OIG) jointly proposed possible waiver designs in connection with Medicare Shared Savings Program (MSSP) to waive the application of the Physician Self-Referral Law, the Federal and anti-Kickback statute, and certain civil monetary penalties law provisions and solicited public input regarding the separate waiver authority related to the CMS Innovation Center. The Internal Revenue Service (IRS) has also proposed guidance around the application of the Internal Revenue Code governing tax-exempt organizations to hospitals or other health care providers participating in the MSSP.

This panel will discuss possible options for structuring a successful ACO both internally and through new relationships with other providers and suppliers. It will also examine structuring an ACO that can participate with both commercial payers and Medicare and Medicaid. With ACOs requiring increased clinical and financial integration, we will also discuss the implications of the fraud and abuse laws and the proposed waivers, with multi-payer ACOs requiring especially careful consideration.

Core Questions:
- How will an ACO governing board need to be designed in order to have the necessary fiduciary responsibility and oversight abilities (financial and audit, fraud and abuse compliance, and new quality measurement and reporting requirements)?
- Is there sufficient guidance for the MSSP and the Innovation Center ACO Pioneer model regarding the design of waivers for fraud and abuse laws?
- What other types of arrangements (i.e., arrangements other than those covered by the proposals) are OIG and CMS considering for waiver protection in connection with the MSSP? What about waivers in connection with other ACO programs?
- If an ACO arrangement doesn't fall within a waiver, does that mean the ACO can't engage in that arrangement? What issues still remain after the waivers?
- Does the IRS provide sufficient guidance and clarity around tax code provisions governing tax-exempt organizations planning to participate in the MSSP?
- How will State regulation of provider groups bearing financial risk affect ACO development and how should ACOs approach this issue?
- What are the biggest legal challenges, and possible strategies, for organizations looking to set-up an ACO with both Medicare and other payers?

The National ACO Summit (Day 1)
Monday, June 27, 2011
Track 3: ACO Legal Issues

3:45 pm – 5:30 pm **Structural Safeguards Against Market Dominance and Antitrust Concerns**
Larry Kocot, JD, MPA, LLM, Deputy Director, Engelberg Center for Health Care Reform; Senior Counsel, SNR Denton LLP *(Moderator)*

1. Paul Ginsburg, PhD, President, Center for Studying Health System Change
2. Melinda Hatton, MPA, JD, Senior Vice President and General Counsel, American Hospital Association
3. Gail Kursh, JD, Deputy Chief, Legal Policy Section, Antitrust Division, US Department of Justice
4. Douglas C. Ross, JD, Partner and Chair, Firmwide Litigation Practice, Davis Wright Tremaine; Governing Council, ABA Antitrust Section
5. Arthur Lerner, JD, Partner, Crowell & Moring LLP

Panel Overview:
Provider consolidation is a growing trend in many markets across the country. With the aim of the ACO-model to integrate providers to provide better coordinated and higher quality care at a lower price, ensuring organizations integrate and coordinate in a way that is pro-competitive is essential to prevent rising prices for consumers. In cooperation with the Centers for Medicare & Medicaid Services (CMS), the Federal Trade Commission (FTC) and the Department of Justice (DOJ) proposed an antitrust enforcement policy for organizations applying and participating in the Medicare Shared Savings Program (MSSP).

The aim of this panel is to discuss how ACO implementation will affect the growing market trend of provider consolidation and how to best structure ACOs to ensure pro-competitive behavior and higher quality of care. We will also discuss the FTC/DOJ proposed methodology of evaluating market power and conducting antitrust analysis for the MSSP.

Core Questions:
- How can we promote care coordination without allowing anti-competitive structures and arrangements to dominant the market place?
- What evidence is there for "growing consolidation among providers" and does acquisition, merger or even joint venture activity always equal "consolidation"?
- What type of competitive concerns might ACOs present?
- How does the DOJ/FTC policy statement regarding the MSSP change the antitrust agencies role in the marketplace and what implications might that have?
- Does the policy statement apply to ACOs that only operate in the MSSP? And if so, why is that given the absence of price competition in Medicare? What if an ACO decides not to contract with commercial payers during the three-year agreement period with CMS?
- The FTC and DOJ have proposed using ACO provider's shares of services with primary service areas (PSA) to determine market share. What are the advantages and disadvantages of this approach? Is this doable for providers? If not, what are other alternatives?
- How did the antitrust agencies arrive at the 30% and 50% screens?
- How will the antitrust agencies coordinate their review of ACOs? Will applicants have an opportunity to address any antitrust concerns during the review process? Is there a possibility for the agencies' reviews diverge? And if so, how should ACO applicants proceed?
- What level of clinical and/or financial integration is necessary to mitigate antitrust concerns and how should that be measured?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 5: Clinical Transformation

9:30 am – 10:45 am **The Role of Clinical Leadership in Transformation**
Elliott S. Fisher, MD, MPH, Director, Population Health and Policy, Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice *(Moderator)*

1. Bart Asner, MD, Chief Executive Officer, Monarch Healthcare; Chairman, Integrated Healthcare Association
2. Michael Barr, MD, MBA, FACP, Senior Vice President, Division of Medical Practice, Professionalism and Quality, American College of Physicians
3. Marilyn A. Follen, RN, MSN, Administrator, Institute for Quality, Innovation & Patient Safety, Marshfield Clinic
4. Jay Want, MD, Principal, Want Health Care, LLC; Chairman of the Board, Center for Improving Value in Health Care

Panel Overview:
For ACOs to succeed in truly transforming clinical practice in way that supports serious quality improvements and improve care coordination, transformation efforts will need to be led by dedicated clinicians. This panel will focus on the role leadership plays in transforming organizations that are on a path to achieving greater accountability and will provide perspective on the role management, technology and clinical information systems, practice redesign, and leadership and vision play in successful clinical transformation and its impact on quality and costs.

Panelists will also describe the interplay between strong leadership and clinical transformation; in particular, panelists will describe how strong and effective organizational leadership facilitates alignment between various actors in a health care system (physicians, nurses, pharmacists, ancillary care providers, and information system personnel) to support a patient-centric and accountable approach to care. The panelists will also discuss the leadership skills and organizational structures that can help engage physicians in clinical transformation.

Core Questions:
- How can leaders initiate meaningful organizational change aimed at achieving greater accountability?
- How can leaders engage different multi-stakeholders (including consumers) in an effort to foster effective clinical transformation?
- What factors need to be in place to enable an organization's readiness to engage in clinical transformation?
- What are examples of organizational barriers that could impede clinical transformation?
- How can leaders foster clinical leadership in everyone else?
- How can leaders engage physicians in clinical transformation and encourage them to see themselves as part of a team responsible for the collective care of a population?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 5: Clinical Transformation

10:45 am – 12:00 pm **Models for Clinical Transformation to Advance Patient-Centered Care**
Kavita Patel, MD, MSHS, Fellow, Economic Studies and Managing Director for Clinical Transformation and Delivery Reform, Engelberg Center for Health Care Reform, The Brookings Institution *(Moderator)*

1. Karen Boudreau, MD, FAAFP, Senior Vice President, Institute for Healthcare Improvement
2. Neil Calman, MD, ABFP, FAAFP President and Chief Executive Officer, The Institute for Family Health, Clinical Professor of Family Medicine and Community Health, Albert Einstein College of Medicine and Yeshiva University
3. Kathryn Correia, President of Hospital Division, ThedaCare
4. David Judge, MD, Medical Director, Massachusetts General Hospital

Panel Overview:
Truly accountable care cannot be achieved by tweaking current ways of providing care. If ACOs are to achieve the Triple Aim, they will need to develop new skills and capacities to caring for a population or community of patients. To achieve this aim the relationship between providers, specialists, hospitals, payers, and consumers will need to fundamentally change. Clinical transformation will need to occur that can create and sustain innovation and improve care coordination across providers and care settings.

This panel will discuss various models for clinical transformation by drawing on various unique experiences and strategies implemented across the country. Without a plan for real clinical transformation that supports improved care coordination and patient-centered care, ACOs will not succeed in improving quality while lowering costs. The panelists will also discuss strategies to help organizations implement clinically transformative care models and strategies for empowering physicians to lead these efforts.

Core Questions:
- How do your models for clinical transformation align with ACO delivery requirements?
- How do you spread your innovations internally and share with other external health care providers?
- What does clinical transformation mean and what does it look like?
- What are the essential characteristics for clinical transformation?
- Where are the greatest opportunities in the system for improved outcomes?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 6: Performance Measurement

9:30 am – 10:45 am **Collaborative Measurement Approaches Between Payers and Providers**
Mark McClellan, MD, PhD, Director, Engelberg Center for Health Care Reform, Leonard D. Schaeffer Chair in Health Policy Studies, The Brookings Institution *(Moderator)*

1. Richard Bankowitz, MD, MBA,FACP, Vice President, Medical Director, Premier Healthcare Informatics
2. Peggy O'Kane, MHA, President, National Committee for Quality Assurance
3. Joachim Roski, PhD, MPH, Fellow and Managing Director, Engelberg Center for Health Care Reform, Brookings Institution
4. Tom Williams, MBA, DrPH, Executive Director, Integrated Healthcare Association

Panel Overview:
Payers and providers play a key role in health care sector progress. Working together, particularly in the context of ACOs, providers and payers have an opportunity create consistent and actionable standards for measurement and explore models that can lead to improvements in care and cost savings. To this end, a number of elements should be explored:

- Arriving at consistent measurement approaches that take into consideration administrative, clinically-enriched, and patient-reported measures;
- Fostering comparability, clarity, and transparency for providers, payers, and consumers with regard to ACO standards, such as how performance measures are defined; and
- Creating consensus based approaches to developing and testing ACO accreditation standards.

This panel will explore how collaborative approaches between payers and providers can lead to an increase in quality and reduce costs through shared savings.

Core Questions:

- What opportunities are there for alignment of measures and methods across multiple providers and payers?
- What are the key elements needed to develop a pathway for performance measurement with payers and providers that goes beyond claims data, but that also includes clinically-enriched and patient-reported measures?
- How do organizations know what is important to the people being served by their health care system?
- What role should the payer and provider play in developing, implementing, and maintaining performance measurement and improvement?
- Should the payer or the provider in an ACO contractual relationship be accountable for measuring progress against the Triple Aim?
- What differences are being seen in the way commercial payers are choosing to measure value and what problems is this causing for hospitals?
- How significant of a problem is fear of transparency when asking community health care agencies to share data they have been reluctant to share in the past?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 6: Performance Measurement

10:45 am – 12:00 pm **Innovations in Measuring and Delivering Patient-Centered Care**
Kalahn Taylor-Clark, PhD, MPH, Research Director and Director, Patient-Centeredness Portfolio, Engelberg Center for Health Care Reform, The Brookings Institution *(Moderator)*

1. John Wasson, MD, Professor of Community and Family Medicine, Professor of Medicine, Herman O. West Professor of Geriatrics, Dartmouth Medical School
2. Lisa Latts, MD, MSPH, MBA, Vice President, Programs in Clinical Excellence, Wellpoint, Inc.
3. Norbert Goldfield, MD, Medical Director, Clinical Research, 3M Health Information Systems
4. Uma Kotagal, MBBS, MSc, Senior Vice President, Quality and Transformation, Director, Health Policy and Clinical Effectiveness, Cincinnati Children's Hospital

Panel Overview:
As one of six domains of quality as defined by the Institute of Medicine, providing "patient-centered" care will be a cornerstone for achieving value in emerging payment and delivery models. First, providing a timely response to patient-reported and outcomes data, which includes information about "what matters to patients" and "what is the matter with them" (e.g. the experience of care, functional status, health risk behavior, engagement level), is an important vehicle for building trust among patients and facilitating improvement in the patient-health professional relationship. Second, patient-reported and outcomes measures can tell health professionals whether they are delivering high quality care to patients and achieving desirable health outcomes. This is especially important for high-risk and high-cost patients who suffer from multiple chronic conditions as well as those who experience disparities in care and outcomes. Third, patient-reported and outcomes data can be used to assess the effectiveness of various delivery models, make comparisons and calculate trends over time, and provide meaningful information to consumers and payers for decision-making and accountability, including public reporting and payment.

This panel will explore effective models for delivering patient-centered care and measuring its effectiveness through the lens of patient-reported information and outcomes data.

Core Questions:
- What are the essential elements to delivering patient-centered care?
- What measures currently exist to assess the effectiveness of delivering patient-centered care?
- How can these measures be used by patients, health professionals, and systems of accountability to achieve higher value in health care delivery?
- What are key elements (e.g. infrastructure, leadership, benefits design, etc.) to ensure effective and sustained delivery of patient-centered care?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 7: Payment Models and Patient Assignment

9:30 am – 10:45 am **New Methods of Paying for Value**
Cary Sennett, MD, PhD, Fellow, Economic Studies and Managing Director for Health Care Finance Reform, Engelberg Center for Health Care Reform, The Brookings Institution, *(Moderator)*

1. Caroline Blaum, MD, MS, Associate Chief, University of Michigan Faculty Group Practice
2. David Bronson, MD, FACP, President, Cleveland Clinic Regional Hospitals; President-elect, American College of Physicians; Immediate Past Chair, AMGA
3. Jay Cohen, MD, MBA, Executive Chairman, Monarch Health Care
4. Mark Shields, MD, MBA, FACP, Senior Medical Director, Advocate Physician Partners; Vice President, Advocate Health Care

Panel Overview:
A primary aim of the ACO model is to move providers away from a volume-based payment system and towards a value-based system. Depending on an ACOs history and environment, different payment models might fit better in different markets. The Medicare Shared Savings Program represents one option; however, other payment models are currently being implemented and tested in both the public and private sectors.

The purpose of this panel is to summarize real world experience with cutting-edge methods for "paying for value," and to consider the issues that must be addressed in order to implement new strategies for value-based purchasing in an accountable marketplace. The panel will describe the many value-based payment options currently in practice and will share some of their advantages and disadvantages. Panelists will also share strategies for organizations with a long history of working in a fee-for-service reimbursement to start transitioning to value-based payments.

Core Questions:
- What is the range of payment options and what has been your experience with them? What worked well, what has been problematic, and what does an organization need to do (or need to have) in order to succeed in a value-based payment environment?
- Is it best to have payors aligned and if so, around what? Or is it desirable to have multiple different programs operating in parallel—to mitigate risk and/or facilitate learning?
- What options exist for "value based payment" within an ACO: that is, what compensation models work best to drive accountable care organizations toward higher value?
- Are there special issues that need to be considered working with small practices?
- How long does it take, and what does it cost, to develop the infrastructure needed to be successful? Over what timeline should an organization expect to recover that investment?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 7: Payment Models and Patient Assignment

10:45 am – 12:00 pm **Assigning Patients to ACOs**
Elliott S. Fisher, MD, MPH, Director, Population Health and Policy, Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice *(Moderator)*

1. Steve Lieberman, MPhil, MA, Visiting Scholar, The Brookings Institution
2. Susan Pantely, FSA, MAAA, Consulting Actuary, Milliman Group
3. Rome Walker, MD, Medical Director, Anthem Blue Cross Blue Shield
4. Cecil Wilson, MD, MACP, President, American Medical Association

Panel Overview:
The methods used to assign or attribute patients to an ACO will profoundly influence both an ACO's ability to perform relative to its financial benchmarks, and the process for engaging patients in the ACO. This panel will discuss key issues related to patient attribution including: (1) retrospective vs. prospective attribution, (2) defining the patient population, (3) identifying eligible services to be used for attribution, (4) determining eligible providers for attribution and (5) the challenges of engaging and informing patients.

The panel will also focus on the impact of the proposed CMS attribution model found in both the NPRM for Medicare Shared Savings Program (MSSP) and the ACO Pioneer Model. Panelists will discuss what the best approach is to ensure clinicians have timely and relevant information on their patient population; thus, allowing providers to maximally impact and partner with patients to initiate ACO care management strategies.

Core Questions:

- What essential information should providers have to provide better care for their ACO population, and how can differing attribution models impact providers' ability to be accountable for a population of patients?
- What are the advantages and disadvantages of prospective and retrospective attribution? What role does data sharing have in mitigating some of these risks?
- How often should a prospective model be re-run to account for new patient entries and exits to ensure accurate patient assignment?
- What types of providers should be considered for assignment, and what role should NPs, PAs, and specialists have in assignment?
- What are the different approaches to patient assignment for Medicare population versus the commercial population?
- How can an attribution model be designed to support beneficiary involvement and engagement?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 8: Funding ACO Start-Up Costs

9:30 am – 10:45 am **Opportunities from the Public Sector**
Daniel Hawkins, Senior Vice President, National Association of Community Health Centers (NACHC), *(Moderator)*

1. Hoangmai Pham, MD, MPH, Senior Advisor, Center for Medicare and Medicaid Innovation, Centers for Medicare & Medicaid Services (CMS)
2. David Meyers, MD, Director, Center for Primary Care, Prevention and Clinical Partnerships, Agency for Healthcare Research and Quality (AHRQ)
3. Tom Tsang, MD, MPH, Medical Director, Meaningful Use Division, Office of Provider Adoption Support, Office of the National Coordinator for Health Information Technology (ONC)

Panel Overview:
The federal government is playing a leading role in driving delivery system reform across the country through new programs and demonstrations, as well as grants and funding for new care models, teams, and infrastructure. With the sweeping changes from the Affordable Care Act, many organizations will be looking to the federal government to help support their own transformations and transitions towards a more value-based and accountable reimbursement and delivery system. This panel will feature a discussion with leaders from the CMS Innovation Center (CMMI), the Agency for Healthcare Research and Quality (AHRQ), and the Office of the National Coordinator for Health Information Technology (ONC) on current opportunities to get assistance advancing the three-part aim of better healthcare, better health and reduced costs and increase access to care.

Core Questions:

- An ACO's success is partly dependent on its investment in certain core competencies, such as new care delivery processes, investments in health IT, community and patient outreach, enhanced primary care services and more. What financial and technical assistance opportunities are available to support providers in these efforts and investments?
- The necessary start-up costs will be difficult for many smaller, community, rural and safety net provider organizations. How can we ensure these organizations can continue to develop and provide high-quality care to underserved areas? *(not AHRQ, more Mai – seeking comment on the advanced payment proposal, another strain is to say ACOs are just one model and there are other models for other providers like these and the parameters will have to be different)*
- Working and complying with various different government agencies can be administratively burdensome for many organizations. How are your respective agencies trying to work together to ease this burden? How is the RWJF and other foundations trying to compliment the work of the federal government to help move in the direction of accountable care?
- Given the response to CMS' proposed rules for ACO formation and operation, what is your view of how and when we may see the development of new integrated care systems, and what will it take to make that happen?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 8: Funding ACO Start-Up Costs

10:45 am – 12:00 pm **Opportunities from the Private Sector**
Bob Kocher, MD, Guest Scholar, Engelberg Center for Health Care Reform, Brookings Institution; Principal and Director, Center for Health Reform, McKinsey *(Moderator)*

1. Richard Salmon, MD, PhD, Vice President and National Medical Executive, CIGNA
2. Jill H. Gordon, JD, MHA, Partner and Co chair, Health Law Group, Davis Wright Tremaine LLP
3. Steve Wiggins, MBA, Managing Director, Essex Woodlands
4. Peter Long, PhD, President and Chief Executive Officer, Blue Shield of California Foundation

Panel Overview:
A successful ACO will require real clinical transformation with improved care coordination, a different business model, new health IT and payment systems, and a more concerted focus on value-driven health care based on the needs of their respective communities. This type of transformation will require considerable new investments and possibly new partnerships and relationships between different types of provider organizations, as well as with payers and suppliers. Many organizations have identified the costs of these investments and new relationships – both economic and organizational costs - to be one of the most significant barriers to implementing new care delivery and payment models. With an ACO's potential success dependent on where they fit into the value chain and who controls the ACO's funds, organizations will have to make investments and establish new relationships carefully and based on market specific information.

The focus of this panel will be on how to make these specific investment decisions and the various pathways available in the private sector to get financial support from outside investors and/or develop new relationships to help fund start-up costs that will ultimately be critical for sustaining a financially successful ACO. The panel will focus on both opportunities for larger systems, as well as smaller, community-based providers – and how some of these entities (larger health care systems and community providers) might be able to start working together.

Core Questions:

- What factors should an organization consider when trying to decide whether an ACO is a worthwhile investment for them? How will this decision matrix change for primary care groups vs. multispecialty groups vs. integrated delivery systems? How do they evaluate where they fit in the value chain in relation to their competitors?
- Are there certain essential investments that the majority of aspiring ACOs will need to make (for example, in health IT)? If so, how much investment can they hope to recoup through future ACO savings? Are there other opportunities for organizations to find financial support for these needed new investments?
- To improve care coordination and identify financial support for meaningful care transformation, hospitals, physician groups, and other organizations are looking to develop new partnerships or relationships. How should organizations approach and evaluate these potential new relationships in an ACO context (especially between physician groups and hospitals)?
- What are some possible strategies for providers and payers to better understand and deliver tailored services to these differing patient populations?
- In an ACO forming between providers and a commercial payer, what type of support should private payers be offering to enhance care coordination and improve data sharing?
- What type of support is available for ACOs looking to target these types of communities? Is there a sustainable pathway for larger health systems to partner with community providers in rural and/or underserved areas?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 9: Fostering Better Care Coordination

1:30 pm – 3:00 pm **Fostering Better Care Coordination**
Susan Dentzer, MA, Editor-in-Chief, *Health Affairs*; Health Policy Analyst, *The News Hour with Jim Lehrer, (Moderator)*

1. Brenda Bruns, MD, Executive Medical Director, Health Plan Division, Group Health Cooperative
2. David Gifford, MD, MPH, Senior Vice President of Quality and Regulatory Affairs, AHCA/NCAL
3. Bruce Leff, MD, Professor of Medicine, School of Medicine; Faculty, Lipitz Center for Integrated Care; Bloomberg School of Public Health, The Johns Hopkins University
4. Mary Naylor, PhD, FAAN, RN, Marian S. Ware Professor in Gerontology, Director, NewCourtland Center for Transitions in Health, School of Nursing, University of Pennsylvania
5. Gene Nelson, D.Sc., MPH, Professor of Community and Family Medicine, Dartmouth Medical School; Senior Faculty Member, Center for Leadership and Improvement, The Dartmouth Institute for Health Policy and Clinical Practice

Panel Overview:
Care coordination is a fundamental property of all healthcare systems but successfully coordinating care will be especially critical in the ACO model where providers are held accountable for total cost and quality of patient care. Accomplishing this will require the use of health IT, smooth management of care transitions (e.g. hospital to home care, use of skilled nursing, in-home support services, etc.) that call for substantial resources. Various organizations have found ways to dramatically improve care coordination, and this panel will address these issues by drawing on the experiences and lessons learned from each of the panelists.

Panelists will share examples of a range of models that have proven to improve care coordination. Examples will include strategies to successful impact provider utilization patterns and methods to coordinate care across the care continuum. There will be a special focus on elderly patients with multiple chronic conditions and the transitions and coordination strategies needed to care for this cohort of patients.

Core Questions:
- What are some of the drivers and necessary building blocks to achieving higher value care coordination? What are the unique challenges facing care coordination for elderly and frail patients?
- How do you engage clinical leadership to enable changes in culture and clinical coordination? How do you engage health plans to facilitate dedicated care coordination for high-risk patients?
- What have you found problematic or effective for successful interventions?
- What assistance or support do providers need to be able to scale and expand care coordination models? How can ACOs help support and advance new innovative models?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 10: Other Providers Helping to Support ACOs

1:30 pm – 3:00 pm **Other Providers Helping to Support ACOs**
Cary Sennett, MD, PhD, Fellow, Economic Studies and Managing Director for Health Care Finance Reform, Engelberg Center for Health Care Reform, The Brookings Institution *(Moderator)*

1. Troy Brennan, MD, Executive Vice President, Chief Medical Officer, CVS Caremark
2. Ralph Brindis, MD, MPH, FACC, Regional Senior Advisor for Cardiovascular Diseases for Kaiser Permanente; Immediate Past President, American College of Cardiology
3. Sheila Johnson, RN, MBA, Director, Clinical Services, Dartmouth-Hitchcock Clinic
4. Neil Kurtz, MD, President and CEO, Golden Living
5. James Crawford, MD, PhD, Senior Vice President, Laboratory Services, North Shore-LIJ Health System

Panel Overview:
While the proposed rule for the Medicare Shared Savings Program emphasizes the centrality of primary care physicians and hospitals, there seems little doubt that improvements in the quality and cost-effectiveness of care will require the meaningful participation of many other providers. This panel will explore the issues and opportunities that face other providers—including nurses, long-term care providers, pharmacists and those who manage pharmacy benefits, specialist physicians and data vendors. Panelists will highlight the importance of developing infrastructure and data flows necessary to align a wide-range of providers and coordinate care, improving medication management and creating strategies for payers who will need to support at-risk providers.

Core Questions:

- What incentives exist—and what need to exist—in order to maximize the opportunities for providers to work together across the full continuum of care, including specialist, post-acute providers, pharmacists, data vendors and others?
- One can imagine "other" providers working with ACOs as suppliers—or as partners? Which makes more sense (and what needs to happen to make it easy for "other" providers to work this way)?
- How will the roles of "other" providers change in an accountable marketplace? Are there new opportunities to create value? Are there opportunities to monetize those/new services (or service lines) to be offered?
- Information needs to flow through the ACO and its supply chain. What needs to happen to assure connectivity? To allow data to flow across the continuum of care? To enable the construction and use—by all participants—of a patient-centered medical record?

The National ACO Summit (Day 2)
Tuesday, June 28, 2011
Track 11: Patient Notification in ACOs

1:30 pm - 3:00 pm **Notifying ACO Beneficiaries**
Kalahn Taylor-Clark, PhD, MPH Research Director and Director, Patient-Centeredness Portfolio, Engelberg Center for Health Care Reform *(Moderator)*

1. Kirsten Sloan, Vice President, National Partnership for Women and Families
2. Jennifer Jackman, Senior Vice President of Accountable Care, Monarch Healthcare
3. Nora Super, MPA, Chief Healthcare, Lobbyist, AARP
4. Walton Francis, Economist and Policy Analyst; Consultant, Centers for Medicare and Medicaid Services

Panel Overview:
Consumer engagement is one of the most critical health reform issues to address as we work to implement accountable care. To be sure, a well-balanced ACO will ensure value-add to existing coverage for consumers while maintaining patient choice. Still, engaging consumers and providing information on their status and benefits in an ACO in a way that is easy for them to understand will be essential to an effective accountable care design. In this panel, we will discuss specific strategies for engaging consumers and notifying them of their status and protections in an ACO.

Core Questions:
- Broadly, what are the main strategies for ensuring consumer engagement in ACOs?
- What is the role of various stakeholders, including CMS, ACOs, and providers, in notifying beneficiaries of their status in an ACO?
- What are key messages that each stakeholder should consider when notifying beneficiaries of their status in an ACO?
- How might prospective versus retrospective assignment of patients affect how patients are notified of their status in an ACO?