



ACCOUNTABLE CARE STRATEGIES

LESSONS FROM THE PREMIER HEALTH CARE ALLIANCE'S
ACCOUNTABLE CARE COLLABORATIVE

Amanda J. Forster, Blair G. Childs, Joseph F.
Damore, Susan D. DeVore, Eugene A. Kroch,
and Danielle A. Lloyd

Premier Research Institute

AUGUST 2012

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Abstract: Accountable care organizations (ACOs)—groups of providers that agree to take collective responsibility for delivering and coordinating care for a designated population—are being promoted as a means to improve health and health care while containing costs. This report shares the perspectives of hospitals and health systems taking part in the Premier health care alliance's accountable care implementation collaborative. Lessons emerging from the collaborative relate to the need for ACOs to have certain core structural components; the viability of different organizational models; the importance of people-centered care in all interactions; the need to align business with value-based payments and design incentives to encourage providers to collaborate; the use of financial modeling to assess the impacts of the accountable care model; the need for investments in information technology to enable care coordination; and the importance of performance assessment across a broad range of clinical quality, efficiency, and satisfaction measures.

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EXECUTIVE SUMMARY

To contain spiraling health care costs, expand access to care, promote wellness, and improve outcomes, the nation's health care providers must work together and be held accountable for their performance. U.S. health care costs have been growing at an unsustainable rate, reaching an estimated 17.3 percent of the gross domestic product in 2009, according to the Centers for Medicare and Medicaid Services (CMS). Yet even with these high costs, consumers do not get as much value for health care spending as those in other nations, as there continue to be gaps and inequities in the quality of health care delivered nationwide.

The nation's quality and cost problems are rooted in the dominant fee-for-service payment system, which has created a health care "production" model driven by volume and based on incentives to do more, rather than to do better. At the same time, incentives reward bad outcomes, as "curing" the harm from a medical error or a preventable readmission earns additional payment. One of the most promising strategies for improvement is the creation of accountable care organizations (ACOs), in which providers take responsibility for a defined population, coordinate care across settings, and are held to benchmark levels of quality and cost. Unlike some previous delivery system reforms, ACOs seek to balance cost control with efforts to improve outcomes and enhance people's satisfaction.

While much attention has been paid to the public policy around ACOs, there has been less focus on the health care organizations and private payers that are building, testing, and bringing to scale new models of care delivery, including ACOs. To develop an ACO model that can be replicated for both public and private payers across many hospitals, health systems, and physician practices, Premier, a national performance improvement alliance of 2,600 U.S. hospitals and 84,000 other health care sites, launched an accountable care implementation collaborative in May 2010. This report provides an overview of ACOs and strategies for their implementation based on the perspectives of hospital and health system members participating in

the collaborative. Several lessons emerged from the collaborative:

- **Six core structural components are needed to implement an effective ACO**, including: 1) a commitment to providing care that puts people at the center of all clinical decision-making, 2) a health home that provides primary and preventive care, 3) population health and data management capabilities, 4) a provider network that delivers top outcomes at a reduced cost, 5) an established ACO governance structure, and 6) payer partnership arrangements. These components go well beyond those detailed in the Affordable Care Act or the Medicare Shared Savings Program. In essence, the Shared Savings Program creates partnerships between a group of providers operating as an ACO and CMS—just one of the elements necessary to deliver integrated care.
- **Many different organizational models could work for ACOs.** It is not necessary for a clinically integrated provider network—and, by extension, an ACO—to be a single, co-owned legal entity comprising physicians and/or hospitals, whether under the Shared Savings Program or in the private sector. Instead, accountability can be achieved through a network of coordinated relationships that fall short of corporate integration. A collaborative arrangement based on contractual relationships among the ACOs owners and provider participants is an acceptable model for an ACO.
- **People-centered care entails more than coordination; it takes into account individuals' experiences at every point at which they interact with the ACO.** ACO leaders must monitor care experiences from the individuals' perspective and be willing to address shortcomings. ACOs must communicate effectively with people, help them manage their conditions, and empower them to use nontraditional means of accessing care, such as remote monitoring of health status, telemedicine, and online portals that include personal health records.

- **To maximize potential to control costs and improve value, it is critical for an ACO to align as much of its business as possible with value-based payments.** Many organizations pursuing accountable care are already participating in alternative payment mechanisms in the private sector, albeit on a limited scale. Working under two different payment systems creates parallel business models—one based on shared savings incentives that reward value and another (the traditional fee-for-service approach) that mainly rewards volume. Aligning Medicare and private-sector payment models, to the extent possible, also will create synergies that facilitate transitions to value-based payments.
- **ACO leaders need to design incentives that encourage providers to work together to deliver effective, efficient care—avoiding unintended consequences that could lead to suboptimal outcomes.** For example, many compensation systems are based on production. In an ACO, physicians will need to be rewarded for productivity, and also given incentives to deliver high-quality care based on predefined measures. Ultimately, compensation systems need to be determined based on the makeup of the physician population, the relationships that exist between providers and payers, and other local factors. Leaders should explore these issues in collaboration with the physicians who will have to work under the new payment structure, and allow them to influence the approach.
- **To ensure adequate funding, ACO planners need financial modeling capabilities to assess the economic impact associated with a system-wide transition to accountable care.** Leaders must have access to resources such as operating cash flow, redistribution of existing capital investments, or external funding to effectively operate and manage the ACO. Financial modeling analyses help providers set appropriate targets for short- and long-term budgets, investments, and other financial needs as they make the transition from fee-for-service to value-based payments. Equally important, financial modeling is essential to evaluate various payment options, including the two Shared Savings Program tracks, capitated payments offered through the CMS Innovation Center, and private payer arrangements.
- **ACOs require an extensive investment in information technology to improve care coordination and prevent duplication of efforts.** However, few providers have developed population health data management capabilities, or have used information technology to streamline and improve the clinical and administrative aspects of care. To succeed as ACOs, providers need seamless care coordination with sophisticated population health status measurement capabilities that will improve health status and reduce overall costs.
- **ACOs must be able to measure and assess their performance on a broad range of clinical quality, efficiency, and patient satisfaction measures.** ACOs typically require de-identified and aggregated reports including data on utilization of services, patient demographics, financial performance, quality scores, and other relevant metrics at least quarterly. Moreover, individual encounter records must be linked across the continuum of service settings to conduct predictive modeling, appropriately target services, evaluate providers' performance in meeting quality targets, and determine interventions that may be required in the near term. But such performance reports are often massive in size and scope. ACOs will need to develop reports in formats that cull through the “noise” to find the relevant information and present it in a digestible and actionable format.

ACCOUNTABLE CARE STRATEGIES: LESSONS FROM THE PREMIER HEALTH CARE ALLIANCE'S ACCOUNTABLE CARE COLLABORATIVE

THE NEED FOR ACCOUNTABLE CARE

To contain spiraling health care costs, expand access to care, promote wellness, and improve outcomes, the nation's health care providers must work together and be held accountable for their performance. Health care costs have been growing at an unsustainable rate, reaching an estimated 17.3 percent of the gross domestic product in 2009, according to the Centers for Medicare and Medicaid Services (CMS).¹ Over the long term, this has had damaging effects, including insurance premium increases that have been growing nearly three times faster than wages.² Yet even with these high costs, research shows that the United States does not get as much value for health care spending as do other nations. There continue to be gaps and inequities in the quality of health care delivered nationwide, as documented by Web sites such as WhyNotTheBest.org.³

The nation's cost and quality problems are rooted in the dominant fee-for-service payment model. Under this model, physicians are paid according to

the number of office visits, tests, or procedures they perform—leading to a health care “production” model driven by volume and based on perverse incentives: the more services consumed, and the more intense those services are, the higher the payments, regardless of the outcomes. The result is a system that pays for:

- more consumption, rather than better outcomes; and
- treatment of illnesses, rather than a culture of wellness.

Such misaligned incentives do more than just run up health care spending. A 2005 article in the *Washington Post* found that hospitals and physicians that provide poor care or harm patients during treatment receive higher payments than those with better outcomes.⁴ This is because treating the negative outcomes of poor care or harm often earns providers additional payment.

Further, various providers often fail to communicate with each other and coordinate care. This can lead to unnecessary or redundant procedures, for example when individuals' health records or medical histories are unavailable to support decision-making. For their part, consumers may not understand how to navigate the health care system or how to care for themselves. Moreover, many believe that more care

EXHIBIT 1. ATTRIBUTES OF ACCOUNTABLE CARE

- ✓ Provider-led
- ✓ Providers and payers co-own responsibility for the cost and quality of care provided to a defined population; shifts both rewards and risks to aligned, integrated care systems
- ✓ Population attribution to ACOs, with opt-outs and choice
- ✓ Health engagement/wellness initiatives that are tailored to the individual
- ✓ Diverse group of providers, including hospitals, specialists, primary care, and postacute care, that can coordinate across settings
- ✓ Robust health information technology infrastructure and performance measurement capacity
- ✓ Providers and payers share population-based data on a timely basis
- ✓ Long-term partnerships with a range of payment options

is better, though the evidence often demonstrates otherwise.

A first step to promote the quality and sustainability of America’s health care system is to better manage chronic illness, which accounts for more than 75 percent of all health care spending.⁵ The creation of accountable care organizations (ACOs) is one of the most promising strategies for improving chronic care. Providers working in ACOs take responsibility for a designated population and work across care settings together to coordinate their care. Primary care “health homes” (also known as “medical homes”) and high-performing hospitals serve as key building blocks of ACOs, along with networks of primary, acute, and postacute care providers.

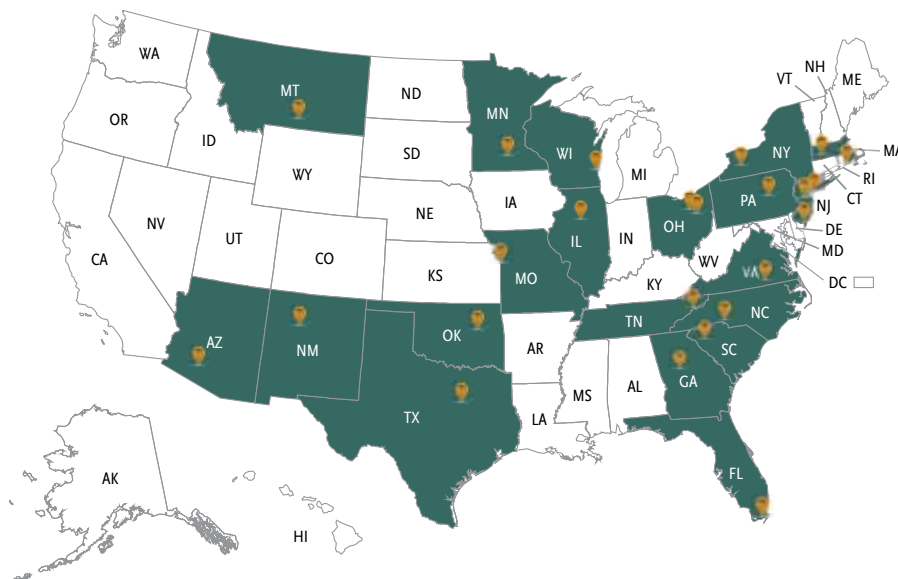
ACOs have the potential to overcome the fragmentation and volume orientation perpetuated by fee-for-service payments by creating incentives to foster

health and wellness. Unlike other delivery reform efforts designed to reduce costs, ACOs balance that need against the need to improve outcomes and enhance satisfaction. Overall, their goals are to empower people to take charge of their health, eliminate waste and unnecessary spending, increase preventive and other care to keep people well, and deliver high-quality services that encourage continued participation (Exhibit 1).

THE PREMIER ALLIANCE’S ACO COLLABORATIVE

Although much attention has been paid to the public policy around ACOs, there has been less focus on the providers and private payers that are building, testing, and bringing to scale new models of care delivery, including ACOs. To develop an effective ACO model that can be replicated across hospitals, health systems,

EXHIBIT 2. PREMIER COLLABORATIVE MEMBERS



- AtlantiCare, Egg Harbor Township, N.J.
- Aurora Health, Milwaukee, Wis.
- Banner Health System, Phoenix, Ariz.
- Baystate Health, Springfield, Mass.
- Billings Clinic, Billings, Mont.
- Bon Secours St. Francis Health System, Inc., Greenville, S.C.; and Bon Secours Richmond Health System, Richmond, Va.—part of Bon Secours Health System, Inc.
- CaroMont Health, Gastonia, N.C.
- Fairview Health Services, Minneapolis, Minn.
- Geisinger Health System, Danville, Pa.
- Hackensack University Medical Center, Hackensack, N.J.
- Heartland Health, St. Joseph, Mo.
- Memorial Healthcare System, South Broward, Fla.
- Methodist Medical Center of Illinois, Peoria, Ill.
- Mountain States Health Alliance, Johnson City, Tenn.
- North Shore-LIJ Health System, Long Island, N.Y.
- Presbyterian Healthcare Services, Albuquerque, N.M.
- Rochester General Health System / GRIPA, Rochester, N.Y.
- Saint Francis Health System, Tulsa, Okla.
- Southcoast Hospitals Group, Fall River, Mass.
- Summa Health System, Akron, Ohio
- Texas Health Resources, Arlington, Texas
- University Hospitals, Cleveland, Ohio
- WellStar Health System, Atlanta, Ga.

and physician practices, Premier, a national performance improvement alliance of 2,600 U.S. hospitals and 84,000 other health care sites, launched an accountable care implementation collaborative in May 2010 for hospitals and health systems.⁶ Similar groups have been launched by the Brookings Institution and Dartmouth Institute for Health Policy and Clinical Practice as well as the American Medical Group Association, although these focus more on physician leadership.⁷ These collaboratives are designed to help providers implement the key capabilities needed to operate an ACO, based on a common model and consistent measures of success, and to glean best practices for doing so.

Premier’s collaborative includes 23 health systems with more than 70 hospitals, a broad variety of payer contracts, and partnerships with thousands of physicians (Exhibit 2). Participating health systems will provide care across 20 states, covering urban, rural, and suburban populations that range in size from 4,000 to 7.5 million residents.

Collaborative participants are working to break down payment silos and create integrated

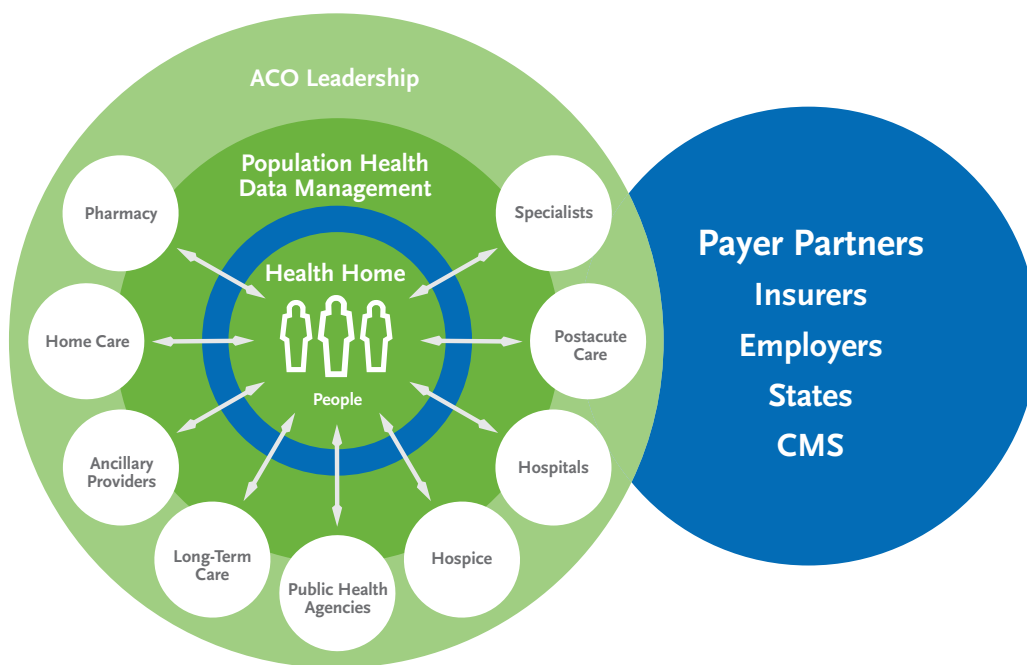
provider networks that are accountable for cost, quality, satisfaction, and population health. This disruptive innovation requires new systems that keep people healthy, an emphasis on early intervention and primary care to improve efficiencies and avoid unnecessary expense, and new shared savings reimbursement structures.

THE MAKING OF AN ACO

To create an accountable care organization, participants first need to define success and then map the operational components needed to achieve it. Measurement is central to determining the success of the ACO and monitoring unintended consequences. Agreeing on the goals is the first challenge in the measurement process. Most organizations pursuing accountable care are pursuing three aims:

1. **Better health care**—Improving the individuals’ care experiences and ensuring that treatments are safe, effective, patient-centered, timely, efficient, and equitable.

EXHIBIT 3. ACO CORE COMPONENTS**



* ACO model graphic property of the Premier health care alliance.
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2. **Better health**—Encouraging better health for the community by addressing the underlying causes of poor health such as lifestyle, lack of preventive care, and delayed intervention.
3. **Reduced cost of care**—Containing the costs of care through rational treatment decisions and case management.

These goals are aligned with the Institute for Healthcare Improvement’s Triple Aim and were further refined based the Department of Health and Human Services’ National Quality Strategy (NQS).⁸

Core Components

Specific corporate functions and system components are required to fully implement an ACO, as depicted in Exhibit 3. Although some U.S. health care organizations have put in place pieces of these accountable care components (described below), none has fully deployed all of them.

These components do not replace the usual operating functions of the existing health care system, such as those required to manage day-to-day physician practices and hospitals. But the operating and business models of these entities are expected to evolve in response to the ACO environment. The six core ACO components include:

1. *People-centered foundation*: The ACO model seeks to engage people, encourage them to play active roles in their care, and increase their satisfaction. A good example of this approach comes from the Billings Clinic, where diabetics are given an annual scorecard listing the measures that must be tracked to keep this condition in check.⁹ Patients and providers can then hold each other accountable for following the care plan.
2. *Health home*: According to the American Academy of Pediatrics, a medical home (or health home) is “not a building, house or hospital, but rather an approach to providing comprehensive primary care.”¹⁰ Health homes seek to provide care that is accessible, continuous, comprehensive, family-

centered, coordinated, compassionate, and culturally effective. The model differs from the disease management models of the 1990s in that health homes are designed to serve all people, rather than just those with certain chronic illnesses. Such organizations exist today. For example, physicians at the AtlantiCare Special Care Center receive a flat fee per patient, per month, rather than being paid for each office visit.¹¹ Individuals have unlimited access and can take advantage of open scheduling to secure same-day appointments. People are monitored using electronic systems to ensure they are meeting their goals, and health coaches help them make healthy choices; one nurse’s sole goal is to encourage all smokers to quit.

3. *High-value provider network*: Since the health home is responsible for primary and preventive care, high-value provider networks include all the other medical services that may be needed to provide high-quality, cost-effective outcomes. These include hospitals, specialists, rehabilitation centers, mental health providers, hospice care, and postacute care. These providers must operate in conjunction with the health home, which is the center of an ACO’s integrated network and responsible for ensuring coordination and seamless transitions between various settings. For example, Geisinger Health System has an integrated network of primary care practices, hospitals, specialists, as well as its own insurance plan, and leverages its providers and community resources to manage and coordinate care.¹²
4. *Population health and data management*: Population health and data management entails the use of health information technology to support the clinical and administrative aspects of care, with the goal of improving health outcomes. It goes beyond the basic electronic health record (EHR) and requires resources to: 1) collect individual health status data; 2) stratify and target populations based on their risk and need for care; 3) provide tools to engage people in their health

using individual health records or online portals; 4) enable connectivity to a health information exchange to ensure portability of records; and 5) support workflow tools that direct physicians toward appropriate, evidence-based care protocols. Equally important, all of these systems must be interoperable, and data must flow freely among them. Aurora Healthcare is an early leader in this area. For example, in 2009 Aurora developed technology that enables providers across its network to view, magnify, and examine X-ray, CT, and MR images.¹³ Physicians can access the images online, thus enabling collaboration and timely responses. Since then, Aurora has adopted database technologies to mine medical records to identify individuals who may benefit from a certain therapy. Aurora's data also can be used to enable scientists around the globe to share information for research and medical discovery.¹⁴

5. *ACO leadership:* A successful ACO requires attentive, innovative, and effective leadership at several levels, from the governance entity that oversees the entire enterprise to the physician groups that participate. In order to build an ACO leadership capability, executives will need to administer corporate functions and at the same time work to transform the culture of all participating organizations. This means managing the new ACO business model, formalizing partnerships with provider participants in joint governance and operations management, as well as shifting the entire delivery system from a focus on volume to a focus on value. This shift brings significant challenges for health care leaders in establishing legally sound organizations that support realignment of clinical processes, new operating structures, and the ability to model the financial implications of shifting reimbursements. An advanced leadership structure can be seen at Summa Health System, which has its own legal structure and governing board to oversee ACO operations. Summa has taken a highly inclusive approach, bringing together primary care physician

leaders, medical and surgical specialists, hospital system representatives, and a new head of ACO operations to form the governing board. Beneath the board sit two committees focused on quality improvement and finances, and task forces have been organized to take on activities such as medication management and postacute care coordination.

6. *Payer partnership:* ACOs will require a major shift in the way public and private payers partner with providers. The goal is to establish deeper and broader relationships based on transparency, shared value propositions, and joint management of population health. These new relationships also should be based on full operational interactions across a wide spectrum of services, including predictive modeling, high-cost case management, disease management, provider performance measurement, network and medical management, and financial reporting. It is important not to take a myopic view of the potential payer partners in any given market. Medicare is one potential partner, either through the Medicare Shared Savings Program or payment demonstrations through the Center for Medicare and Medicaid Innovation (CMMI). But there are other potential partners for ACOs, including commercial insurers, self-insured employers, community programs caring for uninsured residents, and provider-sponsored plans (see section on ACO markets below). Effective, private-payer partnerships are perhaps most well known in Minneapolis, where Fairview Health Services has four fully executed, value-based ACO agreements in place, including one with the local Blue Cross Blue Shield plan and Medica.

These six components go well beyond those detailed in the Affordable Care Act or the Medicare Shared Savings Program for ACOs. That program essentially offers a partnership with CMS as the payer—in other words, just one of the components necessary to deliver integrated care.

THE MODEL FOR A SUCCESSFUL ACO

Exhibit 4 illustrates how an effective ACO might work in practice. At its core are people who have a health home that coordinates their care by acting as the quarterback for service delivery across the system. Providers need to come from across the care continuum (i.e., those delivering urgent, preventive, chronic, and primary care services) to create a high-value network. This model requires the participation of one or more primary care and specialty physician groups and hospitals, as well as ancillary providers, home care, long-term care, hospice, and pharmacies.

In a successful ACO, these providers will be aligned with the organization's goals and have sufficient financial incentives to support high-value care. Moreover, a sophisticated information infrastructure underlies the model to provide the data needed to assess, monitor, and intervene to optimize the health of the entire ACO population. ACO leaders will steer the organization through the economic and cultural shifts

required to move from volume-based to value-based care. Through effective, collaborative relationships, payer partners will support the health home, the specialist network, and other components of the ACO with shared savings compensation. Financial incentives will be aligned to reward improved outcomes, increased efficiency, elimination of waste, enhanced satisfaction with care, and reduced overall costs.

Organizational Models

Assessments of more than 90 markets implementing accountable care principles find that a number of ACO organizational models exist. Stephen Shortell and Lawrence Casalino suggest five models of an “Accountable Care System” (their term for an ACO): a multispecialty group practice; a hospital medical staff organization; a physician–hospital organization; an “interdependent” practice organization; and a health plan–provider organization or network (Exhibit 5).¹⁵ This list compares with the types of organizations

EXHIBIT 4. ACOS IN PRACTICE

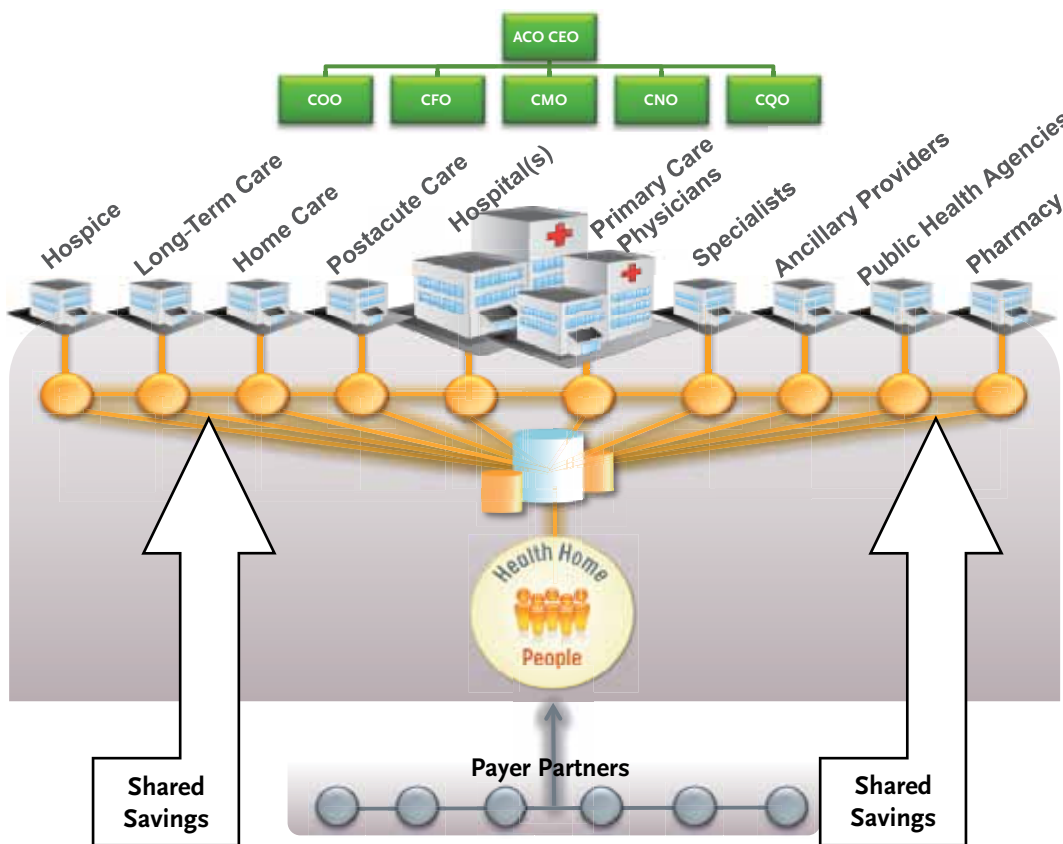


EXHIBIT 5. FIVE MODELS OF ACCOUNTABLE CARE

Model	Characteristics	Examples
Multispecialty group practices	<ul style="list-style-type: none"> • Usually own or have a strong affiliation with a hospital • Contract with multiple health plans • History of physician leadership • Mechanisms for coordinated clinical care 	Billings Clinic (Billings, Montana) Marshfield Clinic (Wisconsin and Michigan)
Hospital medical staff organization	<ul style="list-style-type: none"> • Nonemployee medical staff • Strong partnership between physician and primary admitting hospital • Electronic medical records and quality improvement support • Self-governing medical staff organization 	Memorial Healthcare System (Broward County, Florida) St. Vincent Hospital (Billings, Montana)
Physician–hospital organization	<ul style="list-style-type: none"> • Nonemployee medical staff • Function like multispecialty group practices • Potential to reorganize care delivery for cost effectiveness 	Hoag/Greater Newport Physicians (Newport Beach, California)
Interdependent practice organization	<ul style="list-style-type: none"> • Smaller groups of physicians, often in rural areas, that jointly contract with health plans • Active in practice redesign and quality improvement • Structure that provides leadership, infrastructure, and resources 	Catholic Healthcare West/Hill Physicians (Bay Area, northern California)
Health plan–provider organization/network	<ul style="list-style-type: none"> • Partnership between health plans and providers • Quality and cost improvements generate insurance products as well as improved outcomes • Integration with insurers’ disease management and quality improvement systems 	Geisinger Health System (Danville, Pennsylvania) Summa Health System (Akron, Ohio)

Source: S. M. Shortell and L. P. Casalino, “Health Care Reform Requires Accountable Care Systems,” *Journal of the American Medical Association*, July 2, 2008 300(1):95–97.

considered by the Congressional Budget Office to be “Bonus-Eligible Organizations”: “physicians practicing in groups, networks of discrete physician practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, integrated delivery systems, or community-based coalitions of providers.”¹⁶

Many organizational models, particularly those that include hospitals, are viable options for ACOs. It is not necessary for a “clinically integrated” provider network—and, by extension, an ACO—to be a single, co-owned legal entity comprising physicians and/or hospitals, whether under the Medicare Shared Savings Program or in the private sector. Instead, accountability can be achieved through a network of coordinated relationships that fall short of corporate integration. The providers in the community and the degree of desired ownership generally determine the chosen approach. A “collaborative arrangement” based on a contractual relationship among the ACO owners and participants could be an acceptable model.

Capabilities, Activities, and Success Factors

In order to function, ACOs must implement a range of capabilities and supporting activities.

Keeping people at the center. People-centered care entails more than coordination across settings of care. It also includes careful attention to overall experiences at every point at which they interact with the ACO. For example, when a person enters the provider’s office, is he or she greeted by friendly staff members who introduce themselves? Do clinicians have easy access to medical records so that people do not have to repeat their medical history multiple times? Upon discharge, have physicians and nurses adequately explained to people and their families the procedures for care at home, taking into account their level of health literacy? ACO leaders must monitor care experiences from the individual’s perspective, and be willing to address identified issues.

ACO’s also need to communicate with people, help them manage their own conditions, and empower them to use nontraditional models to access care,

including remote monitoring of health status, telemedicine for rural settings, and online portals for accessing personal health records.

Integration of old and new. Attention must be paid to the integration of new ACO-based operating activities with previously existing activities. Even though organizations will need to change their policies and work practices to partner with others, an emerging ACO can take advantage of the best practices already in place and expand them across the network. Leaders should identify areas in which the ACO is not serving its population sufficiently and expand services to fill the gaps.

Selecting and engaging physicians. ACOs need to foster physicians' confidence in the care model, particularly in highly competitive markets. Since people tend to follow their physicians, the ACO network of primary and specialty care providers is essential to its success. In selecting provider partners, preference should be given to practices that are engaged and ready for the transition to a value-based structure, as well as those with the best track records of cost and quality performance. Once providers are selected, ACOs should continue to engage physicians by sharing performance metrics on a real-time basis and holding open discussions about the new incentive and compensation system.

It may be difficult for physicians to make the shift from a volume-based delivery system to a system in which they are accountable for the cost and quality of care. Both physicians and staff will need to commit to changing their work culture and habits. For example, they will need to develop strategies for managing care between visits, rather than focusing on care delivered in the office. People, too, may resist playing an expanded role in managing their health. Physicians will need to explore new approaches to engaging patients, especially those who do not comply with recommended care. For instance, primary care physicians need to screen for depression, which may interfere with individuals' ability to take their medication, engage in physical exercise, or improve their eating habits.

Value-based contracting. Most provider-payer contracts focus on the terms of payment, typically fee-for-service reimbursement that may include capitated payments for some portions of the covered population. The contracts that ACO leaders are currently entering into with payer partners include much broader terms such as people-centeredness criteria, quality metrics, information technology capacity, delegated care management functions, and expanded financial incentives. In the early years, these contracts most likely will pay claims according to the preexisting arrangements, but additional financial incentives for participating providers will be necessary. For example, CMS will continue to pay ACO providers based on the existing Medicare fee-for-service system (i.e., the physician fee schedule and inpatient prospective payment system). However, ACO contracts will need to set out quality benchmarks and spending levels, as well as the method by which any savings generated as a result of ACO activities are to be shared.

ACO contracts also need to take into account the financial realities facing providers as they make the transition to value-based care, ensuring providers are able to earn adequate income as they seek to avoid unnecessary care. ACOs need to explore the following financial considerations:

- The potential impact on volume and revenue associated with implementing an ACO. These analyses should consider various combinations of beneficiary populations to the ACO, by major payer category (i.e., Medicare, Medicaid, and private insurance).
- The financial impact of a variety of shared savings arrangements, ranging from fee-for-service plus potential shared savings incentives to full risk capitation.
- Various shared savings distribution models between providers and payers.
- The total medical cost of services, including services provided by in-network as well as out-of-network providers.

- Total medical costs per member, per month by major service line and payer in order to understand the historical spending pattern of the ACO population and allocate spending shifts.
- Changes to utilization patterns that may occur as systems make the transition to accountable care, such as increased delivery of primary care and decreased inpatient services.
- Drivers of labor costs and staff assignments to support ACO activities during the transition to accountable care. In some cases, existing staff members can be assigned new roles. In others, new individuals with different skills and competencies will need to be hired.

High-value postacute care services. To be successful, an ACO must have a system in which postacute care can be efficiently delivered by and coordinated among ancillary providers, such as skilled nursing facilities, home health agencies, infusion services agencies, and end-of-life care (e.g., palliative or hospice care). ACOs need to

build infrastructure to ensure timely care and support the appropriate movement of individuals across the care continuum. Without this foundation, managers will have little control over the care provided for the ACO population and little leverage for improvement initiatives (e.g., reducing hospital admissions and readmissions) across the spectrum of care.

Physician compensation and other incentives. ACO leaders will need to design compensation and incentives that align physicians in the effective provision of care. Physicians should be rewarded for productivity, while also motivated to deliver outcomes based on predefined metrics and measures. The pros and cons of a variety of compensation and incentive models are listed in Exhibit 6. Ultimately, an ACO's compensation model needs to be locally determined, based on the unique makeup of the physician population, the relationship that exists between providers and payers, and other factors.

ACO leaders should discuss these payment options in collaboration with the physicians who will have to work under them.

EXHIBIT 6. COMPENSATION MODELS

Model	Elements	Implications for Productivity and Resource Utilization
Straight salary	Income level set; may include bonus/incentive or provision for guaranteed income	Provides assurance of income level Without bonus, offers little financial incentive and may support minimum effort
Equity/equal shares	Income level based on revenues left after expenses, which are divided equally	Rewards lower utilization; may allow less-productive physicians to capitalize on the work of more-productive colleagues
Production or productivity-based compensation	Income based on percentage of either billings or collections, or on resource-based relative value scale units that are assigned to procedures or visits; overhead is allocated among physicians	Rewards physician effort—but also greater utilization, more referrals, and more procedures; affected by patient mix (i.e., proportion of patients with commercial insurance, Medicaid/Medicare, and no insurance)
Incentive-based compensation	Some component of income is tied to performance around the ACO core goals (better health care, better health and reduced costs)	Rewards physician efficiency, appropriate utilization, and patient-centered focus in care delivery
Capitation	Income based on distribution of moneys from payers—either equally among physicians or based on a predetermined formula	Rewards delivery of cost-efficient, effective care Influenced by marketplace and contract negotiating skill level

Financing. Leaders must have financial resources such as operating cash flow, redistribution of existing capital investments, or external funding to effectively operate and manage the ACO. This will be particularly important during early periods, when there will be costs associated with investments in new technologies, key staff, and implementation of new policies and procedures. There are few estimates of accountable care expenses. A recent report issued by the American Hospital Association states that start-up costs for a hospital-based ACO could range from \$5.3 million to \$12 million, depending on the size and scope of the program.¹⁷ Moreover, ongoing operating costs could range from \$6.3 million to \$14 million each year. Being able to fund these costs through a combination of increased operating efficiencies, new patient populations, new investment capital, and shared savings will be vital to ensuring long-term success.

ACOs require comprehensive financial modeling capabilities to assess the economic impact of a system-wide transition to accountable care. Such analyses will help providers set appropriate targets for short- and long-term budgets, investments, and other financial needs as they shift to value-based payments. Equally important, financial modeling is essential for health systems to evaluate various payment options, including the Medicare shared savings tracks, capitated payments offered through the CMS Innovation Center, and private payer arrangements.

Specific considerations to model include the ACO size and level of shared savings. A larger population enables providers to spread cost and quality risk across a broader pool, potentially increasing the size of shared savings payments. At the same time, the number of hospital admissions and consumption of services will decrease, while staff time and delivery of preventive care services rises, and the shared savings payments must offset these losses.

Targeted care management interventions. Often, decision-makers design care management programs for narrowly defined, high-risk populations. For instance, complex

case management seeks to manage extremely high-cost cases, such as patients with severe trauma or those undergoing organ transplantation. Disease management programs focus on those with specific chronic diseases, such as diabetes or asthma. The downside of such approaches is that the investments will benefit a small proportion of the total population. Further, comorbidities and risk factors that are not concurrently addressed will diminish the impact of targeted interventions. Consequently, significant outlays of time and money may not “move the needle” for the population as a whole.

To avoid this, ACO administrators should target care management interventions at broad segments of the population. It is also important to consider a wide range of services, including prevention and wellness programs in conjunction with case and disease management programs. Targeting such programs requires segmenting individuals by risk (e.g., predictive modeling) to identify those at highest risk of experiencing additional medical care and expenses, no matter what their condition. Individuals at lower risk should be evaluated to determine if preventive and wellness programs may be useful to keep them in good health. Patients with clinically stable, chronic disease may benefit from disease management programs. Different types of care management have differing potential for impact and different time frames for demonstrating outcomes. Moreover, the overall care management approach needs to be fluid to accommodate changes needed to serve healthy people who become sick, and vice versa.

Value measurement. Performance measures are needed for each of the ACO core goals (better health care, better health, and reduced cost of care) to assess ACOs and their impact on community health. However, population-level measures across the continuum are not always available, and many measures rely on labor-intensive processes of manually abstracting data from medical charts and the integration of claims data to account for all services received.

Performance measures that have been adopted by CMS as well as many private payers include those developed by the National Committee for Quality Assurance, such as the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is used by more than 90 percent of America’s health plans to assess performance on important dimensions of care and service. Other measures assess community health and wellness and the overall experience of care, as collected through the Consumer Assessment of Healthcare Providers and Systems.¹⁸

Measures used to assess ACO performance are in their infancy, and are generally inadequate for assessing population health. There are a variety of reasons for the lack of robust measures, including a lack of data needed and the inability of many organizations

to blend administrative claims data with clinical data to produce meaningful clinical and efficiency measures. However, some measures can be captured from survey or claims data (Exhibit 7).

Joint medical management processes. Many payers use medical management processes to monitor utilization and incentivize lower-cost choices. In ACOs, it will be essential to create joint medical management processes that involve both the payers and clinicians. At a minimum, payer partners and participating providers need to agree to measures of success based on high-level metrics such as total per member, per month costs of care as well as detailed measures such as the cost of care for specific clinical services. A sample distribution of medical management responsibilities is shown in Exhibit 8.

EXHIBIT 7. SAMPLE ACO PERFORMANCE METRICS

Aim	Subaims	Metric	Metric Description
Health of the population	Primary and secondary prevention—prevention and screening	f1	Colorectal screening, adults 50–75
		f2	Breast cancer screening, females 40–69
		f3	Flu shot, adults 65+
		f4	Pneumonia vaccination status, adults 65+
		f5	Comprehensive diabetes care—HbA1c control (<8%), adults 18–75
	Tertiary prevention—prevention of disease progression	f6	Prevention of harm (composite)
		f7	Risk-adjusted mortality/1,000
		f8	Evidence-based care for hospitalized cases (composite)
Experience of care	Satisfaction	f9	Global rating of all health care
		f10	Global rating of personal doctor
		f11	Global rating of specialist seen most often
		f12	Composite score of getting needed care
		f13	Composite score of shared decision-making
Cost per capita and services delivered	Cost PMPM	f14	Total cost PMPM (e.g., medical and Rx)
		f15	Total cost PMPM trend
	Utilization	f16	Admissions per 1,000/year (possibly with case mix)
		f17	30-day readmissions (all-cause) rate
		f18	ED visits per 1,000
		f19	Hospital admissions for ambulatory care–sensitive conditions

EXHIBIT 8. SAMPLE DISTRIBUTION OF MEDICAL MANAGEMENT RESPONSIBILITIES

Capability	Related Operating Activity	Site Accountable for Operating Activity			
		ACO		Centralized Medical Management Within ACO	Payer
		Health Home	High-Value Network		Centralized Medical Management by Payer
Utilization Management System	Precertification				X
	Concurrent review		X (for ACO facilities)		X (for non-ACO facilities)
	Discharge planning		X (for ACO facilities)		X (for non-ACO facilities)
	Management of transitions of care	X (for health home members)	X (for providers other than health homes)		
	Decision support/ Optimizing care of preference-sensitive conditions, those where legitimate treatment options exist	X	X	X	
Pharmacy Management System	Pharmacy & therapeutics committee			X	X
	Formulary development			X	X
	Physician profiling			X	
	Generic optimization	X	X		
	Pharmacy clinical management	X	X		
Medical Policy System	Formulation of medical policy				X
	Communication of medical policy				X
Disease Management Case	Population identification			X	X
	Patient education	X		X	
Management	High-risk case management	X (for health home members)	X (for providers other than health homes)		
	Catastrophic case management			X	

Realistic timelines for cost reduction and resource utilization. Leaders must carefully orchestrate cost-reduction efforts during establishment of the ACO. Initial cost-saving efforts should focus on reducing inefficiencies and eliminating redundant processes. Because interventions to improve quality generally do not provide an immediate return on investment, these initial cost savings will be essential for carrying the enterprise until the fruits of quality and safety improvements are realized.

ACO leaders must carefully plan for the future by leveraging financial models and budgeting tools that

can simulate a range of scenarios and their effects on business and contingency plans. Leaders must be able to see a potential return on investment along a specific timeline, taking into account the local market, proposed population, payment model, and quality metrics. To this end, if an ACO successfully identifies and engages people who have lacked care in the past, the expenses associated with providing preventive care may initially increase. However, the downstream costs of preventing these people from utilizing emergency or other hospital services with late-stage diseases will decrease.

PAYMENT OPTIONS

Many organizations pursuing accountable care are already participating in alternative payment mechanisms in the private sector, albeit on a limited scale. To maximize results, it is critical for an ACO to align as much of its business as possible with value-based care and payment. Bringing Medicare and private-sector payment models into synch, to the extent possible, will facilitate this.

CMS is doing what it can to ease this transition by allowing for shared savings within the Medicare ACO program or through the ACO Pioneer Program led by the Innovation Center—thus giving providers the ability to choose an approach that most closely aligns with payment arrangements they already have in place with private payers.¹⁹ In some areas, particularly where managed care is prevalent, ACOs are prepared to accept additional risk, including partial or full capitation, and will not want to diverge from this model to participate in shared savings (either through an up-side only or a reciprocal risk arrangement). Whichever payment track an ACO chooses, it is important to drive consistency across payers so that providers are working under a uniform set of goals, incentives, and payment models.

Although there are numerous variants, most providers pursuing accountable care are considering one of four payment alternatives.

Fee-for-Service Plus Bonus

Under this model, payers continue to pay ACOs on a fee-for-service (FFS) basis for all services, but add in a year-end bonus if spending is lower than a benchmark level. In the majority of cases, there is no down-side risk for the ACO if it exceeds its spending target. However, over time, most payers are requiring ACOs to accept symmetrical risk with capped bonuses and losses.

Bundled Payments Plus Bonus

This allows payers to make one payment for hospital, physician, and possibly postacute services provided during an episode of care. This could be a shorter period associated with a hospitalization or a longer period for

ongoing treatment of chronic conditions. Over time, this payment model is intended to reduce overall spending. However, in order to ensure that spending declines and quality improves, payers will need to either withhold full payment until quality and cost improvements are demonstrated, or put in place a penalty structure to recoup funds from ACOs that do not achieve these goals.

Global Capitation

Under comprehensive care payments, a single price would be paid for all services provided to anyone cared for by the ACO over the course of a year. Adjustments to payments would be made based on health status and quality of care. The underlying payments would continue to be paid on an FFS basis, but at the end of the year, payments that exceed what was expected would either be recouped or withheld. Similar withholds or penalties also would be needed to ensure quality improvement targets are hit.

Capitation

Another model would entail monthly, risk-adjusted capitated payments. These rates could be set based on projected spending, but adjusted monthly based on the risk scores of the ACO's patients. The capitated amounts could be set well below projected FFS rates, guaranteeing savings for the payer. However, if quality targets are met, ACOs would earn back the savings generated beyond the guaranteed savings. Or, the capitation rates could be set modestly below the FFS rates and a quality penalty applied if benchmarks are not achieved, thus obviating the need for a withhold. This could be applied, for example, as a partial capitation model where only physician services are capitated, and institutional claims are paid on the fee-for-service plus bonus method.

Regardless of the payment option selected, each shares common attributes. For instance, in all models the ACO is held accountable for total costs, including costs for care delivered outside of the ACO provider networks. Also, under all models no bonuses or incentive payments would be paid unless quality standards are met.

SHARED SAVINGS MODELS

Under a shared savings model, the payer would pay all claims for a specified target population. ACO leaders would focus resources on the interventions most likely to optimize health outcomes for this population. Data on the agreed-upon measures of success would be compiled for the population after a performance period.

If the actual cost of care for the population is less than the projected cost (possibly minus a target or confidence interval), the excess funds would be placed in a savings pool. The ACO would receive a percentage of the savings, subject to its achievement of benchmark levels of performance on measures of quality and patient experience.

A clear definition of the target population for which the ACO will be responsible is essential. The target population can be defined in several different ways: all members of a particular health plan, all members in a particular geographic area, or all members participating in a limited ACO arrangement focused on a specific diagnosis.

The experience of participants in CMS' Physician Group Practice Demonstration Project suggests that the most equitable method of attribution is to assign patients to the ACO that includes the site at which they received the bulk of their primary care services. In some markets, specialists, nurses, and other providers may also be assigned to the ACO. To use this method, the ACO provides the payer with a list of primary care providers. The payer identifies the target population based on historical use of services from these providers and distributes this list to the ACO. The payer also creates a historical record of the outcomes for the identified target population, including the total cost of care and anticipated cost trend.

A critical element of the shared savings model is defining success. ACO leaders need to negotiate and have clarified in the contract the specific metrics that constitute success, including a target medical cost. ACO leaders also need to ensure clarity in the contracts regarding payments relative to achievement of the specific metrics. For example, if the ACO meets quality goals but fails to attain cost goals will it be eligible for payment?

Under a partial capitation contract, the ACO might receive prospective payment for a subset of services, such as inpatient facility care. Other savings might be calculated as above. Inpatient services would be excluded from these calculations because the ACO would already have received payment for inpatient services and—to the extent that the total cost of inpatient care was less than the capitation received—would have collected its incentive payment for inpatient services.

Under a full capitation contract, the payer would pay the ACO a fixed monthly amount based on the number of individuals in the targeted population. In most cases, ACO participants would continue to submit claims to the payer and the payer would continue to pay non-ACO providers on a fee-for-service basis. However, the costs of services provided outside the ACO would likely be included in the financial reconciliation, depending on the terms of the contract.

ACO MARKETS AND EXAMPLES OF ACCOUNTABLE CARE IN ACTION

Since CMS issued regulations for the Medicare Shared Savings Program, there has been a great deal of discussion on its merits and whether it is a viable option for organizations pursuing accountable care. However, it is important for provider organizations to understand that there are many markets in which to test innovative, coordinated care delivery models.

In private markets, accountable care principles can be seen in many places as providers and payers move toward new, value-driven models of care in lieu of traditional fee-for-service models. These providers are meeting quality metrics, implementing improved care processes (such as coordinating care transitions and engaging patients), assuming risk, forming partnerships

with payers and other providers, offering incentives for population health and wellness, and deploying health IT.

Based on assessments of nearly 90 markets, it is clear that there are at least six other partners or populations, beyond Medicare, to target in the creation of ACOs.

Employee Health Plans

Like other major employers, many health systems use incentives to promote healthy behavior among their employees. For example, value-based benefit designs encourage healthy choices. This could involve offering lower premiums, copayments, and/or deductibles for those who participate in wellness programs, or reduced copayments for medications treating high blood pressure, diabetes, and high cholesterol.

Some health systems such as the Cleveland Clinic are taking the lead in this area, encouraging their own employees with chronic illness to enroll in disease management programs and designing benefits to reward employees for taking cost-saving measures, such as using generic drugs. Such health systems may be interested in forming their own ACO, or working with one to deliver care to their employees.

Self-Funded Employers

Large, self-insured employers may also be interested in having ACOs provide their care. In Maine, Bath Ironworks, a self-funded employer with 10,000 employees, is implementing a shared savings model for their employee health plan with a select handful of health systems.

This company projected health spending on a per capita basis for employees and made an agreement with Central Maine Medical Center that if the company came in under the target in 2011, it would split the savings with the health care organization. There is no penalty if the company falls short of its target.

Health Plans/Insurers

Insurers are beginning to enter into accountable care agreements with health systems to create new insurance products. Several agreements throughout the country have been announced, including the following:

- Aetna and the Carillion Clinic²⁰
- Humana and Norton Healthcare health system²¹
- CIGNA and Piedmont Medical Group²²
- Three major Minnesota insurers and Fairview Health Services²³

The rewards for meeting mutually agreed upon quality standards and cost reductions include bonus payments and shared savings to the accountable care network.

Medicaid

A growing number of state Medicaid programs are embracing principles of accountable care, particularly targeted care management and health homes. Moreover, a number of states, including Illinois and New Jersey, passed laws that would enable Medicaid beneficiaries to be cared for in ACOs.²⁴

Community Care of North Carolina, for instance, places Medicaid enrollees in health homes for primary care and care management. Each network operates as a virtually integrated health system, with a medical management committee of local doctors, a medical director, a clinical pharmacist, and care managers who follow up with patients and identify special patient needs.

As one of the oldest such program in the country, Community Care of North Carolina has had impressive results. It has seen the number of emergency department visits by asthma patients fall by 40 percent between 2003 and 2005, for example, all the while spending \$574 million less than projected for primary care case management services.

The Uninsured

The Camden Coalition of Healthcare Providers in New Jersey uses care management programs for the city's uninsured residents with both complex medical conditions and social issues—individuals who tend to overuse the city's emergency departments. Using an outreach team consisting of a social worker, a health outreach worker/medical assistant, and a nurse practitioner, the Care Management Project helps the 115 enrollees stabilize their social environment and health conditions and works to find them a long-term health home. Team members visit patients in homeless shelters, abandoned homes, hospital rooms, and street corners.²⁵

Providers in the area are able to avoid duplication and ensure greater levels of coordination using the Camden Health Information Exchange (HIE), an electronic health record interface that enables providers to access patient data across clinics, practices, hospitals, and health systems. Launched in November 2010, the Camden HIE is the first of its kind in New

Jersey and covers an entire geographic area, linking information from all three hospitals in the city.

Individual Markets

An example of accountable care in individual markets can be seen in Minnesota, where providers and payers are offering “baskets of care,” or a bundle of health care services packaged together to create incentives for providers to cooperate and develop innovative approaches to reducing health care costs while improving quality. Each basket of care is paid for at a set rate and offered as a product that consumers are able to purchase.

Succeeding in the individual market will depend on finding the right payer partner that is willing not only to design products for individuals, but also to partner with the accountable care network to manage care. To keep costs down for individuals, it will be essential to include effective care management and chronic disease management programs in the benefits package.

EARLY CHALLENGES AND POLICY RECOMMENDATIONS

Since many organizations are working to deploy ACOs in the near term, early work has focused on removing barriers that could stand in the way of creating fully functional ACOs. However, there are factors that are proving difficult for ACOs to address. Policy and other changes are needed before full implementation of ACOs can occur.

Health Information Technology and Meaningful Use

ACOs require an extensive investment in technologies such as electronic health records (EHRs) to improve coordination and convenience. However, few providers have developed population health data management capabilities, or used information technology to streamline and improve the clinical and administrative aspects of care. Most health systems only have limited IT capacity to coordinate care across settings. To succeed,

providers need seamless care coordination with sophisticated population health measurement capabilities.

Moving forward will require a phased approach, ultimately leading to care coordination and clinical integration through the following levels:

- *Transaction*—IT supporting individual providers in delivering care and measuring outcomes.
- *Interaction*—Basic care coordination capabilities with initial population-based metrics.
- *Integration*—Care coordination capabilities improve and health status measurement is possible.
- *Collaboration*—Seamless care coordination with demonstrable improvement in population health status.
- *Transformation*—The ACO core goals of better health care, better health, and reduced costs of care are achieved for all covered patients.

Detailed requirements for each of these levels are shown in Exhibit 9.

Gain-Sharing

In many respects, ACOs are large-scale gain-sharing arrangements. Although a standardized approach to gain-sharing will not accommodate all ACO stakeholders, agreements to share risk and rewards should incorporate the following four principles. These principles can be easily adapted to local situations and provide enough guidance to avoid unintended consequences such as stinting on care or “cherry picking” populations.

1. Identify specific targets that reduce cost or lower unnecessary variation in a manner that ensures patient safety and high-quality care.
2. Objectively evaluate whether these targets were met, and measure the realized savings.
3. Share success in a manner that rewards hospitals and physicians equitably and avoids perverse incentives.

- Engage in a process of continued monitoring to ensure the quality of care is not adversely affected, if not improved.

Following these four steps will encourage providers to work together to identify areas of excess or waste, such as by avoiding errors or taking advantage of economies of scale rather than cutting needed services. These principles also will ensure that adequate checks and balances are in place, and any payment policies that conform to them should be allowed. They will safeguard against setting overly aggressive goals, while continuous monitoring of process and outcome measures will keep track of care quality.

Change Management

Managing the cultural, operational, and organizational changes necessary are some of the most challenging aspects of creating and maintaining a successful accountable care organization.

As any health care leader who has gone through an acquisition or merger knows, bringing

together diverse corporate and team cultures is complex. Managing this well is critical for fostering the collaboration needed to support the ACO model.

ACO planners must take a critical look at the core competencies the new organization will need in its leaders, and then complete an inventory of skills—and gaps—across the existing organizational leaders. ACOs require leaders who have facility with quality metrics, physician leadership, driving culture change, actuarial capabilities, as well as analytics and information technology.

Leaders should enter into this exercise recognizing that the ACO model is, for the most part, a new one, and the core competencies required may well be different from those needed for leadership of health plans or hospitals.

Because ACO management will require an unparalleled level of collaboration, flexibility, and cooperation, the personality and differences in decision-making styles among staff also should be assessed. Human resources tools are available to measure these areas; these could be helpful in matching people to

EXHIBIT 9. COORDINATED CARE HIT ROADMAP

	Transaction	Interaction	Integration	Collaboration	Transformation
	IT supports individual providers in delivering care and measuring outcomes	Basic care coordination capabilities emerge with initial population-based metrics	Care coordination capabilities improve and health status measurement is possible	Seamless care coordination with demonstrable improvement in population health status	Triple Aim goals realized across the population
Accountable care sustainability					<ul style="list-style-type: none"> Advanced population analytics Continuous process improvement Risk and financial management
Population management				<ul style="list-style-type: none"> Evidence-based standards Team-based care collaboration Individual accountability 	
Clinical integration			<ul style="list-style-type: none"> Outcomes measurement and reporting Virtual care team coordination Individual engagement 		
Care coordination		<ul style="list-style-type: none"> Clinical decision support Care management and registries Population analytics 			
Meaningful use	<ul style="list-style-type: none"> Process measurement and reporting Health information exchange Clinical systems (ancillary, EHRs, EMRs) 				

roles within the new ACO organization and maximizing communication and teamwork. Training, incentives, and innovative recruitment policies will help build a cohesive and effective management team as part of the shift from a hierarchical to a team-based and shared decision-making organization.

Assessing leaders' ability to thrive in an ACO will be a difficult exercise, because some people may

not be well suited to roles within the new organization. Certainly, a successful ACO will need to shift resources from some activities to others, which will affect personnel at all levels. For example, an ACO will continue to require staff capable of measuring patient satisfaction, but with a focus on the whole continuum of care, not simply the inpatient experience. The ACO will likely need additional primary care providers and, possibly,

CULTURE CHANGE ISSUES

Each component of the ACO is potentially affected by significant culture change issues, as listed below.

High-value network:

- Developing reimbursement models for physicians
- Sharing power with physicians
- Focusing on people, not just patients
- Shifting toward process-oriented thinking

Health home:

- Educating stakeholders about the ACO and their role in the organization
- Communicating to primary care providers to encourage them to want to change, as opposed to changing because of fear:
 1. Success of the ACO is reliant on physicians' role in driving the new care model
 2. Need for a critical mass of engaged physicians
 3. Need for one physician champion for each four to five physicians to articulate the ACO's goals, validate early attempts at improvement, etc.
- Ensuring effective processes are in place to foster physician leadership

Payer partnership:

- Communicating the need for transparency in the market
- Implementing a new way of thinking

ACO leadership:

- Shifting from the siloed approach of care to focusing on the continuum
- Addressing generational gaps among providers (for example, how to communicate to providers of the "old school" of thought)
- Changing organizational hierarchy so primary care providers are placed at the top of the pyramid
- Avoiding the depiction of the ACO in a hierarchical fashion—that is, a network rather than a pyramid

People-centered foundation:

- Empowering people to manage their care, which will affect their health and provider satisfaction
- Facilitating communication among physicians to coordinate care
- Dealing with physician autonomy associated with new behaviors (for example, involving the people in care decisions, the use of care models)
- Evolving the role of physicians so they work as part of a team

Public policy and communication:

- Developing a shared understanding of ACO-related terminology
- Clearly explaining the net effect and financial ramifications of change and articulating the financial "tipping point" of the new ACO model

fewer specialists. Because of shifts to more cost-effective sites for various procedures, the ACO may need to close one or more inpatient units (or hospital) and retrain staff for other care venues and functions. Similarly, the ACO may need additional home health and care management staff who are able to care for a variety of patient needs, and fewer bedside nurses assigned strictly to a single hospital unit. Nurses may be needed for work in different settings, such as call centers.

Engaging Consumers

In an ACO, accountability should run both ways, with consumers as well as providers taking responsibility for improving health and wellness. But individuals have varying levels of health literacy and may face social, economic, or other challenges that stand in the way of improved health.

Hence, an ACO must give people tools, educational materials, and incentives to become engaged health care consumers. They must introduce and explain the ACO model of care delivery. They also should offer incentives to engage people, including free screenings or wellness services, gym memberships, copayment and deductible waivers, transportation vouchers, and/or financial rewards, for meeting key health goals (e.g., a gift card if individuals attend diabetes education classes or complete a health risk assessment). Such incentives could provide substantial value to consumers, particularly vulnerable populations such as the frail/elderly or the indigent, and will give an ACO the ability to direct and improve care.

Consider the following example, shared by one of the hospitals participating in the collaborative. A disabled, low-income Medicare beneficiary has uncontrolled diabetes but cannot afford the copayments and transportation costs to attend diabetes education classes or physician visits. The individual does not meet Medicaid eligibility, but also does not meet the hospital's charity care guidelines for a reduced deductible. The health system is legally precluded from waiving copayments or providing transportation for free. As a result, several times a year when the beneficiary's prescriptions run out, the patient lapses into a diabetic coma, arrives at the hospital emergency department via

ambulance, and is admitted to the inpatient setting for care.

Such examples of individuals "falling through the cracks" of the health system occur too often. To date, there has been some resistance to allowing added incentives because of a fear that ACOs will provide marketing material, rather than legitimate health services, to consumers. But given that people are typically assigned to an ACO, there should be no need for marketing to persuade them to "enroll." Moreover, health care providers are often regarded as trusted community leaders, and should be allowed to take an active role in helping people meet their basic needs. This becomes even more important in an ACO, particularly because some models, including the Medicare Shared Savings Program, do not place any obligations on individuals to remain within the ACO network. Thus, the only way to retain consumers is by engaging them in a wide array of care management and care coordination programs.

Performance Data

In order to judge their success, ACOs must be able to measure and assess performance on a broad range of clinical quality, efficiency, and satisfaction measures. The ACO's own internal data will not suffice for the required activities. To do this, ACO providers will need access to a much broader set of data for current as well as prior periods for trend analysis, and will need to coordinate with payer partners to ensure performance reports are accurate, timely, and actionable.

ACOs typically require de-identified and aggregated reports with data on utilization, population demographic characteristics (e.g., race, sex, and other characteristics, financial performance, quality scores), and other relevant metrics at least quarterly, and preferably on a monthly basis, to form a comprehensive view of their effectiveness. Moreover, individual records must be linked across the continuum of service settings. This information is required on an ongoing basis to conduct predictive modeling, appropriately target services based on the needs of the population, evaluate providers' quality performance, and establish performance targets and other interventions. But such

claims files are often large, unwieldy reports. ACOs will need to request data in formats that cull through the “noise” and share reports with stakeholders in a digestible, actionable format.

Moreover, because ACOs take responsibility for an entire population, it is critical for them to track the services people receive outside of the ACO provider network. This can only be done if payer partners provide them with claims data from across the care continuum. Further, having the full picture of services provided is critical to understanding where opportunities exist to improve care and contain costs.

Equally important, ACOs should have access to pharmacy data to improve quality and reduce costs, even though pharmacy expenses may not be included in the shared savings calculations. For example, pharmacy data can be used to identify high-risk cases (e.g., diabetics on insulin); monitor medication compliance (e.g., filling prescriptions on the right schedule); check appropriate use of medications (e.g., polypharmacy interactions); and identify beneficiaries who will hit the “doughnut hole” in coverage (risking noncompliance).

CONCLUSIONS AND NEXT STEPS

Like many other countries, the United States is looking for ways to expand access to care while improving its quality and efficiency. Over the years, various health care delivery models, including the managed care model of the 1990s, have been tried with limited success.

Accountable care organizations offer a dramatic shift in health care financing and delivery—a change that will touch virtually everyone providing, receiving, or funding care. By emphasizing wellness and prevention and facilitating clinical integration across providers—with people at the center—ACOs have tremendous potential to improve population health. But

there is no single path to the envisioned future, nor is the journey to high-value health care free of obstacles.

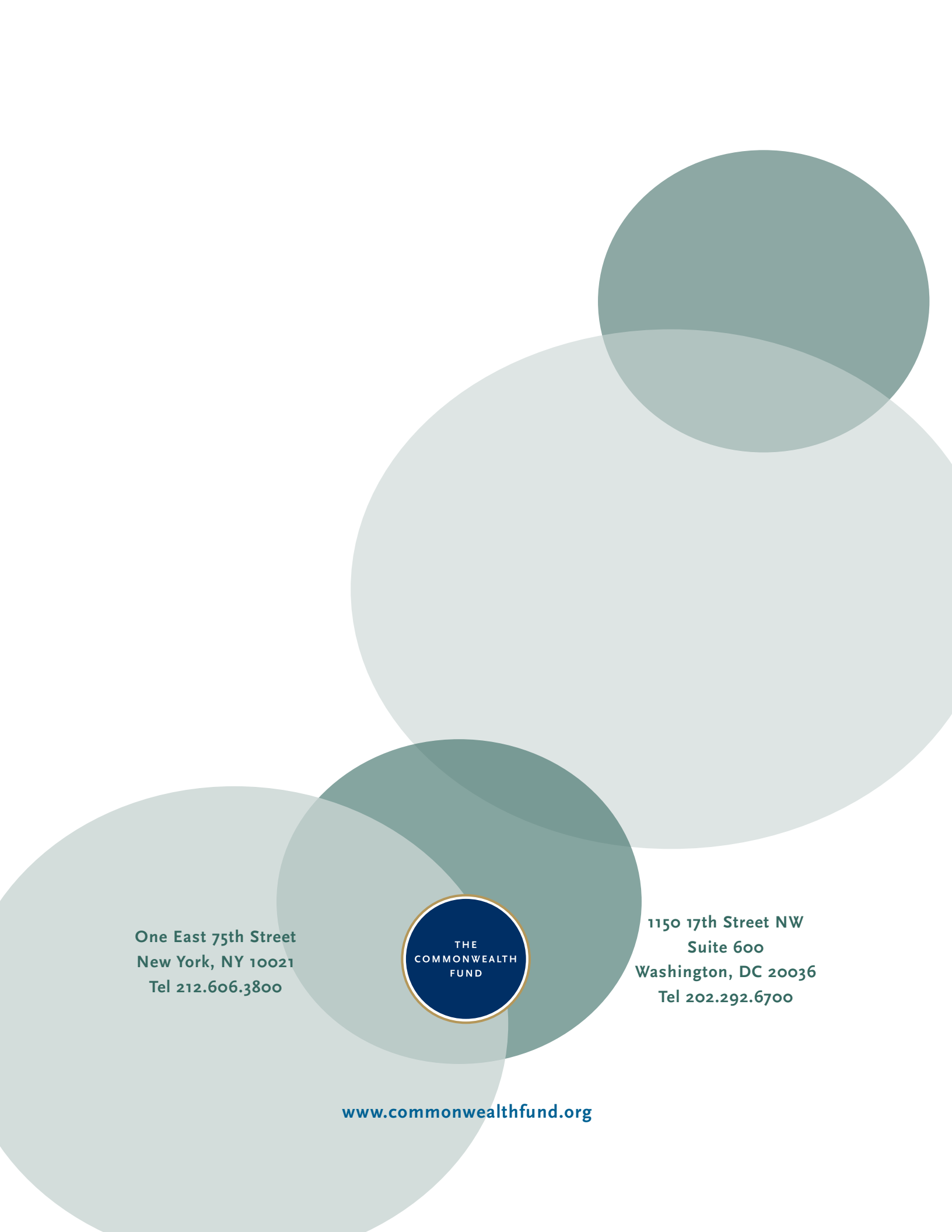
There remain many unknown factors like the following: If an ACO reduces costs, what portion of the savings should it be allowed to keep? How do ACO participants put in place high-value provider networks? How should participants forge partnerships with payers based on shared savings and shared data? What consumer protections need to be put in place to protect people from unintended consequences? How should payments be divided between the physicians, specialists, nurses, and others providing care? What financial benefits will flow to covered individuals? How should ACOs be organized and led? How fast can ACOs be implemented given the cultural, financial, and operating changes required? The authors will explore these issues in future studies assessing organizational readiness to pursue accountable care, as well as case studies documenting best practices and lessons learned from participants in the Premier collaborative.

Successful deployment of ACOs on a nationwide scale will require research and testing of the broadest possible range of ACO models. Perhaps even more important, the key to success will be continued flexibility to test different organizational models, payer–provider relationships, performance measures, and payment approaches, so that ACOs will be truly able to meet the needs of their communities. Many provider organizations are attempting this work now, and making assessments as to their effectiveness. No one segment of health care can accomplish this work on its own, and success will be easier to achieve with good partnerships that span the care continuum. Ultimately, whether ACOs gain widespread adoption will depend on the degree of cooperation that health care stakeholders are able to reach.

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