

NATIONAL ACCOUNTABLE CARE ORGANIZATION SUMMIT

Ritz-Carlton Hotel, 1150 22nd Street, NW, Washington, DC

June 7 - 9, 2010

Panel Briefs

The briefs that follow offer high-level summaries of the key issues to be covered in each panel, as well as some of the core questions that will be addressed during the moderated Q&A portion of the panel discussions.

DAY 1: Monday, June 7, 2010

The core aims of Day 1 are to clearly define the guiding principles of accountable care organizations (ACOs), summarize the practical experiences with ACO-like models, and outline a clear set of questions and remaining issues about how to expand these early models into a national ACO implementation strategy. These discussions will help inform the rest of the conference agenda.

- 2:00 p.m. – 3:00 p.m. [Early Experiences with ACOs as a Foundation for Broader Testing](#)
- 3:30 p.m. – 4:30 p.m. [Can Accountable Care Reforms Work in Other Environments?](#)
- 4:30 p.m. – 5:45 p.m. [Core Questions for Successful ACO Implementation](#)

DAY 2: Tuesday, June 8, 2010

Conference activities will focus on addressing key questions and remaining issues about ACOs identified in Day 1, including: interactions between ACOs and other reforms, performance measurement and reporting, payment models, operational tools and strategies, models of clinical transformation, and governance and legal issues related to starting an ACO.

- 8:15 a.m. – 9:30 a.m. [Interactions between ACOs and Other Reforms](#)
- 9:30 a.m. – 10:30 a.m. [Performance Measurement and Reporting](#)
- 11:00 a.m. – 12:15 p.m. [ACO Payment Models](#)
- 1:30 p.m. – 2:30 p.m. [ACO Operational Tools and Strategies](#)
- 2:30 p.m. – 3:30 p.m. [Models of Clinical Transformation in ACOs](#)
- 4:00 p.m. – 5:15 p.m. [ACO Governance and Legal Issues](#)

DAY 3: Wednesday, June 9, 2010

The day's events will focus on ACOs from a government policy perspective, as well as discuss the future of the ACO and dissemination strategies.

- 9:00 a.m. – 10:15 a.m. [Next Steps on ACOs – The View from Washington](#)
- 11:00 a.m. – 12:00 p.m. [Response Panel: Next Steps on ACOs – The Way Forward](#)

DAY 1: Monday, June 7, 2010

2:00 p.m. Early Experiences with ACOs as a Foundation for Broader Testing

Mark McClellan, *Director, Engelberg Center for Health Care Reform at Brookings (Moderator)*

Allen Dobson, *Vice President, Carolinas Healthcare System*

J. Marc Overhage, *President and CEO, Indiana Health Information Exchange*

Edward G. Murphy, *President and CEO, Carilion Clinic*

John Pilotte, *Director, Division of Payment Policy Demonstrations Medicare Demonstration Program Group, Office of Research, Development and Information, Centers for Medicare & Medicaid Services*

Overview:

In response to decades of rising health care costs without corresponding improvements in the quality of care, policymakers, providers, and payers across the country have been working to develop reform models that “bend the cost curve” and reward high quality and efficient care. Several past and ongoing demonstrations are using shared savings as a way of altering the health care system’s perverse payment incentivizes.

One such demonstration is the Physician Group Practice (PGP) demonstration (implemented in 2005). In this demonstration, 10 large physician group practices were selected by the Centers for Medicare & Medicaid Services (CMS) to test whether incentivizing care management through a shared savings payment model would lead to cost savings and quality improvement for Medicare beneficiaries. Under this payment model, provider groups continue to receive fee-for-service payments (FFS), but are eligible for additional payments if they are able to slow the growth of Medicare spending relative to the local market while also improving quality. The CMS Medicare Health Care Quality (MHCQ) Demonstration (implemented in 2009) builds on the PGP demonstration by testing a similar payment and quality improvement model in multi-stakeholder organizations, rather than only highly integrated physician group practices. Like the PGP demonstration, participating sites are eligible to share in savings achieved by improving care and reducing costs for Medicare beneficiaries and, in the case of one MHCQ demonstration site, the dually eligible.

The Brookings-Dartmouth Accountable Care Organization (ACO) Learning Collaborative has been working with pilot sites to develop and test ACOs and shared savings payment models with multiple payers, as well as to disseminate lessons learned for these sites through the Brookings-Dartmouth ACO Learning Network. With the passage of health care reform, other collaborative efforts to advance the ACO model are also beginning. As ACOs are implemented under both private and public payers, including through the Medicare Shared Savings Program, it will be critical to learn from both the successes and limitations of past and ongoing attempts at using shared savings to promote efficient and quality health care.

Core Questions:

- What lessons can we draw from the development, implementation, and early results of the PGP demonstration and the more recent implementation of the MHCQ demonstrations?
- What are some of the initial technical and implementation challenges of previous shared savings efforts and how can these challenges be addressed in the future implementation of ACOs?
- How can we ensure that the lessons learned for past and ongoing ACO demonstrations are disseminated and available to providers, payers, purchasers, policymakers, and consumers across the country?

DAY 1: Monday, June 7, 2010

3:30 p.m. Can Accountable Care Reforms Work in Other Environments?

John M. Bertko, *Visiting Scholar, The Brookings Institution (Moderator)*

Meredith B. Rosenthal, *Associate Professor, Health Economics and Policy, Harvard School of Public Health*

Francis "Jay" Crosson, *Associate Executive Director, The Permanente Medical Group*

Craig McKnight, *Senior Vice President and CFO, Phoenix Children's Hospital*

Overview:

The goal of an accountable care organization (ACO) is to support improvements and investments in care quality through the possibility of shared savings and bonus payments. Early efforts at establishing formal shared savings payment programs have focused primarily on highly integrated and established provider groups. For example, the Centers for Medicare & Medicaid Services (CMS) implemented the Physician Group Practice (PGP) demonstration, focusing on larger, physician group practices, to test whether shared savings models would work in an environment where there is the greatest chance of success. More recently, CMS implemented the Medicare Health Care Quality (MHCQ) Demonstration, which builds on the PGP Demonstration by testing a similar shared savings model in multi-stakeholder organizations that can but are not required to include physician group practices.

Given the fragmentation of the health care system and the heterogeneity in the size, organizational structure, and market environments of different provider, purchaser, and payer arrangements around the country, it is critical that future shared savings payment models, including ACOs, adopt a flexible approach that supports broad participation by a wide range of providers. For example, while ACOs can be integrated delivery systems, they can also be organized in a number of provider configurations, including individual practice associations, regional collaborations, and both "real" and "virtually" integrated provider groups. They may also involve non-traditional health providers, such as public health and wellness programs with different payer participants. Recent experiences and pilot projects with ACO-like models in a range of provider settings in California suggest promise for ACOs in a variety of other provider configurations.

Testing shared savings payment structures such as ACOs among a broader range of provider organizations will not only offer the greatest opportunity for reducing the financial strain on our nation's health system, but will also provide opportunities to gather more evidence on what types of reform approaches are most effective and under what conditions. ACOs are designed to work under a range of payment models, from the traditional fee-for-service model to different pay-for-performance arrangements and capitated models. However, ACOs will likely change the relationship between different provider groups and will require new management structures to navigate these new relationships. Successful ACO implementation will require addressing a number of challenges, including: how to ensure high quality care while reducing costs, how to establish specific baseline functional capabilities and infrastructure requirements, and how to encourage broad participation in market environments where market power is unevenly distributed.

Core Questions:

- What is the minimum organizational effort that is needed to have a successful ACO effort? How many primary care providers (PCPs), medical specialists, surgical specialists, hospitals, and other providers need to participate in an ACO to make it effective?
- What specific baseline functional capabilities and infrastructure should be required of ACOs? At the start? After two years?
- What criteria should be used to evaluate ACOs in a range of different provider configurations or market environments?
- How can providers and payers take advantage of existing infrastructures and relationships to form ACOs? Are there specific organizational models that are particularly suited for developing

- How can we encourage broad participation in ACOs in market environments where one party (e.g., provider systems or one dominant payer) may have significantly more market power than the other? What other "powers" or regulatory functions are needed? Can employer coalitions help?
- What are the challenges and advantages for forming an ACO for academic medical centers? How do certain hospitals, such as children's hospitals, fit in?

DAY 1: Monday, June 7, 2010

4:30 p.m. Core Questions for Successful ACO Implementation

Elliott S. Fisher, *Director, Center for Population Health, The Dartmouth Institute for Health Policy and Clinical Practice (Moderator)*

Robert S. Galvin, *Director, Global Healthcare, General Electric Company*

Sabrina Corlette, *Director, Health Policy Programs, National Partnership for Women and Families*

Susan D. DeVore, *President and CEO, Premier, Inc.*

Don Lorton, *Executive Vice President and CFO, Carilion Clinic*

Overview:

Accountable care organizations (ACOs) have the potential to change the health care system in favor of a coordinated, accountable, efficient, and patient-centered system. Implemented correctly, ACOs could help realign payments away from volume and intensity towards quality and efficiency. However, to deliver on this potential, providers and payers must surmount a series of challenges to successfully transform the health system's culture and practice. With the creation of the Medicare Shared Savings Program through the Patient Protection and Affordable Care Act (PPACA), identifying and addressing these challenges has become even more pressing.

Many challenges and questions remain regarding how to implement a successful ACO. Some challenges identified in early ACO-like models in Medicare and through the Brookings-Dartmouth ACO Pilot Project include identifying the most effective governance and organizational structures, gaining support from key stakeholders, establishing the necessary data capabilities, addressing legal concerns, ensuring quality of care, negotiating contracts, and choosing a shared savings model. As ACOs become more widespread and adopted by a wider range of provider groups, patients will need to be aware of the dual purpose of ACOs to not only encourage cost containment but also incentivize high quality care. It will also be important to carefully balance the potential for more efficient care from increased care coordination with the risk of physician and hospital consolidation leading to price inflation and less affordable health care. Furthermore, it will be critical to identify the numerous other payment and care delivery reforms (including bundled payments, the patient-centered medical home, and other reforms that will be supported through the Center for Medicare & Medicaid Innovation) that can work in conjunction with ACOs to support care quality improvements. Thoughtfully and thoroughly addressing these and many other questions will help ensure that ACOs to have the opportunity to encourage higher quality and more efficient care.

Core Questions:

- What core elements of a health care system contribute to the success of an ACO? How can these elements be assessed to find the degree of readiness? How can we best evaluate what core elements contribute to an ACO's success?
- What operational steps can health systems take to move providers toward a culture of team-based, rather than fragmented care? How can a health system align physician incentives within the ACO to increase the likelihood of success?
- How can providers develop relationships with multiple payers while limiting the ability of payers to use the ACO as a competitive advantage? What role should state and federal regulators play?
- What data capabilities are necessary to gather the performance and financial information essential to ACO implementation? What data should the providers and payers produce?
- How can an ACO engage patients, purchasers, and communities in the model? How can payers and providers develop a working relationship that will keep the community's best interests in mind? What do ACOs need to do to enhance patient outcomes and experiences so that patients are motivated to stay within the ACO?

- What qualifying criteria should be required before a group of providers can be considered an ACO? What ongoing monitoring criteria should be required, and what quality thresholds met, before an ACO can receive any shared savings or other bonus payments?
- What kinds of financial modeling need to be done? By the hospital partner? By the physician group partners?

DAY 2: Tuesday, June 8, 2010

8:15 a.m. Interactions between ACOs and Other Reforms

Mark McClellan (*Moderator*)

Francois de Brantes, *CEO, Bridges to Excellence*

Stephen M. Shortell, *Dean, School of Public Health, University of California at Berkeley*

Peter Basch, *Senior Fellow, Center for American Progress; Medical Director, Ambulatory EHR and Health IT Policy, MedStar Health*

Overview:

While accountable care organizations (ACOs) try to realign the payment incentives in the health care system to reward quality and efficiency, they will need to work in tandem with other reforms in order to achieve these goals. Several reforms in particular have real potential to work in conjunction with ACOs to “bend the cost curve” and improve care, including health information technology (IT) infrastructure, bundled payments, and the patient-centered medical home.

For example, the American Recovery and Reinvestment Act (ARRA) of 2009 will appropriate \$29 billion in Medicare and Medicaid payments to hospitals and physicians by 2016 to support the meaningful use of health IT. Measures used in ACOs would be supported by such enhanced use of health IT, which would facilitate better coordination of care and other cost-saving, quality-improving measures. Infrastructure improvements in health IT could also allow sites to access real time feedback with regard to the effectiveness of specific reforms in improving care.

Bundled payment programs, which compensate providers with a single payment for each episode or condition they treat, represent a potentially complementary reform that can help ACOs manage care and transfer pricing, as well as align internal incentives. The goal of bundled payments is to encourage health care providers to deliver more efficient care by having them assume financial risk for the cost of their services. ACOs could also be supported by the implementation of patient-centered medical homes, which provide additional monthly payments to primary care providers who take additional steps to support prevention, disease management, and care coordination. Better management and prevention of chronic conditions could lead to greater savings for ACOs.

Implementing these complementary reforms could help support and enhance the success of ACOs; similarly, the implementation of shared savings models under ACOs will be critical in helping to ensure the long-term effectiveness and financial sustainability of these other reforms. However, the successful implementation of these complementary reforms will require some upfront investments. While recent legislation, including the ARRA and the Patient Protection and Affordable Care Act (PPACA), provides some upfront funding, additional thought is needed on how to financially support these reforms in the short-term.

Core Questions:

- How does the ACO complement other reform models? And vice versa? Are there certain reform models that would not work within an ACO?
- Does PPACA support groups attempting to implement multiple reforms simultaneously? Conversely, if an ACO participates in the Medicare Shared Savings Program, will they be restricted from receiving government support for other reforms?
- How can a shared savings payment model help to ensure that infrastructure and care delivery investments are effective and sustainable?

DAY 2: Tuesday, June 8, 2010

9:30 a.m. Performance Measurement and Reporting

Elliott Fisher (*Moderator*)

Chris Queram, *President and Chief Executive Officer, Wisconsin Collaborative for Healthcare Quality*

Steve Findlay, *Senior Health Policy Analyst, Consumers Union*

Tom Williams, *Executive Director, Integrated Healthcare Association*

Joachim Roski, *Managing Director, High-Value Health Care Project, Engelberg Center for Health Care Reform at Brookings*

Overview:

Measuring and publicly reporting performance is a cornerstone of accountable care organizations (ACOs). To reduce costly errors, and to improve the quality of care delivered to patients, providers in an ACO are accountable for a patient's entire episode of care, and for all of the care that patient receives – whether the care is delivered within or outside of the ACO. To ensure this accountability, providers will need to be measured on an agreed-upon set of performance standards that focus on the necessary details of implementation, as even small differences in measures can lead to non-comparable results. In addition, ACOs must meet the performance targets in order to receive shared savings. This creates incentives for individual providers within the ACO to meet these quality targets in order to participate in the ACO and obtain their portion of shared savings, as well as to motivate improved care delivery. Performance measurement will also help reassure patients that ACOs are not only a vehicle for cost containment, but also a method for improving and rewarding high quality care.

As ACOs develop, it will be important to take a practical focus to performance measurement and concentrate on implementing a standard set of “starter” measures. Given the current limited capacity of most systems to gather performance information, these standards may initially include only claims-based measures that are already collected by health systems. However, as ACOs progress over time, more comprehensive performance measures will need to be developed that encompass patients' experiences of care, health outcomes, and health status. The adoption and continued development of health information technology (IT) also will be crucial in supporting more comprehensive performance measurement. And the development of agreed upon national performance measures, obtainable with a reasonable level of health IT capability, will help promote quality performance measurement in ACOs, and, in turn, create positive incentives for providers and empower patients.

Core Questions:

- How does the importance of performance measurement differ among consumers, payers, and providers? What goals should performance measurement serve?
- What level of health IT sophistication is required for adequate performance measurement? How will this affect the potential development of consistent, national measures?
- How can ACOs tie performance measurement to shared savings for individual providers? Inside the ACO, should providers be measured in pods (or practices)? If so, how big should these pods be to ensure provider engagement? Is it necessary to tie performance measures to provider payments in the ACO?
- Do we need to measure quality across several payers in order to have sufficient numbers of events to be statistically valid?
- What performance measures are the Brookings-Dartmouth pilot sites aiming for in future years of the ACO?
- How quickly can we be ready to move beyond claims data as a method of calculating performance for a national program?
- How can an ACO incorporate patient reported data, including patient experience surveys, quality of life measures, and functional health status reports?
- Should an ACO provide performance reports first privately to providers before sharing its performance reports with the public community?

DAY 2: Tuesday, June 8, 2010

11:00 a.m. ACO Payment Models

Steven M. Lieberman (*Moderator*)

Stuart Guterman, *Assistant Vice President and Director, Program on Payment System Reform, The Commonwealth Fund*

Thomas B. Bradley, *Unit Chief, Health Systems and Medicare Cost Estimates Unit, Congressional Budget Office*

Steve Hester, *Senior Vice President and Chief Medical Officer, Norton Healthcare*

Noah D. Rosenberg, *Partner, Rosenberg and Kaplan*

Harold Miller, *President and CEO, Network for Regional Healthcare Improvement*

Overview:

Provider payment methodologies can have a significant impact on the eventual success of any health care organization, including an accountable care organization (ACO). Yet, given that there is still limited evidence on which models are most effective in different market environments and under different provider configurations, ACOs should be encouraged to test a variety of different payment models.

Potential models could include “one-sided” or “asymmetric” payment models, which would allow ACOs to share in savings without any performance risk for exceeding spending benchmarks or failing to meet quality goals. Models could also include “two-sided” or “symmetric” payment models, which would provide ACOs with an opportunity to receive proportionately larger bonus payments in exchange for accountability for costs that exceed preset goals. Finally, advanced ACOs could adopt a range of “partial capitation” models, which would reduce the relative importance of fee-for-service (FFS) payments by replacing a portion of an ACO’s FFS payments with capitated payments and issuing bonuses or penalties based on whether the ACO met budget and quality benchmarks.

Flexibility is important for the ACO model so that a broad range of such models can evolve in different reform environments and under different provider arrangements. Also critical for a payment model’s sustainability and effectiveness is its ability to get buy-in from multiple payers. And perhaps most important to the long-term success of ACOs is the development of an overarching structure that supports the evolution of payment models from “one-sided” shared savings arrangements to models that promote more significant provider accountability and strengthen providers’ ability and incentives to deliver high-quality, cost-effective care in innovative ways.

Core Questions:

- Do ACOs need to be encouraged towards more complex payment (symmetric) models or can they achieve quality and efficiency goals with simpler payment (asymmetric) models? If so, how should the payment framework be developed to encourage ACOs to transition toward more sophisticated payment models that require greater accountability and drive the development and adoption of infrastructure and functional capabilities over time?
- How active of a role should the Centers for Medicare & Medicaid Services play in encouraging ACOs to take on greater accountability over time?
- What criteria should be used to evaluate whether an ACO has the necessary infrastructure and functional capabilities to transition toward a more advanced payment models?
- Given that some past experiences with capitation and physician-hospital collaborations failed in part due to lack of demonstrated provider capacity in handling risk and managing care effectively, what kinds of financial safeguards should be established to aid ACOs in managing risk (e.g., cap on maximum losses, full or partial reinsurance arrangements, withhold models)?

DAY 2: Tuesday, June 8, 2010

1:30 p.m. ACO Operational Tools and Strategies

Steven M. Lieberman (*Moderator*)

Eric T. Nielsen, *Chief Medical Officer, Greater Rochester IPA*

Kathryn V. Fitch, *Principal and Healthcare Management Consultant, Milliman*

Paul Katz, *CEO, Intelligent Healthcare LLC*

Mike Cracovaner, *CEO, New Pueblo Medicine*

Overview:

In order to achieve shared savings through improvements in care quality and reductions in cost, ACOs will need to adopt a number of new operational tools and strategies. The efficient care delivery required for a successful ACO can best be achieved through care coordination, integration, and care management strategies that are supported by an effective health information technology (IT) infrastructure that provides usable and timely data. By implementing health IT systems, data management and analytical tools can be put in place to monitor progress, evaluate performance against targets, and make real-time program adjustments based on these findings.

A solid health IT infrastructure with functioning data management systems can also help lead to more advanced care integration and coordination strategies, such as disease and utilization management and patient-centered medical homes. By creating an ACO, some organizations will be able to utilize and expand existing care strategies based on the new potential for shared savings. Effective management structures for ACOs should help align incentives for health care providers within an ACO and create tiered reimbursement structures and service line agreements to help achieve shared savings.

For most provider groups, building a health IT infrastructure, utilizing data analytics, and implementing care management strategies will require thoughtful planning and significant time and resource investments. It will be critical for aspiring ACOs to invest in the right and most cost effective health IT infrastructure based on their organizational structure and capabilities, as well as develop methods to finance the up-front costs of building this infrastructure. Furthermore, national dissemination of which strategies and tools best lead to share savings for differing care settings will be critical for ACOs to truly “bend the cost curve” and improve the quality of care.

Core Questions:

- What are the critical functional capabilities and infrastructure components that potential ACOs should consider developing? Which components should they buy versus rent? To what extent will these functional and infrastructure needs vary in differing care environments (e.g., rural versus urban areas)? What is the best way to ensure that the various operational tools and strategies are interoperable and support one another?
- Are there successful models of health IT, data analytic tools, or disease and utilization management programs that potential ACOs could model their efforts after, particularly those that are low-budget? What type of operational tools and strategies are available to engage the small primary care practices that may not have the capability of converting to electronic medical records or becoming patient centered medical homes?
- What avenues are available for potential ACOs to get financial support to develop necessary operational tools and infrastructure?
- How do you get independent – and often times competing – physician groups to work together to change their behavior and improve outcomes?
- Many of the avoidable episodes of care are also currently revenue streams to the hospital. How can an ACO use effective management strategies and operational tools to eliminate these avoidable costs without negatively impacting the hospital?

DAY 2: Tuesday, June 8, 2010

2:30 p.m. Models of Clinical Transformation in ACOs

Elliott Fisher (*Moderator*)

Carol Beasley, *Director of Strategic Projects, Institute for Healthcare Improvement*

Dogu Celebi, *Chief Medical Officer, Ingenix*

Donald H. Crane, *President and CEO, California Association of Physician Groups*

Mark Shields, *Senior Medical Director, Advocate Health Care*

Lewis Sandy, *Senior Vice President, UnitedHealth Group*

Overview:

In today's health care system efforts at clinical transformation are often met with resistance in a payment system that rewards volume and intensity rather than quality and efficiency. Still, some health systems have developed innovative means to increase the quality and efficiency of patient care. In *Checklist Manifesto*, Atul Gawande tracks the simple efficiency of a checklist in improving delivered care and decreasing the rate of infections and readmissions. Similarly, many health systems have turned to a system of comparative effectiveness research in which hospitals gather data on the effectiveness of care to encourage providers to adopt more effective treatments and care patterns.

For an ACO to be successful it will need to engage in real clinical transformation that encourages clinical integration, tracks and better utilizes data to improve care and lower costs, changes patient's benefit designs, and moves away from a fee-for-service (FFS) payment system towards one that rewards higher performance. These changes will require real leadership from providers, purchasers, and payers, but especially from physicians and hospitals. There will also need to be new support for primary care doctors, a more concerted focus on engaging patients and their families, new relationships with community health centers, and an increased linking of health IT infrastructure to disease registries and other tools that enhance evidence-based treatment.

Despite these innovative efforts, the upfront costs of instituting such clinical transformations are high and providers lack the financial incentive to participate in the effort. ACOs try to address these clinical transformation challenges by offering shared savings to providers, so that health systems may be willing to invest the initial resources necessary to effectively transform clinical practice.

Core Questions:

- How can data feeds help identify areas needing improvement? How can a data warehouse be used to track improvement and areas of focus? What data systems/analytics need to be in place to aid clinical transformation?
- How can a health system learn from its peer hospital or medical group organizations?
- What are the best incentives to get providers to participate in clinical transformation efforts?
- How can ACOs realign financial incentives to maintain the integrity of health professions and institutions? What processes can an ACO put in place to increase patient accountability?
- How can ACOs encourage care by primary care physicians or the most appropriate provider?
- Is shared savings enough to get systems to invest in care transformations? Or will providers require additional upfront support? If so, where could that upfront support come from?

DAY 2: Tuesday, June 8, 2010

4:00 p.m. ACO Governance and Legal Issues

Douglas A. Hastings, *Chair, Board of Directors, Epstein Becker & Green, PC (Moderator)*
Robert Homchick, *Partner and Chair, Health Law Group, Davis Wright Tremaine LLP*
Chris Janney, *Partner, Health Care Group, Sonnenschein Nath & Rosenthal LLP*
Christi J. Braun, *Principal, Ober, Kaler, Grimes & Shriver*
David Narrow, *Staff Attorney, Federal Trade Commission*

Overview:

The creation of accountable care organizations (ACOs), both in response to Section 3022 of the Patient Protection and Affordable Care Act (PPACA) and in the private market, raises a variety of potential legal issues that could implicate the fraud and abuse laws (Stark, anti-kickback, and civil money penalty) and the antitrust laws (Sherman Act, Sections 1 and 2, Clayton Act, Section 7). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) also need to be taken into account when discussing the sharing of patient data between the different provider groups participating in ACOs. In addition, states have laws similar or related to the above that will require thought and attention when developing ACOs. Finally, ACO formation necessarily raises organizational, structural, and governance issues as providers seek to position themselves to succeed in the accountable care environment.

The policy goals of the PPACA clearly seek to move away from pure fee-for-service (FFS) medicine and to drive more coordinated and cost-efficient care. This will require greater collaboration among providers. It will also be a challenge for the regulatory community and the private sector to get the balance right when judging collaborative behavior – for example, distinguishing between a “good” collaboration that has led to streamlined clinical integration and more efficient care, and a “bad” one formed simply to manipulate price.

Under present law, some exceptions and safe harbors as well as past rulings by federal agencies can help guide ACO participants. Further, the PPACA grants the Health and Human Services Secretary the authority to waive the requirements of the Social Security Act of 1965 for programs operating under the new Medicare Shared Savings Program, specifically Sections 1128A and 1128B and Title XVIII. In order to ensure compliance with the various laws discussed above, ACOs will need to pay considerable attention to their structure and operations and be mindful of evolving enforcement trends in the months and years ahead.

Core Questions:

- Are there particular governance structures or legal precautions that all groups becoming ACOs should consider?
- How can shared savings be distributed to physicians in a way that does not violate the Stark law or the anti-kickback law?
- How can ACOs ensure that incentives to reduce unnecessary procedures do not violate the civil money penalty law?
- What are the actual and potential implications for ACOs (and competing health care providers wishing to get together to establish them) of the antitrust laws’ constraints on horizontal agreements/joint conduct by or among competitors?
- What are the implications for ACOs of the antitrust laws’ limitations on competitors coming together structurally through mergers and acquisitions?
- What issues must be addressed to ensure that patient data sharing practices between provider groups within an ACO are in compliance with HIPAA regulations?

DAY 3: Wednesday, June 9, 2010

9:00 a.m. Next Steps on ACOs – The View from Washington

Steve M. Lieberman (*Moderator*)

James Hester, *Director, Health Care Reform Commission, Vermont State Legislature*

Chris Dawe, *Professional Staff Member, Finance Committee, United States Senate*

Aaron McKethan, *Program Director, Beacon Community Cooperative Agreement Program,*

Office of the National Coordinator for Health IT, Department of Health and Human Services

Mark E. Miller, *Executive Director, Medicare Payment Advisory Commission*

Overview:

The recently-enacted health care reform legislation includes many provisions aimed at increasing accountability for health care quality and cost. Most directly, the law creates a Medicare Shared Savings Program, to be established by 2012, that will allow providers organized as Accountable Care Organizations (ACOs) to share in cost savings. The legislation authorizes the participation of a broader range of provider organizations than previously authorized under Medicare shared savings demonstrations (e.g., Physician Group Practice and Medicare Health Care Quality Demonstrations), as well as new evaluation methods. The law also authorizes a pediatric ACO demonstration project, similar to the Medicare Shared Savings Program, which allows pediatric medical providers organized as ACOs to receive incentive payments under Medicare.

Importantly, the legislation also establishes a Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare & Medicaid Services (CMS). This Center will have the authority to test a broad range of innovative payment and delivery system models that could work with ACOs to improve care quality and reduce costs. In addition, beyond the provisions mentioned above, the law includes many other programs that encourage accountability and support ACOs, including patient-centered medical homes and the hospital readmissions reduction program.

As the implementation of the legislation begins, CMS will need to ensure that provider groups across the country clearly understand the requirements and goals for ACOs set forth in health care reform law, while leaving them enough flexibility and autonomy to innovate. CMS will also need to help ensure that providers and payers understand how the Medicare Shared Savings program can work in tandem with private payers to improve care quality while reducing costs. As health care in the United States tries to move toward a system that rewards quality and value, continued support and guidance from both federal and state policymakers will be needed.

Core Questions:

- What is required in terms of information, processes, and timeline to determine whether ACOs are achieving positive results?
- How would we know if ACOs are having poor results?
- What is the appropriate balance between innovation (flexibility) and standards (requirements)?
- What additional actions (if any) should either Congress or CMS take over the next 18 months (i.e., before 2012)? Should CMS support private sector ACO initiatives? If so, how can CMS best support private payer ACO initiatives? Does CMS have sufficient resources to support a large ACO commitment for Medicare?

DAY 3: Wednesday, June 9, 2010

11:00 a.m. Response Panel: Next Steps on ACOs – The Way Forward

Elliott S. Fisher and Mark McClellan (*Co-Moderators*)

Ann Robinow, *Founder and Former President, Patient Choice Healthcare Inc.*

Sam Nussbaum, *Executive Vice President, Clinical Health Policy, WellPoint*

Frank A. Johnson, *Executive Director, Maine Division of Employee Health & Benefits*

Joel T. Allison, *President and CEO, Baylor Health Care System*

Bart Asner, *CEO, Monarch Healthcare*

Overview:

The passage of national health reform legislation was the key step in reforming our health care system; successfully implementing the reforms that encourage quality and lower costs is the next challenge. If implemented correctly, accountable care organizations (ACOs) could help realign the current payment system away from rewarding volume and intensity, and towards performance and efficiency. Even before the health care reform legislation, ACOs were emerging as a promising payment reform model for a wide range of provider groups. Now, with health care legislation creating the Medicare Shared Savings Program in 2012, ACOs could play a leading role in realigning payment incentives for both public and private payers.

The next steps for promoting accountability for the quality and cost of health care will require addressing several critical issues. For an ACO to be able to effectively improve the quality of patient care, it will need a critical mass of participating providers, payers, and patients. As an ACO incorporates these providers and patients, however, they will need to consider legal and regulatory issues, especially those surrounding anti-trust and the sharing of patient data. The providers forming an ACO will also require real clinical transformation that may require considerable up-front financial and technical support, as well as data systems that digitally integrate care across providers, and accurately track performance measures relating to both quality and budgeting. Finally, the creation of an ACO may change the nature of relationships between stakeholders in the health care system – most notably between hospitals and physicians – requiring leadership from across the health care system. While each ACO must address their own unique set of local issues, many best practices do exist across the continuum of ACOs that, if properly disseminated, could help spread the model of accountable care across the country, bend the cost curve, and improve the quality of care.

The implementation of a successful ACO that earns shared savings for lowered costs and increased quality will require technical assistance, support for clinical transformation, and an open exchange of best practices. With national leadership and support, as well as additional research, ACOs have real potential to start reforming financial incentives to reward quality and efficiency.

Core Questions:

- How can we ensure that ACO best practices are quickly evaluated and disseminated?
- What types of technical assistance, support for clinical transformation, and information exchange around best practices will potential ACOs need for successful implementation?
- How will providers, public and private payers, the government, and other stakeholders move forward *together* to bring accountability into our health care system?