ACCOUNTABLE CARE ORGANIZATIONS REPORT

What are Accountable Care Organizations?

The term Accountable Care Organization (ACO) was formalized by Dr. Elliott Fisher in a 2006 *Health Affairs* article to describe the development of partnerships between hospitals and physicians to coordinate and deliver efficient care (Fisher, 2006). The ACO concept, which had been in existence before the Elliot Fisher article, seeks to remove existing barriers to improving the value of care, including a payment system that rewards the volume and intensity of provided services instead of quality and cost performance and widely held assumptions that more medical care is equivalent to higher quality care (Fisher et al., 2009).

The ACO concept envisions the development of legal agreements between hospitals, primary care providers, specialists, and other providers to align the incentives of these providers to improve health care quality and slow the growth of health care costs. ACOs would reach these goals by promoting more efficient use of treatments, care settings, and providers (Miller, 2009).

The success of the ACO model in fostering clinical excellence and continual improvement while effectively managing costs hinges on its ability to incentivize hospitals, physicians, post-acute care facilities, and other providers involved to form linkages that facilitate coordination of care delivery throughout different settings and collection and analysis of data on costs and outcomes (Nelson, 2009).

This predicates that the ACO will need to have organizational capacity to establish an administrative body to manage patient care, ensure high quality care, receive and distribute payments to the entity, and manage financial risks incurred by the entity.

The ACO model was included in national health care reform legislation as one of several demonstration programs to be administered by the Centers for Medicare and Medicaid Services (CMS), along with bundled payment and other key care delivery approaches. ACOs participating in the CMS program would assume accountability for improving the quality and cost of care for a defined patient population of Medicare beneficiaries. As proposed, ACOs would receive part of any savings generated from care coordination as long as benchmarks for the quality of care are also maintained. Health care reform provides a definition for the ACO model included in the demonstration programs. However, many details have yet to be defined.

Many experts believe ACOs in general will include certain core characteristics, including the participation of a diverse group of providers—including primary care physicians, specialists, and a hospital—and the ability to administer payments, determine benchmarks, measure performance indicators, and distribute shared savings (Deloitte, 2010). However, they could vary in their structure and payment model. For example, the ACO program proposed in health reform legislation limits provider exposure to financial risks, as it does not deviate from the current fee-for-service payment system and includes no payment penalties. On the other hand, ACOs that are being paid a fixed price are responsible for financial gain or loss.

This report focuses on the overall concept of the ACO and will attempt to highlight specifics of the ACO model proposed in health reform legislation where differences appear in existing literature.

Distinguishing Between ACOs and Earlier Care Delivery Initiatives

Health maintenance organizations (HMOs) and patient-centered medical homes (PCMHs) share commonalities with the ACO concept as large-scale attempts to improve health care delivery and payment. Even though the ACO model builds upon these previous attempts at health care delivery reform, there are variations between the ACO model and HMOs and PCMHs.

- ***ACOs and PCMHs***

The PCMH model, which emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care, can be viewed as being complementary to the ACO model (Devers and Berenson, 2009). Both models promote the utilization of enhanced resources—including electronic health records, patient registries, and increased patient education—to achieve the goal of improved care (Miller, 2009). However, unlike the ACO model, the PCMH does not offer explicit incentives for providers to work collaboratively to reduce costs and improve quality. Also, the PCMH model calls specifically for primary care providers to take responsibility for coordinating care, which could prove challenging if these providers do not have resources or established relationships with other providers to undertake these tasks.

The ACO model is expected to address some of the limitations in the PCMH model. For instance, the ACO model fosters accountability for care and costs by offering a joint payment to all providers involved in the provision of care. Also, the ACO model does not specify any type of provider to take the role as administrator of the ACO, but rather, offers characteristics for the types of organizations/providers that could assume the role of administrator. Also, unlike the PCMH model, a variety of payment models have been proposed for the ACO model, ranging from traditional fee-for-service payment to full capitation. Despite these key differences in the PCMH and ACO models, it is important to note that, far from being competing models, the PCMH structure could aid providers in taking on the additional accountability and administrative activities necessary to become an ACO.

- ***ACOs and HMOs***

The key difference between the ACO concept and HMOs lies in the payment structure and level of provider risk involved. While HMOs have typically been arranged around capitation, ACOs recognize variation in regional health care markets and the ability of providers to accept new payment models (Devers and Berenson, 2009). One proposed payment approach for public and private-sector ACO programs is the —shared savings‖ approach, used in the Brookings-Dartmouth and Medicare ACO program, where providers receive regular fee-for-service payment but qualify to share in any savings resulting from cost reduction and meeting predetermined performance and/or utilization targets. Other payment methods proposed in current literature for ACOs include a bundled payment, negotiated by the providers and payers, for an episode of care or capitation, similar to HMOs. It is important to note that the type of payment approach adopted is closely related to the level of financial risk that the providers are expected to assume. The primary criticism of the HMO model is that by making cost reduction its primary goal it sometimes sacrificed the quality of care. Providers participating in HMOs have also complained about the inadequate payment rates and high level of financial risk involved in the HMO model. Policymakers believe the ACO model incorporates some of these lessons learned from the HMO model.

ACOs and Health Care Reform

The Patient Protection and Affordable Care Act calls for the creation of an ACO program administered by CMS by January 1, 2012. Qualifying providers, including hospitals, physician group practices, networks of individual practices, and partnerships between hospitals and other health care professionals will be eligible to form ACOs. ACOs will —be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it ‖ and will also be expected to meet specific organizational and quality performance standards—which are still to be determined by CMS—in order to be eligible to receive payments for shared savings. The legislation does not provide specifics on how ACOs will be held financially accountable, as they will not be subject to financial risks in the form of payment penalties if they do not achieve their savings targets (CMS, 2010). Some of the additional stipulations for ACOs include:

- ACOs must have a formal legal structure to receive and distribute shared savings to participating providers.
- Each ACO must employ enough primary care professionals to treat their beneficiary population (minimum of 5,000 beneficiaries) as deemed sufficient by CMS.
- Each ACO must agree to at least three years of participation in the program.
- Each ACO will have to develop sufficient information about their participating health care professionals to support beneficiary assignment and for the determination of payments for shared savings.
- ACOs will be expected to include a leadership and management structure that includes clinical and administrative systems.
- Each ACO will be expected to have defined processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.
- ACOs will also be required to produce reports demonstrating the adoption of patient-centered care.

Potential Impacts of ACOs

Given the recent emergence of ACOs, providers considering participation in the CMS program do not have a long history of research on practicing ACOs to review. A limited amount of research exists on payment and delivery initiatives similar to ACOs that have been tested since as early as 1998 (shown below). These models include a combination of federal, regional, state, and local initiatives. These efforts offer some evidence on the potential impact of ACOs to reduce costs, improve coordination, and better align incentives of providers, payers, and patients. These efforts also share some of the critical characteristics of the ACO concept, including care coordination, evidence-based practice, and the sharing of savings based on improvements in quality and reductions in cost.

Precursors of ACOs :

Community Care of North Carolina
Since 1998, the state of North Carolina has operated Community Care of North Carolina, an enhanced medical home supported by the state's Medicaid program. The program builds community health networks organized collaboratively by hospitals, physicians, health departments, and social service organizations to manage care. Each enrollee is assigned to a specific primary care provider, while network case managers work with physicians and hospitals to identify and manage care for high-cost patients. A study by the University of North Carolina found that the program saved roughly $3.3 million in the treatment of asthma patients and $2.1 million in the treatment of diabetes patients between 2000 and 2002, while reducing hospitalizations for both patient groups. In 2006, the program saved the state roughly $150 to $170 million (Kaiser Commission, 2009).

Physician Group Practice Demonstration:
In 2005, Medicare developed the Physician Group Practice Demonstration, a group of ten provider organizations and physician networks to test shared savings. Providers are incentivized to coordinate care delivered to Medicare patients. Physician groups receive cost and quality performance payments if they achieve Medicare savings of more than two percent and additional bonuses beyond the two percent threshold. Performance payments are designed to reward both cost efficiency and performance on 32 quality measures phased in through the life of the demonstration. Through year three of the program, all ten participating sites achieved success on most quality measures, and five collectively received over $25 million in bonuses as a share of $32 million in Medicare cost reductions (McClellan et al., 2010).

Pathways to Health, Battle Creek, Michigan:
In 2006 Integrated Health Partners participated in a chronic disease initiative with Blue Cross Blue Shield of Michigan (BCBSM). The initiative was later restructured into Pathways to Health, a framework that includes several local health care stakeholders such as insurers, consumers, and employers interested in reducing hospitalization and improving chronic care delivery in their area. Pathways to Health features key ACO concepts such as a patient-centered medical home, value-based purchasing, and community buy-in. The collaborative is currently developing a new payment structure and improving its patient data collection efforts. BCBSM reports that hospitalizations for conditions that can be prevented via better ambulatory care have dropped 40 percent over the three-year life of the program (Simmons, 2009).

Even though the models in Above include some characteristics of ACOs and could provide some insight in the impact of ACOs, federal and private sector ACO programs(shown below) that are currently underway or planned for the future could provide better lessons for providers and payers interested in participating in ACOs

Sample ACO Pilots:

Brookings/Dartmouth Accountable Care Collaborative:
The Brookings Institution and the Dartmouth Institute for Health Policy are currently collaborating on the development of an ACO model focusing on local accountability, shared savings, and enhanced performance measurement. Roanoke, Virginia-based Carilion Clinic, a multi-specialty group practice with more than 500 physicians and seven hospitals, has been selected by the Brookings/Dartmouth collaborative as a pilot site for ACO adoption, along with Norton Health System in Louisville and Tucson Medical Center in Arizona.

Baylor Health System:
Dallas-based Baylor Health System, a 13-hospital system with 4,500 physicians, is currently developing an ACO model with a bundled payment system to control costs and improve care coordination. Baylor is directly marketing the ACO concept to employers, offering lower costs in exchange for participation in specific health insurance plans (Deloitte, 2010).

Robert Wood Johnson Foundation Medical School:
A pilot ACO program at Robert Wood Johnson Foundation Medical School in New Jersey will engage 100-500 physicians, several specialties, and six hospitals (Deloitte, 2010). The ACO's payment structure is still to be determined, but system leaders envision that the effort will link up the Robert Wood Johnson Medical Group—the state's largest multi-specialty network—with the 30 to 40 percent of primary care practices that have existing relationships with the school (Nelson, 2009).

Premier ACO Collaboratives
In May 2010, the Premier health care alliance announced plans to launch a two-track system for its member hospitals to participate in an ACO. The first effort, the ACO Implementation Collaborative, will consist of members who already possess the critical characteristics and relationships needed for successful ACO participation. The second effort, the ACO Readiness Collaborative, is designed to prepare hospitals by helping them to develop the skills and operational capacity necessary to implement in the future. To date, 70 hospitals and 5,000 physicians in 15 states have signed up for the two collaborative.

Key Questions to Consider

Hospitals and other providers interested in participating in private sector and CMS ACO programs need to consider their preparedness in the face of the limited information available and identify steps to undertake to facilitate participation in the emerging ACO programs. To aid hospitals, physician groups, and other organizations in making this assessment, we identify the following key questions that still need to be addressed and attempt to answer them with information available from the literature.

1. What are the key competencies required of ACOs?

2. How will ACOs address physician barriers to integration?

3. What are the legal and regulatory barriers to effective ACO implementation?

4. How can ACOs maintain patient satisfaction and engagement?

5. How will quality benchmarks be established?

6. How will savings be shared among ACOs?

1. What are the key competencies required of ACOs?

In order to qualify for the CMS program, participating ACOs will have to formalize a management structure to coordinate operations between participating providers and create a system for distributing shared payment. In general, the tasks and goals of ACOs will require both the ACO administrator and participating providers to possess certain core competencies.

- Leadership
- Organizational culture of teamwork
- Relationships with other providers
- IT infrastructure for population management and care coordination
- Infrastructure for monitoring, managing, and reporting quality
- Ability to manage financial risk
- Ability to receive and distribute payments or savings
- Resources for patient education and support

The structure of some care delivery organizations, such as Integrated Delivery Systems (IDSs) may facilitate the formation of an ACO because they may already possess the competencies identified in the literature. IDSs typically already assume some accountability for cost and quality, and often possess the population health data needed to effectively administer an ACO (Miller, 2009). IDSs with high-functioning leadership structures to handle the legal and clinical requirements of the ACO model may be best prepared to qualify for an ACO at present (Hastings, 2009).

Other care delivery organizations such as Multispecialty Group Practice (MSGP), Physician-Hospital Organization (PHO) and Independent Physician Association (IPA) may possess a partial list of the competencies and need to work on developing others. However, free-standing hospitals, post-acute care providers such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs), and small physician practices, can also position themselves to successfully participate in an ACO with appropriate technical assistance and/or practice redesign.

In addition to the core competencies identified in the literature above, there are other important competencies cited by thought leaders that could help organizations participating in an ACO acclimate to the novel care delivery and payment structure:

- ***Spread*** – ability to aggressively identify and disseminate best practices that promote efficiency of care delivery, improved quality of care, and reduced cost within an organization. This competency is important both at the individual institution level as well as the ACO level.

- ***Reach*** – established linkages between ACOs (or participating organizations) and public health/community resources in their catchment area to facilitate the transition of patients from the care delivery setting back into the community.

- ***Regional Health Information Exchange*** – participation in a multi-stakeholder health information exchange to share health care information with the goal of improving health and care in the community.

2. How will ACOs address physician barriers to integration?

Overcoming physician attitudes favoring autonomy and individual accountability over coordination will pose a major challenge to hospitals pursuing an ACO model, especially if they do not currently enjoy strong affiliations with physician groups who have admitting privileges (Fisher et al., 2006). Physician groups who are already part of integrated health systems may have an early edge in comparison to independent practice associations preparing to join an ACO. Physician groups will also have to be convinced that a strong business case exists for ACO development, and some groups may resist capitation and potential penalties for physicians related to quality performance, as have been proposed for some ACO models (Deloitte, 2010).

Other challenges may include deciding on the appropriate reimbursement model that is attractive to physicians and that falls within the existing legal requirements. Organizations participating in an ACO will also need to navigate differences in what they consider to be the appropriate use of potential shared savings. While hospitals may choose to use savings to offset any expenditures related to the ACO implementation or decrease in revenue stream resulting from reduction in volume, primary care physicians may choose to use the savings to pay for care management and information technology infrastructure (Miller, 2009).

3. What are the legal and regulatory barriers to effective ACO implementation?

The actualization of the ACO concept will prove challenging in the current legal environment. Sharing financial incentives across providers and incentivizing the use of evidence-based protocols can place participating providers at risk of violating federal laws that govern physician self-referral for Medicare patients and laws that protect patients and federal health care programs from fraud and abuse.

Hospitals preparing to join both federal and private-sector ACO programs may need to assess and potentially revise their existing contracts with other providers also taking part in the ACO. Implementing the ACO concept, which may require hospitals and physicians and other providers to accept one payment for all services and share financial incentives, could be in violation of previous interpretations of the Anti-Kickback Statute and Civil Monetary Penalty Law (Fader, 2010). Uncertainty about the antitrust consequences will deter precompetitive, innovative arrangements. Nonprofit hospitals would need to determine whether their involvement with participating, for-profit physician practices as part of an ACO complies with IRS guidelines for nonprofit institutions (Fader, 2010).

The health care reform bill does not create safe harbors or exceptions that address the operation of ACOs under current laws. However, the bill does permit the Secretary of Health and Human Services (HHS) to waive the requirements of the Anti-kickback, Stark, and Civil Monetary Penalty laws as necessary to administer ACOs (Bass, Berry, and Sims, 2010).

4. How can ACOs maintain patient satisfaction and engagement?
Medicare beneficiaries participating in the ACO program may not necessarily be aware of their assignment within an ACO and will be able to continue to choose their providers, including those who are not participating in their assigned ACO (CMS, 2010). However, adequate patient education will still be necessary to ensure that patients do not regard the ACO model unfavorably. Patients will need to understand how ACOs will impact the care they receive in the form of better quality, efficient care, and improved health outcomes resulting from coordinated care.

Since health outcomes are largely dependent on patients' participation in care, providers will need to actively engage consumers in the care that they receive and ensure that patients have a basic understanding of health care costs and the importance of efficient care delivery (Miller, 2009). Lastly, ACOs could maintain accountability to patients by measuring and reporting on patients' experience of care, in addition to reporting on costs and health outcomes (Miller, 2009).

5. How will quality benchmarks be established?
A critical component of the administration of ACOs that has not been determined in federal health reform and other key literature pertains to the quality benchmarks to which providers will be held accountable. Health reform legislation leaves the final decision of measure selection for ACOs to federal health officials, and the available literature does not provide guidance on how to choose appropriate measures.

As the CMS program and other private ACO initiatives are established, it is important to ensure that the quality benchmarks established and how they are interpreted and reported are standardized nationwide. The measures will also have to be applicable to different care providers and span care settings to accommodate the set of providers included in an ACO.

Lastly, the benchmarks will need to include a combination of process, outcome, and patient experience measures in order to accurately evaluate all aspects of care provided.

6. How will savings be shared among ACOs?
Payment reform is an important component of ACOs, since it is the main vehicle for holding providers accountable for the quality and cost of care that they provide. Experts have proposed several payment approaches for ACOs, which correlate with the level of risk that providers are expected to assume. Shortell and Casalino propose a three-tiered approach for risk-reward payment. In the first tier, which involves no risk, providers will receive shared savings and bonuses for meeting defined quality measures and staying under the expected costs of delivering care to patients. In the second tier, providers will receive shared savings for managing costs and hitting quality benchmarks, and will be liable for care that exceeds spending targets. In the third tier, providers assume greater risk and are paid through full or partial capitation. They could also qualify for substantial bonuses for meeting quality and patient experience targets (Shortell and Casalino, 2010).

The proposed payment model in health reform is a combination of the first and second tier of the Shortell/Casalino model. However, the specifics of it are yet to be defined by federal health officials. The model of payment for any ACO, as well as associated bonuses and penalties, will have to be substantial enough to generate change in the way care is delivered.

Conclusions

While some parallels exist between ACOs and existing efforts to coordinate care and integrate provider activities, substantial gaps exist in how an ACO will be structured and the impact that it will actually have on care delivery, quality, and costs. The early consensus emerging from ACO researchers appears to be that the model shows some promise as a driver of both quality improvement and cost control via care coordination (Devers and Berenson, 2009).

Hospitals and health systems considering ACO participation should assess their capabilities in several key core competencies that will likely be necessary for successful ACO implementation, including IT infrastructure, resources for patient education, team-building capabilities, strong relationships with physicians and other providers, and the ability to monitor and report quality data. Providers should be prepared to make major investments in these areas where necessary (Shortell and Casalino, 2010). ACOs whose members already possess many of these characteristics are expected to be most successful at implementation in the short run (Deloitte, 2010).

However, even providers who already possess key organizational, technical and clinical competencies may find that adjusting to an ACO will still require the sustained development and strengthening of those capacities in order to be successful (Devers and Berenson, 2010).

CMS SUMMARY:

Appendix – Medicare ACO Q & A Document
Medicare "Accountable Care Organizations"
Shared Savings Program – New Section 1899 of Title XVIII
Preliminary Questions & Answers
CMS/Office of Legislation

The Affordable Care Act (ACA) improves the health care delivery system through incentives to enhance quality, improve beneficiary outcomes and increase value of care. One of these key delivery system reforms is the encouragement of Accountable Care Organizations (ACOs). ACOs facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. This document provides an overview of ACOs and the Medicare Shared Savings Program.

Q: What is an "Accountable Care Organization"?

A: An Accountable Care Organization, also called an "ACO" for short, is an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.

For ACO purposes, "assigned" means those beneficiaries for whom the professionals in the ACO provide the bulk of primary care services. Assignment will be invisible to the beneficiary, and will not affect their guaranteed benefits or choice of doctor. A beneficiary may continue to seek services from the physicians and other providers of their choice, whether or not the physician or provider is a part of an ACO.

Q: What forms of organizations may become an ACO?

A: The statute specifies the following:

1) Physicians and other professionals in group practices
2) Physicians and other professionals in networks of practices
3) Partnerships or joint venture arrangements between hospitals and physicians/ professionals
4) Hospitals employing physicians/professionals
5) Other forms that the Secretary of Health and Human Services may determine appropriate.

Q: What are the types of requirements that such an organization will have to meet to participate?

A: The statute specifies the following:

1) Have a formal legal structure to receive and distribute shared savings
2) Have a sufficient number of primary care professionals for the number of assigned beneficiaries (to be 5,000 at a minimum)
3) Agree to participate in the program for not less than a 3-year period
4) Have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings. 5) Have a leadership and management structure that includes clinical and administrative systems
6) Have defined processes to (a) promote evidenced-based medicine, (b) report the necessary data to evaluate quality and cost measures (this could incorporate requirements of other programs, such as the Physician Quality Reporting Initiative (PQRI), Electronic Prescribing (eRx), and Electronic Health Records (EHR), and (c) coordinate care
7) Demonstrate it meets patient-centeredness criteria, as determined by the Secretary. Additional details will be included in a Notice of Proposed Rulemaking that CMS expects to publish this fall.

Q: How would such an organization qualify for shared savings?
A: For each 12-month period, participating ACOs that meet specified quality performance standards will be eligible to receive a share (a percentage, and any limits to be determined by the Secretary) of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. The benchmark for each ACO will be based on the most recent available three years of per-beneficiary expenditures for Parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. The benchmark for each ACO will be adjusted for beneficiary characteristics and other factors determined appropriate by the Secretary, and updated by the projected absolute amount of growth in national per capita expenditures for Part A and B.

Q: What are the quality performance standards?
A: While the specifics will be determined by the HHS Secretary and will be promulgated with the program's regulations, they will include measures in such categories as clinical processes and outcomes of care, patient experience, and utilization (amounts and rates) of services.

Q: Will beneficiaries that receive services from a health care professional or provider that is a part of an ACO be required to receive all his/her services from the ACO?
A: No. Medicare beneficiaries will continue to be able to choose their health care professionals and other providers.

Q: Will participating ACOs be subject to payment penalties if their savings targets are not achieved?
A: No. An ACO will share in savings if program criteria are met but will not incur a payment penalty if savings targets are not achieved.

Q: When will this program begin?
A: We plan to establish the program by January 1, 2012. Agreements will begin for performance periods, to be at least three years, on or after that date.

Source: https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf

How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations

The Patient Protection and Affordable Care Act of 2010 directs the Centers for Medicare and Medicaid Services (CMS) to create a national voluntary program for accountable care organizations (ACOs) by January 2012. ACOs are provider groups that accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the groups' clinicians.

Accountable Care Models

Accountable care organizations will be largely based on physician practices that, in turn, may be organized as patient-centered medical homes. Many ACOs will also include hospitals, home health agencies, nursing homes, and perhaps other delivery organizations. There are at least five different types of practice arrangements that could serve as ACOs. These are the integrated or organized delivery system, multispecialty group practices, physician-hospital organizations, independent practice associations, and "virtual" physician organizations, all described below.

1. **Integrated Delivery Systems**

Integrated delivery systems involve a common ownership of hospitals, physician practices, and—in some cases—an insurance plan. Some examples are Kaiser Permanente, Group Health Cooperative of Puget Sound, and Geisinger Health System. These systems typically have aligned financial incentives, electronic health records, team-based care, and resources to support cost-effective care.

2. **Multispecialty Group Practices**

Multispecialty group practices usually own or have a strong affiliation with a hospital. Examples of this type of arrangement include Mayo Clinic and Cleveland Clinic. They usually do not own a health plan but, rather, have contracts with multiple health plans in their areas. Most have a long history of physician leadership and highly developed mechanisms for providing coordinated clinical care.

3**. Physician-Hospital Organizations**

These organizations are a subset of the hospital's medical staff. One example is Advocate Health in Chicago. Most were formed in the 1990s in response to managed care pressures to negotiate with health plans. Some function like multispecialty group practices, focusing on reorganizing the delivery of care to achieve more cost-effective coordination. Although they may be less well suited than integrated delivery systems or multispecialty practices to qualify as ACOs, many could structure themselves to meet the criteria for that type of organization.

4. **Independent Practice Associations**

Independent practice associations consist of individual physician practices that came together largely for purposes of contracting with health plans. Over time, however, many of these have evolved into more-organized networks of practices that are actively engaged in practice redesign, quality improvement initiatives, and implementation of electronic health records. One example is Hill Physicians Group, in Northern California. Such organizations could qualify as ACOs, and that might encourage other independent practice associations to evolve similarly, given sufficiently strong financial incentives and technical assistance.

5. **Virtual Physician Organizations**

Finally, a number of small, independent physician practices, many located in rural areas, can organize to become "virtual" physician organizations, such as Community Care of North Carolina. This process can be led by individual physicians in rural areas or by a local medical foundation, state Medicaid agency, or similar organization that can provide the leadership, infrastructure, and resources to help small practices develop disease registries; implement electronic health records; share information; and provide better-coordinated, cost-effective care. These virtual networks could qualify as ACOs and serve as models for other groups of small practices.

Physicians can choose one or more of the above models, depending on what best fits their needs and local circumstances. But because there are so many options, the payment systems that the CMS creates for ACOs should evolve with the models chosen. Specifically, the more-integrated forms of accountable care, such as integrated delivery systems and multispecialty group practices, are capable of assuming the greatest risk. This would make them natural candidates for capitation or bundled payments, in which providers assume a relatively greater share of risk.

In contrast, less structurally integrated forms of ACOs, such as virtual physician organizations and more loosely organized independent practice associations, are best suited—at least initially—to low degrees of risk. For them, a form of limited, partial capitation for selected illnesses may be most appropriate.

To facilitate delivery system transformation and focus attention on desired health outcomes, payment systems need to change. Payment based on outcomes achieved, rather than on volume of services provided, will be the motivation for providers to focus their attention on improving the underlying systems of care.

Considerable technical assistance will be needed to implement the learning system for the development of ACOs. This will be particularly true for loosely organized independent practice associations and virtual physician networks, which currently lack the size and resources to become ACOs.

Key References and Sources:

Accountable Care Organizations – AHA Research Synthesis Report

Summary: This AHA Research Synthesis Report presents an overview of Accountable Care Organizations (ACOs), including a discussion on the potential impact of ACOs, key questions to consider in developing an ACO, and a review of the key competencies needed to be an effective ACO. This report focuses on the overall concept of ACO yet highlights the specifics of the ACO model proposed in health reform legislation.
http://www.aha.org/aha/content/2010/pdf/09-26-2010-Res-Synth-Rep.pdf

Proposals:
1. Fisher, E.S., Staiger, D.O., Bynum, J. and Gottlieb, D.J. (2006) Creating Accountable Care Organizations: The Extended Hospital Medical Staff. *Health Affairs* (26: w44-w57).

Summary: The article introduces the concept of accountable care organizations and explores the concept of the ―extended hospital medical staff, ‖ defined as a hospital-associated multi-specialty group practice tightly aligned to a specific hospital through direct or indirect referrals. The article assesses a group of hospitals and their extended medical staffs on their performance with heart attacks, colon cancer, and hip fractures, finding that hospitals and extended medical staffs who performed high on quality measures tended to have tighter affiliations with each other. The authors conclude that the extended medical staff model can bolster performance measurement, foster local accountability for capacity decisions, and improve quality and lower costs. The article also outlines some of the barriers to change, including the fee-for service payment system, the cultural importance U.S. physicians traditionally place on autonomy and the difficulty less tightly aligned hospitals and physician groups will have in adjusting to a new model.
http://content.healthaffairs.org/cgi/content/abstract/26/1/w44

2. Fisher, E., McClellan, M., Bertko, J., Lieberman, S., Lee, J., Lewis, J. and Skinner, J. (2009) Fostering Accountable Health Care: Moving Forward in Medicare. *Health Affairs (Web exclusive).*

Summary: The authors survey the variation in health care costs and outcomes in the United States, and propose the ACO model as part of a major realignment of payment incentives to support providers in improving care. The article advocates for increased accountability for providers to improve quality and manage costs, a shift away from practices that reward providers based on the volume and intensity of services and the use of transparent, meaningful performance measures to evaluate results. The article calls for ACOs to create formal legal structures, assume responsibility for a defined population of Medicare beneficiaries, and participate in public reporting of performance measures. In exchange, ACOs would receive shared savings for meeting quality standards while keeping costs below defined benchmarks.

http://content.healthaffairs.org/cgi/reprint/28/2/w219

3. Shortell, S. and Casalino, L. (2010) Implementing Qualifications Criteria and Technical Assistance for Accountable Care Organizations. *Journal of the American Medical Association*, 303 (17): 1747-1748.

Summary: The authors suggest a three-tiered system of ACO qualification, with each level representing graduated levels of assumed risk and payment incentives. In this model, Level I ACOs would assume no financial risk but would be eligible for shared savings for meeting quality and spending targets. Level II ACOs would receive greater proportions of shared savings but would assume some risk for not meeting agreed-upon targets. Level III ACOs would be paid through full or partial capitation. The article also explores the implementation hurdles that prospective ACOs must pass, including practice redesign, process improvement, EHR implementation and leadership development.

4. Miller, H. (2009) How to Create Accountable Care Organizations. *Center for Healthcare Quality and Payment Reform*.

Summary: This comprehensive assessment surveys the potential of the ACO model for improving quality and controlling costs, and examines the ways ACOs will impact primary care physicians, hospitals and consumers. The article notes several potential areas of improvement for hospitals participating in ACOs, including improved efficiency of patient care, the use of less costly treatment avenues, reductions in health care-acquired conditions and reductions in preventable admissions. The author concludes that ACOs will not adhere to a single formula, and asserts that while long-term improvements are possible, providers should prepare both organizationally and financially for an extended transition period.
http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf

5. MedPAC (2009) *Report to the Congress: Improving Incentives in the Medicare Program.* Chapter 2.

Summary: The report explores different potential models for ACOs administered by CMS, including a voluntary program with bonuses for meeting quality and spending targets and a mandatory model with physicians assigned to hospitals based on Medicare claims. The article concludes that ACOs could slowly incentivize change, emphasizing the importance ACOs will need to place on coordination, system thinking and constant refinement.
http://www.medpac.gov/chapters/Jun09_Ch02.pdf

6. Devers, K. and Berenson, R. (2009) Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries? *Robert Wood Johnson Foundation.*

Summary: The authors survey the potential of ACOs for managing patients' continuum of care across different institutional settings, better allocation of resources and serving as a framework for improved performance measurement of patient populations. The article concludes that ACOs have the potential to improve quality and reduce costs, but will require years of practice and refinement to reach those goals.

http://www.rwjf.org/qualityequality/product.jsp?id=50609

Evaluation of demonstration projects:

7. Simmons, J. (2010) The Medical Home as Community Effort. *Health Leaders.* (April 2010, pp. 50-51).

Summary: The author looks at the three-year-old Pathways to Health collaborative in Battle Creek, Michigan, an effort that brought together Integrated Health Partners, Battle Creek Healt System and local health plans to create a framework including a patient-centered medical home, value-based purchasing and community buy-in. The article focuses on the development of the ACO, as providers, consumers and health plans met and ultimately formed a leadership team. The article details efforts to retain accurate patient data and implement Plan-Do-Study-Act ideals, while creating a new bundled payment structure. So far, Blue Cross Blue Shield of Michigan reports that hospitalizations —for those conditions that better ambulatory care can prevent ‖ have dropped forty percent.
http://www.healthleadersmedia.com/content/MAG-249300/Quality-The-Medical-Home-as-Community-Effort

8. Kaiser Commission on Medicaid and the Uninsured. (2009) *Community Care of North Carolina: Putting Health Reform Ideas into Practice in Medicaid.*

Summary: This article assesses North Carolina's Community Care of North Carolina program, an enhanced medical home model operated by the state's Medicaid program. The program relies on nonprofit community networks of hospitals, physicians, health departments and social service organizations to manage care, and notes that the program saved roughly $3.3 million in the treatment of asthma patients and $2.1 million in the treatment of diabetes patients between 2000 and 2002, while reducing hospitalizations for both patient groups. In 2006, the program saved the state roughly $150 to $170 million. The article concludes that the practices developed by CCNC show promise as tools to implement health reform national and provide —coordinated, cost effective care to low-income individuals with significant health needs. ‖
http://www.kff.org/medicaid/upload/7899.pdf

9. Nelson, Bryn. (2009) Quality over Quantity. *The Hospitalist.*

Summary: The article considers the role integrated systems have played in inspiring ACOs, and surveys a handful of ACO pilots, including Carilion Clinic in Virginia and Robert Wood Johnson Medical School in New Jersey. The article explores possible ACO frameworks, noting that successful models will include the key concepts of local accountability, shared savings and enhanced performance measurements.
http://www.the-hospitalist.org/details/article/477391/Quality_over_Quantity.html

Other Published Literature

10. CMS Office of Legislation (2010) *Medicare Accountable Care Organizations Shared Savings Program: Preliminary Questions And Answers.*

Summary: The document provides an overview of the ACO Shared Savings Program as established in the 2010 Patient Protection and Affordable Care Act, and explores some of the questions emerging from providers regarding ACO participation, including eligibility for shared savings, quality performance standards and the release of future information from CMS concerning the ACO program.
https://www.cms.gov/OfficeofLegislation/Downloads/AccountableCareOrganization.pdf

11. McClellan, M., McKethan, A.N, Lewis, J.L., Roski, J., and Fisher, E.S. (2010) A National Strategy to Put Accountable Care Into Practice. *Health Affairs.* (29, No. 5: 982-990).
Summary: The authors analyze ACOs in the context of recent health care reform legislation, suggesting that ACOs should have flexibility in terms of design but should broadly be provider-led organizations centered on primary care, with payments linked to quality improvement and cost reduction, and increasingly sophisticated performance measurement. The article discusses the structures of a variety of potential payment models, including partial capitation models integrating flat payments with bonuses and penalties related to performance and cost benchmarks, and —symmetric ‖ paym en tm odels that offer providers proportionately larger bonuses as they assume greater accountability for costs. The authors conclude that ACOs may have a modest impact on the transformation of payment models in the short-term, but have the potential to drive clinical and financial transformation in the long run.
http://content.healthaffairs.org/cgi/content/abstract/29/5/982

12. Davis, G. and Rich, J. (2010) Health Care Reform: ACOs and Developments in Coordinated Care Delivery, Shared Savings and Bundled Payments. *McDermott Newsletters*.

Summary: The authors compare ACOs to Physician Hospital Organizations (PHOs), arguing that while PHOs were organized mainly to facilitate managed care contracting, while ACOs aim to better coordinate care as a means to both improve quality and control costs. The article also notes some of the key elements of an effective ACO—including medical homes, networks of specialists, care integration and reimbursement models that reward cost-effective high-value-care, and summarizes the provisions of recent health care reform legislation related to ACOs and bundled payment.
http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/6699b22c-127a-4cf0-a80b-bab7a75767de.cfm

13. Burke, T. and Rosenbaum, S. (2010) Accountable Care Organizations: Implications for Antitrust Policy. *Robert Wood Johnson Foundation*.
Summary: The authors detail the relationship between ACOs and federal antitrust policy. Specifically, the article outlines the emphasis the judiciary system has placed on clinical and financial integration as a prerequisite to joint efforts between providers, and notes that arrangements that do not meet financial integration standards are susceptible to violating antitrust statute. The article summarizes several recent antitrust cases brought by the Federal Trade Commission in the context of clinical integration, with examples of both sustained partnerships and those rejected by the legal system. The article concludes that taken together, the decisions support the enforcement agencies' position that in order to justify anti-competitive practices, partnerships between providers must demonstrate collective effort to improve quality and control costs beyond what would have been achieved independently.
http://www.rwjf.org/qualityequality/product.jsp?id=57509

14. Fader, Henry C. (2010) Are Accountable Care Organizations in Your Vocabulary? *Pepper Hamilton, LLP.*
Summary: The author details the legal framework for structuring an ACO, arguing that the entity will require a separate administrative staff that is separate from both the hospital and physicians. That staff would be charged with monitoring and providing care both within the hospital and outside the hospital. The article also emphasizes the importance of clinicians in an ACO model, and assesses the hurdles ACOs will have to overcome to comply with antitrust and anti-kickback statutes.
http://www.pepperlaw.com/publications_update.aspx?ArticleKey=1757

15. Deloitte. (2010) *Accountable Care Organizations: A New Model for Sustainable Innovation.*
Summary: The article outlines the promise of the ACO model for improving care delivery, summarizing the structural guidelines of ACOs included in recent health reform legislation and discussing emerging ACO pilots in Massachusetts, Vermont and Colorado. The article argues that the degree of integration within current physician models may be a predictor of early success in creating an ACO. The authors assert that successful ACOs will be defined by strong leadership, governance and operational clinical management capabilities, and outlines the challenges of physician buy-in, consumer response, the structure of payments and managing risk before concluding that ACOs will need to carefully structure provider relationships, accept that results may be slow in materializing and commit themselves to continual improvement as clinical conditions change over time.

http://www.deloitte.com/view/en_US/us/Industries/US-federal-government/center-for-health-solutions/research/bc087956da618210VgnVCM100000ba42f00aRCRD.htm

16. Hastings, D.A. (2009) Accountable care organizations and bundled payments in Health Reform. *Health Law Reporter.*

Summary: The author surveys the landscape of proposed health reform legislation, and notes several legal challenges to ACO development, including the revision of contracts between providers participating in ACOs, compliance with anti-kickback and antitrust statutes, new compliance responsibilities related to adherence to ACO regulations and public reporting, the increased responsibilities of leadership and board management and the integration of bundled payments with ACOs. The article concludes that ACOs and bundled payments both show promise as drivers of health care quality improvement.
http://www.ebglaw.com/files/37716_BNA%20Article%20-%20Accountable%20Care%20Organizations%20and%20Bundled%20Payments%20in%20Health%20Reform.pdf

17. Bass, Berry, and Sims (2010) *The ABCs of ACOs.*

Summary: The article analyzes the legal requirements and hurdles providers will face as they prepare for ACO implementation. Specifically, the article explores ACO compliance with the Anti-Kickback Statute, the Stark Law, antitrust laws and the Civil Monetary Penalty Law, noting that while health care reform legislation did not create safe harbors or exceptions to these statutes in connection to the development of ACOs, the Secretary of HHS has been authorized to waive requirements of these statutes as necessary.
http://www.bassberry.com/files/Publication/f55dbab0-b844-4a1f-bf0a-0e34ebab8d7d/Presentation/PublicationAttachment/a98eb254-ce4f-48f3-924b-0e91896128f7/HealthReformImpact29April2010.pdf