



# ADVANCING NATIONAL HEALTH REFORM

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## **Implementing Accountable Care Organizations**

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## EXECUTIVE SUMMARY

As the nation gears up to implement the newly-minted comprehensive healthcare reform law, the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148 (2010)), there is broad agreement on the need for fundamental reform of healthcare delivery and payment systems. At the current annual rate of healthcare spending, the Medicare Trust Fund will be bankrupt in 2017. At the same time, there is urgent need to provide more coordinated and cost effective care to all Americans and, particularly, to the growing number of people with chronic illness. Expanding health insurance coverage to nearly all Americans and legal immigrants will only add to the challenge of reforming the delivery system.

The success of innovative, cost-containing payment mechanisms depends on the capabilities of health care providers to respond effectively to new payment incentives. In this Policy Brief, we focus on Accountable Care Organizations (ACOs)—an “umbrella” concept that links an organizational structure—real or virtual integration among providers—with a payment and performance measurement approach that ensures accountability. In private sector pilot programs and under the new healthcare reform law, ACOs are defined as groups of providers, which may include hospitals, that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services.

The diversity of medical practice forms can be reduced to four models that have the potential to qualify as ACOs: the [integrated delivery system \(IDS\)](#), the [multi-specialty group practice \(MSGP\)](#), the [physician-hospital organization \(PHO\)](#), and the [independent practice association \(IPA\)](#) and its variations. We recommend that the Secretary of the U.S. Department of Health and Human Services (HHS):

1. Establish a three-tier structure of qualification for ACO designation. The tiers or levels would be based on the degree of financial risk assumed by the ACO and the degree of rewards that could be achieved by meeting performance targets.
2. Link payment approaches to the ACO qualification levels. Level I ACOs should receive primarily [fee-for-service](#) payment with shared savings for providing quality care at lower than overall expenditure targets. Level II ACOs should receive more [bundled payments](#) and [episode-of-care based payments](#). Level III ACOs should receive partial and global [capitation](#) payments.
3. Require Medicare and Medicaid and private insurance plans to provide patients with a choice of at least one ACO where feasible.
4. Assign Medicare and Medicaid patients who have not selected a provider to an ACO from where they have been receiving the majority of their care. Private insurance plans could do the same.

Given that most physicians currently practice in organizations that lack the elements to participate as a Level II or Level III ACO, and many even as a Level I ACO, considerable technical assistance will be needed for widespread implementation to occur. We recommend that:

1. The private sector, professional associations, and the CMS [Quality Improvement Organizations \(QIOs\)](#) should provide administrative, governance and legal assistance for establishing ACOs.

2. Private sector organizations, professional associations, and CMS QIOs should also provide practices with technical assistance to develop the capabilities to compete for performance based rewards. This includes assistance in practice redesign, the development of process improvement capabilities, implementation of care coordination models, development of healthcare teams and related capabilities.
3. The [Office of the National Coordinator for Health Information Technology \(ONC\)](#) should set aside funds to assist ACOs in implementing [electronic health records](#) with the interoperability that links all participating providers in the ACO.
4. Special assistance should be provided to practices in developing the needed clinical and managerial leadership for success. Emphasis should be given to on-site programs. This assistance can be provided by the Medicare QIOs, private sector organizations, and large hospitals and integrated delivery systems. One promising approach is that of partnering an integrated delivery system or multi-specialty practice with practices seeking to develop their leadership capabilities.
5. In all of the above, particular attention should be given to loosely organized IPAs and small practices who desire to become ACOs.

CMS (and other payers) should move rapidly to pay providers for keeping people healthy, preventing disease and disability, and for coordinating comprehensive chronic care management. This means moving away from paying ACOs based on units of service provided, to paying based on health outcomes achieved for a given population of patients. New payment methods also need to be combined with incentives for improving quality and the patient experience and incentives are needed to encourage more physicians to join or form ACOs. In particular:

1. Specific payment models and approaches should be linked to different levels of ACO qualification criteria.
2. Public and private payers should establish a common set of quality, cost, and patient experience measures on which to base paying for positive results.
3. CMS and private insurers should provide incentives for physicians who wish to join high performing ACOs by providing grants and loans particularly targeted to loosely organized IPAs and small physician practices.
4. CMS should establish medical and nursing loan forgiveness programs for those who wish to join high performing qualified ACOs.
5. CMS should provide incentives to encourage Academic Medical Centers to form ACOs to provide medical and other health science professional students with exposure to ACO-based care delivery.
6. The Center for Medicare and Medicaid Innovation within CMS should partner with private sector organizations and professional societies in spreading successful ACO and associated Patient-Centered Medical Home models throughout the country.

In order to facilitate innovations in payment, incentives, and ACO formation, laws, regulations and policies in five major legal areas may require changes. Otherwise, the providers and organizations that form the ACO could find themselves in violation of the federal antitrust law (which prohibits anti-competitive behavior), state corporate practice of medicine statutes (which generally prohibit a business corporation from employing physicians or practicing medicine), the federal anti-kickback statute (which prohibits the offer or receipt of remuneration in return for referrals for services reimbursable under

Medicare or Medicaid), the federal Stark law (which governs physician self-referrals), and the federal civil monetary penalties law.

1. HHS should form a taskforce involving experts from the Federal Trade Commission, legal and regulatory scholars, and others to examine the legal and regulatory barriers to ACO formation.

Establishing organizational qualifications and patient linkage criteria, providing technical assistance and aligning payment and incentives to co-evolve with practice organizations must also be accompanied by accountability for the total cost and quality of care provided.

1. HHS should form a taskforce of representatives from the [Agency for Healthcare Research and Quality \(AHRQ\)](#), private sector organizations, and professional associations to provide ongoing review of new measures of costs, quality, outcomes, and patient experience for purposes of updating the accountability criteria by which to assess ACO performance.
2. AHRQ or a similar agency within HHS should report on cost, quality, outcome, and patient experience performance for the country at large for all providers including ACOs.
3. Data on the cost, quality, outcome, and patient experience performance of ACOs should be made publicly available to patients, providers, payers, the general public, and on the insurance exchanges.

Not all providers will benefit equally from the changes in the healthcare system we advocate, and which the 2010 health reform law embraces. In fact, some will not benefit at all. But the American healthcare system as a whole will. With considered attention paid to implementation and learning, all providers will be given the opportunity to succeed and to improve over time. What is clear is that a new platform of healthcare delivery is needed to meet both the demand and needs of the increased number of Americans with insurance coverage and the equally compelling challenge of sustaining the affordability of such coverage over time.

# Implementing Accountable Care Organizations

## INTRODUCTION<sup>i</sup>

As the nation gears up to implement the newly-minted comprehensive healthcare reform law, the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148 (2010)), there is broad agreement on the need for fundamental reform of healthcare delivery and payment systems. At the current annual rate of healthcare spending, the Medicare Trust Fund will be bankrupt in 2017. At the same time, there is urgent need to provide more coordinated and cost effective care to all Americans and, particularly, to the growing number of people with chronic illness. Expanding health insurance coverage to nearly all Americans and legal immigrants will only add to the challenge of reforming the delivery system.

Various alternatives to [fee-for-service](#) payment have been proposed. These include full and partial [capitation](#), [episode-of-care based payment](#), [bundled payments](#) and others. But their success is likely to depend not only on the specific approaches to payment that are adopted, but also on the capabilities of providers to respond. In this Policy Brief, we focus on Accountable Care Organizations (ACOs)—an “umbrella” concept that links an organizational structure—real or virtual integration among providers—with a payment and performance measurement approach that ensures accountability. There are many challenges to implementing the ACO concept.<sup>1,2</sup> We set forth some key considerations and offer some specific recommendations involving organizational qualifications and patient linkage criteria, technical assistance, payment and incentives and accountability.

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<sup>i</sup> Terms in blue, underlined font are defined in the Glossary, beginning on page 15.

## The ACO Model

The Accountable Care Organization (ACO) model is based on three design principles: (1) provider-led organizations that are collectively accountable for the entire continuum of care—that is for the overall costs and quality of care for a defined population of patients; (2) payment reforms that reward quality improvements and slow spending growth, while avoiding excessive new financial risk for provider organizations; and (3) reliable performance measurement to support improvement and provide public confidence that lower costs are achieved with better care.<sup>3</sup> The Patient Protection and Affordable Care Act establishes a national voluntary program in which ACOs apply for certification from the Secretary of the U.S. Department of Health and Human Services (HHS) to participate in a Medicare Shared Savings Program, which will be created before January 1, 2012.<sup>4</sup> In addition, the law creates a Pediatric Accountable Care Organization Demonstration Project and expands the scope and purpose of the Medicare Rural Flexibility Program to allow for ACO incentive payments.<sup>5</sup>

ACOs are defined as groups of providers that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services.

In private sector pilot programs and under the new legislation, ACOs are defined as groups of providers, which may include hospitals, that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services. A variety of payment models are envisioned and encouraged (for example, [targeted expenditure caps](#), partial [capitation](#) and [bundled payments](#)).<sup>ii</sup> The Secretary of HHS is charged with setting annual quality targets as a condition of participation and can issue regulations to permanently implement successful models. Preference may be given to ACOs that participate in similar arrangements with payers in addition to Medicare and Medicaid.<sup>iii</sup>

### Organizational Qualifications

Most Americans receive their medical care from physicians who practice in a variety of settings and have admitting privileges at local hospitals. This diversity, however, can essentially be reduced to four models of practice potentially able to meet ACO qualification criteria, keeping in mind that there are currently no legal requirements or standards for ACOs beyond what the new healthcare law provides in the Medicare context. These four models are the [integrated delivery system \(IDS\)](#), the [multi-specialty group practice \(MSGP\)](#),

<sup>ii</sup> The Patient Protection and Affordable Care Act (PPACA) includes new patient care models that contemplate innovations in payment structures, e.g., a National Pilot Program on Payment Bundling (PPACA § 3023) and the new Center for Medicare and Medicaid Innovation (CMI) within the Centers for Medicare and Medicaid Services (CMS), whose purpose is to test innovative payment and service delivery models that reduce expenditures while enhancing or preserving quality (PPACA § 3021).

<sup>iii</sup> But note that providers who participate in *another* shared savings program—including one created by the new Center for Medicare and Medicaid Innovation (Section 1115A of the Social Security Act, 42 U.S.C. § 1315a (added by the PPACA § 3021)), or any other program or demonstration project that involves shared savings—may not also participate in an ACO (PPACA § 3022). The same limitation applies to providers who participate in the independence-at-home medical practice pilot program.

the [physician-hospital organization \(PHO\)](#), and the [independent practice association \(IPA\)](#) and its variations.<sup>6,7,8</sup> It is clear that with their greater infrastructure and resources, most IDs and large MSGPs would meet most of the qualification criteria that might be developed for ACOs. PHOs and IPAs might be expected to show greater variability in meeting ACOs eligibility criteria depending on the stringency of the criteria themselves. In this regard, a balance must be struck between developing criteria stringent enough to induce desired changes and yet not so stringent that it bars or “de-motivates” a substantial number of practices from seeking qualification.

We recommend creating a three-tier system of qualification.<sup>9,10</sup> Under a three-tier system, practices would submit a three-year plan to the Secretary of HHS or to the [Centers for Medicare & Medicaid Services \(CMS\)](#) for achieving qualification status at the various levels. Each level would have associated with it a risk-reward relationship which would increase from Level I to Level III.

**Level I ACOs** would bear little or no financial risk,<sup>iv,11</sup> but be eligible to receive shared savings bonuses if they met quality benchmarks and reduced per-beneficiary spending below their agreed-upon target. To qualify as a Level I ACO, the following minimum requirements would be established:

- 1) Establish a legal practice entity with a designated governance and management leadership in place for purposes of accountability;
- 2) Demonstrate the capacity to report a basic set of performance measures based on [administrative data](#);
- 3) Include within the ACO a sufficient numbers of primary care physicians to serve a required minimum number of patients for performance measurement reporting;
- 4) Provide a plan for handling transitions between inpatient and outpatient care; and
- 5) Have an established process for receiving patient feedback on care provided.

**Level II ACOs** would be eligible to receive a greater proportion of savings below a target, but also be at risk for spending above the target. These ACOs would be required to meet the following additional criteria:

- 1) Participate in more comprehensive performance measures that include validated patient experience measures and clinical performance on the care of defined chronic disease populations such as those with asthma, diabetes, and congestive heart failure; and
- 2) Meet specific standards for financial reporting including financial projections and minimum cash reserve.

To qualify as a **Level III ACO**, which could be reimbursed through full or partial [capitation](#), providers would need to meet all of the above criteria as well as:

- 1) Publicly report comprehensive performance measures—drawn from electronic health records and patient reports—of health-related outcomes and quality of life and care experience for specific populations, including primary care patients and those with specific high frequency conditions such as acute myocardial infarction, diabetes and major elective surgical procedures; and

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<sup>iv</sup> Note that ACOs that demonstrate clinical integration but do not share “substantial” financial risk would receive less presumptive protection from antitrust scrutiny, although this is not an absolute bar on Level I ACO formation. This issue is further detailed below.



- 2) Meet additional more stringent standards for financial reporting and be required to hold larger cash reserves.

The above are intended only as examples and should be adjusted based on current knowledge of physician practices across the country and data that accumulate over time. What is important is the idea that practices can start at a low level of developing the capabilities to provide cost-effective coordinated care and advance to higher levels over time with the associated risk reward relationship adjusted accordingly. Level I ACOs would receive a smaller proportion of shared savings, or bonus payments for cost reduction and quality improvement, but would also assume the least risk. Level II ACOs would be eligible for greater payment rewards and incentives but would also assume greater risks. The Level III ACOs would be eligible for the greatest rewards but also share the greatest risk.

Practices can start at a low level of developing the capabilities to provide cost-effective coordinated care and advance to higher levels over time with the associated risk reward relationship adjusted accordingly.

### **Patient Linkage**

Patient linkage to ACOs would be determined either through assignment by the patient's insurer (CMS in the case of traditional Medicare) or by the patient's voluntary choice. Most Americans with insurance coverage currently choose a personal physician or provider system that accepts the patient's insurance coverage. For the uninsured and those without a designated personal physician or provider linkage, assignment could be made based on the provider with whom the person received the majority of care. Systems that care for the uninsured, including public hospitals and [Federally Qualified Health Centers \(FQHCs\)](#), could create safety-net ACOs that would help facilitate this assignment process. In neither case—choice or assignment—would patients be “locked in” beyond a given year. The point of having patients choose or be assigned to an ACO is so that (1) the ACO and the payer know that the patient is part of the ACO's population; and (2) the ACO can demonstrate to the patient that there are benefits to seeking care within the ACO.

### **Recommendations: Organizational Qualifications and Patient Linkage**

- Establish a three-tier structure of qualification for ACO designation. The tiers or levels would be based on the degree of financial risk assumed by the ACO and the degree of rewards that could be achieved by meeting performance targets.
- Link payment approaches to the ACO qualification levels. Level I ACOs should receive primarily [fee-for-service](#) payment with shared savings for providing quality care at lower than overall expenditure targets. Level II ACOs should receive more [bundled payments](#) and [episode-of-care based payments](#). Level III ACOs should receive partial and global [capitation](#) payments.
- Require Medicare and Medicaid and private insurance plans to provide patients with a choice of at least one ACO where feasible.
- Assign Medicare and Medicaid patients who have not selected a provider to an ACO from where they have been receiving the majority of their care. Private insurance plans could do the same.

## Implementing ACOs

### **Technical Assistance**

Given that most physicians currently practice in organizations that lack the elements to participate as a Level II or Level III ACO—and even as a Level I ACO—considerable technical assistance will be needed for widespread implementation to occur.<sup>12,13,14</sup> The technical assistance required falls into two broad categories. First, provider organizations will need support to develop the contractual, legal, financial, and budget targeting relationships with payers—Medicare, Medicaid, and private insurers—that are required to establish the gain-sharing programs and support performance reporting requirements. We recommend developing replicable models and templates that could guide provider groups as they begin to form ACOs. An example developed by the California Association of Physician Groups is provided in Appendix 1.

Second, providers will need help with the clinical transformation in practice that will be essential to improve the quality of care while slowing the growth of healthcare costs. Private sector organizations, professional associations, and the CMS [Quality Improvement Organizations \(QIOs\)](#) can provide assistance in practice redesign, process improvement and quality improvement, teamwork, electronic health record implementation, and leadership development. Each of these is centered on developing a better patient care experience and better patient outcomes. These ACO building blocks mutually reinforce each other.

Practice redesign must address the limited time that most physicians have to spend with patients and take into account the demands being made by the growing prevalence of chronic illness. Examples of changes that practices will need assistance with include open access scheduling that facilitates same-day appointments, group visits for patients with similar conditions, planned visits based on examination of data and the patient's health status and needs prior to the scheduled visit, increased use of email communication and “e-visits” to help patients manage their healthcare between scheduled in-person visits, development of patient self management support programs, and increasing the roles and responsibilities of other health professionals such as nurses, physician assistants, pharmacists, dietitians, and social workers. Loosely organized [IPAs](#) and small physician practices should be targeted for such assistance in practice redesign.

In addition to organizational structural changes, many practices will need assistance in learning the skills and tools associated with process and continuous quality improvement. In many respects, these are the tools that will be needed to make the organizational structural changes and in particular, to assess whether or not they are working. Examples range from basic statistical analysis tools such as [run charts](#), and [plan, do, study, act \(PDSA\)](#) cycles to more comprehensive sophisticated approaches involving [Lean Production](#) and [Six Sigma](#) techniques used in other industries. Again, loosely organized IPAs and small physician practices will particularly need such assistance.

Key to effectively coordinating care will be the ability to work in teams. Many of the more mature [IDSs](#) and [MSGPs](#) attribute their relative success to teamwork. Working with patients with chronic illness requires a continuous flow of data, information, and knowledge

among all involved providers, necessitating teamwork not only within practices but across practices and settings in the ACO. A premium will be placed on these [relational coordination](#) needs to manage the patient’s care across the continuum.<sup>15</sup> Teams are also needed to do the process improvement work noted above. Most physicians and other health professionals have been trained to work and make decisions as individuals. With few exceptions, working in teams is not the predominant form of practice. Again, private sector organizations, professional associations, and the CMS [QIOs](#) can provide assistance for such team-building skills as assessing who should be assigned to various teams, taking into account status differences among team members, establishing the norms, roles, and responsibilities of the team, training team members to deal with conflict, working on improving communication and deciding how performance could be measured and rewarded—among other issues.<sup>16</sup>

The need for assistance in adapting and implementing [electronic health records \(EHRs\)](#) is well recognized. A significant portion of the \$19 billion allocated by the Obama administration in the American Recovery and Reinvestment Act of 2009 will go to provide technical assistance to hospital and physician practices to implement EHRs. The concern, however, is that much of this assistance is likely to be siloed; that is, it will provide assistance to individual hospitals and physician practices to implement EHRs within their own setting but fail to address the interdependence and interoperability issues themselves, such as the imperative to communicate data, information, and knowledge across settings. This will be particularly problematic for the formation of ACOs, which, by definition, must assume responsibility for the care of defined populations across settings. We recommend earmarking some funds (or targeting additional funds) to be used by ACOs in implementing EHRs with interoperability that links all participating providers in the ACO. Such assistance will also need to take into account both information and knowledge needed to manage patient care, external public reporting, and accountability needs requiring aggregation of data across all patients. Again, loosely organized [IPAs](#) and small physician practices should be targeted for such assistance.

We recommend setting aside funds to be used by ACOs in implementing Electronic Health Records with interoperability that links all participating providers in the ACO.

A frequently overlooked aspect of technical assistance for improving the healthcare delivery system performance is leadership. Yet very little happens without it. Leadership is particularly important in times of uncertainty and change. Many of the success stories of established IDs and MSGPs can at least be partially attributed to leadership enjoyed by these organizations from their early founding. The success stories (to date) of some [PHOs](#), IPAs, and small physician practices are less frequent than those of IDs and MSGPs but can also be attributed to their leaders. The challenge is to develop a broader base of clinical and managerial leadership across the country. A cadre of leaders is needed that can “activate” the implementation of practice redesign, process improvement, teamwork, and data imperatives noted above. Evidence-based frameworks of effective leadership exist, built on a set of transformational, implementation, and people competencies.<sup>17</sup> It is one thing for individuals to develop their leadership skills, but what is increasingly needed is for organizations to develop leadership competencies throughout the organization. Thus, organizations are increasingly turning to team-based leadership development programs both

on and off site, organized around the daily challenges facing the organization. A similar approach will likely be needed for sustaining ACO development. This will be difficult because busy physicians and other healthcare professionals have little time for such investment. This is particularly true for the loosely organized IPAs and small physician practices that are unlikely to “close shop” for a week to participate in an off-site team leadership development program. More likely to succeed are on-site leadership programs developed (perhaps with outside assistance) within the ACO itself. This will be more feasible for those ACOs that contain at least one relatively large MSGP or hospital with some resources and experience in leadership development that can be made available to others within the ACO. For the loosely organized IPAs and small physician practices, we recommend developing creative “network” models of assistance supported by foundations or the free assistance provided by CMS QIOs).<sup>18</sup> We also recommend using existing ACOs, particularly established IDSs and MSGPs, or organizations such as the [Council of Accountable Physician Practices \(CAPP\)](#) to provide such assistance in return for receiving a technical assistance payment bonus from CMS. This “twinning” concept involves using existing organizations to partner with other organizations to provide “organizational mentoring” and technical assistance.

#### **Recommendations: Technical Assistance**

- The private sector, professional associations, and the CMS [Quality Improvement Organizations \(QIOs\)](#) should provide administrative, governance and legal assistance for establishing ACOs.
- Private sector organizations, professional associations, and CMS QIOs should also provide practices with technical assistance to develop the capabilities to compete for performance based rewards. This includes assistance in practice redesign, the development of process improvement capabilities, implementation of care coordination models, development of healthcare teams and related capabilities.
- The [Office of the National Coordinator for Health Information Technology \(ONC\)](#) should set aside funds to assist ACOs in implementing [electronic health records](#) with the interoperability that links all participating providers in the ACO.
- Special assistance should be provided to practices in developing the needed clinical and managerial leadership for success. Emphasis should be given to on-site programs. This assistance can be provided by the Medicare QIOs, private sector organizations, and large hospitals and integrated delivery systems. One promising approach is that of partnering an integrated delivery system or multi-specialty practice with practices seeking to develop their leadership capabilities.
- In all of the above, particular attention should be given to loosely organized [IPAs](#) and small practices who desire to become ACOs.

#### **Payment and Incentives**

CMS (and other payers) should move rapidly to pay providers for keeping people healthy, preventing disease and disability, and for coordinating comprehensive chronic care management. This means moving away from paying ACOs based on units of service provided, to paying based on health outcomes achieved for a given population of patients. Examples include [global capitation](#) or a fixed sum per member per month; [partial capitation](#), for example for professional services with at risk shared savings for hospital care; defined

[episode-of-care payments](#) for conditions such as diabetes or asthma; [bundled payments](#) for physicians and hospitals in treating selected conditions such as [AMI](#), [CABGS](#), total hip and total knee replacements; and related payment methods. As a guiding principle, the payment method should approximately match the risk/reward criteria of the ACO. For example, Level III ACOs qualifying for the highest level of risk/reward might be paid predominantly by global capitation. Level II ACOs might be paid primarily by partial capitation or episode-of-care based payment and some bundled payments for specific conditions. Level I ACOs might be primarily paid initially by [fee-for-service](#) but begin to introduce some episode-of-care and bundled payments for a limited number of conditions. In each case, however, adjustments would be made for the health status of the population served. On the cost side, adjustments would be also made for regional differences in cost of living using the area wage index or similar metric.

New payment methods need to be combined with incentives for improving quality and the patient experience. The payment system should be structured so that physicians and hospitals in high-performing ACOs are better off than those outside ACOs, but physicians and hospitals in poorly performing ACOs would be better off if they left the ACO. Recent evidence suggests that ACOs need to have at least 50 primary care physicians for statistically reliable cost and quality measures to be useful.<sup>19</sup> Based on the recommendations of the [Institute of Medicine](#),<sup>20</sup> the [National Quality Forum](#)<sup>21</sup> and [NCQA HEDIS](#)<sup>22</sup> measures can be used to gauge achievement. Some of the “quality bonus” earned might be based on achieving a minimum standard, such as reaching 75% of patients eligible to receive mammography screening. Others might be based on performance relative to other organizations using comparative percentile scores, such as being in the top quartile for [AMI](#) adjusted mortality. Still other measures might be based on the degree of improvement from the baseline score, such as a 25% improvement in the percentage of diabetic patients with blood sugar level less than nine, or a 25% reduction in preventable hospital readmissions or admissions for ambulatory sensitive conditions regardless of absolute score achieved or percentile ranking relative to others. It is likely that in many cases, payers will use a combination of the above. These direct “quality bonus” incentives may be particularly helpful for Level I and Level II ACOs as they gain experience and build their capability to provide the more cost-effective care demanded by payment methods that move away from fee-for-service. The growing experience of existing pay-for-performance programs can also inform these decisions.<sup>23</sup>

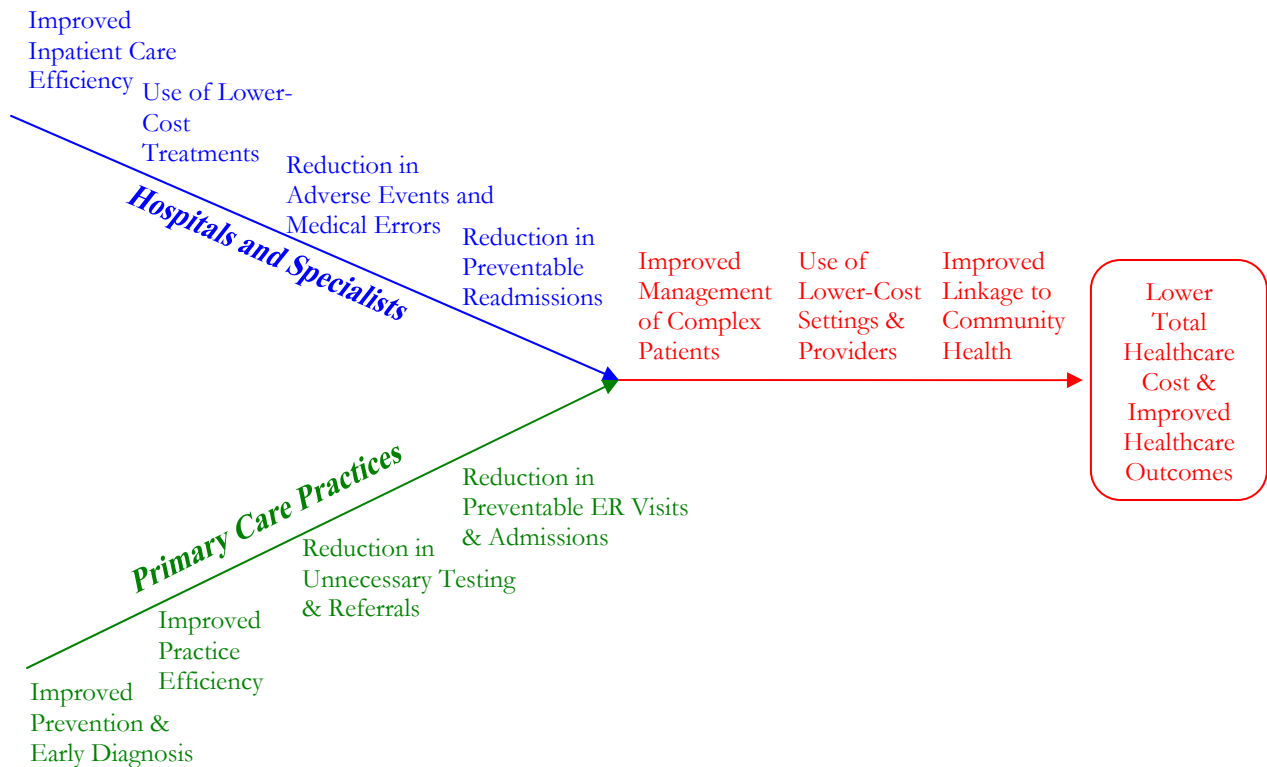
The payment system should be structured so that physicians and hospitals in high-performing ACOs are better off than those outside ACOs, but those in poorly performing ACOs would be better off if they left the ACO.

Direct incentives are also needed to encourage more physicians to join or form ACOs and to develop and participate in patient-centered medical homes. Additional payments to providers willing to assume responsibility for providing comprehensive care coordination should also be considered. CMS and private payers might provide grants to loosely organized [IPAs](#) and small physician practices to encourage them to consider becoming an ACO. In addition, CMS and private payers might provide low interest loans which could be forgiven if the provider organization meets predetermined quality criteria such as those described above, or qualifies as an ACO and then moves up the ACO levels of capability. Further, a medical school loan forgiveness program could be implemented for

younger physicians who join an ACO that has demonstrated superior performance. This provides an incentive for younger physicians to join high performing ACOs and also provides incentives for developing or established ACOs to improve performance in order to have access to the best young physicians available. Finally, CMS might offer financial incentives to Academic Medical Centers to form ACOs which would have the added benefit of graduating physicians and other health science professionals with experience working in an ACO practice environment.

Experimentation with the above payment and incentive methods should reside with the new CMS [Center for Medicare and Medicaid Innovation \(CMI\)](#). The CMI should interpret its charge of spreading successful models and practices throughout the country to include working with the [Quality Improvement Organizations \(QIOs\)](#) and private sector organizations such as the Institute for Healthcare Improvement and professional societies and associations. Innovations in *both* payment and practice models are needed to recognize that payment and practice organization must necessarily co-evolve. New payment methods and incentives stimulate the development of new organizational capabilities. But at the same time it is important to realize that innovation will ramp up slowly: a relatively small number of provider organizations are currently capable of managing a population of patients under a fully capitated or global budget. A summary of the value added (that is, cost reducing and quality enhancing) activities that can result from the alignment of payment and provider organization capabilities is shown in Figure 1.1.

**Figure 1.1 Opportunities for Value-Added Healthcare Delivery**



Source: Adapted from H.D. Miller, *How To Create Accountable Care Organizations* (2009).<sup>24</sup>

### Recommendations: Payment and Incentives

- Specific payment models and approaches should be linked to different levels of ACO qualification criteria. See earlier recommendation.
- Public and private payers should establish a common set of quality, cost, and patient experience measures on which to base paying for positive results.
- CMS and private insurers should provide incentives for physicians who wish to join high performing ACOs by providing grants and loans particularly targeted to loosely organized [IPAs](#) and small physician practices.
- CMS should establish medical and nursing loan forgiveness programs for those who wish to join high performing qualified ACOs.
- CMS should provide incentives to encourage Academic Medical Centers to form ACOs to provide medical and other health science professional students with exposure to ACO-based care delivery.
- The [Center for Medicare and Medicaid Innovation](#) within CMS should partner with private sector organizations and professional societies in spreading successful ACO and associated Patient-Centered Medical Home models throughout the country.

### Legal Barriers to Payment and ACO Formation

In order to facilitate innovations in payment, incentives, and ACO formation, laws, regulations and policies in five major legal areas may require changes. Otherwise, the providers and organizations that form the ACO could find themselves in violation of the federal antitrust law (which prohibits anti-competitive behavior),<sup>v</sup> state corporate practice of medicine statutes (which generally prohibit business corporations from employing physicians or practicing medicine),<sup>vi</sup> the federal anti-kickback statute (which prohibits the offer or receipt of remuneration in return for referrals for services reimbursable under Medicare or Medicaid),<sup>vii</sup> the federal Stark law (which governs physician self-referrals),<sup>viii</sup> and the federal civil monetary penalties law.<sup>ix,25,26,27</sup>

First, as physicians group together into large entities and in turn partner with hospitals to form ACOs, careful examination of antitrust law and applicable antitrust safe harbors is needed.<sup>28,29,30</sup> There are concerns regarding the market power that some ACOs might develop, particularly in rural areas. While the U.S. Department of Justice (DOJ) and Federal Trade Commission (FTC) have created more relaxed antitrust scrutiny exceptions in the forms of antitrust safe harbors and a “rule of reason analysis” standard in their guide to federal antitrust enforcement in healthcare, the Statements of Antitrust Enforcement Policy in Health Care,<sup>31</sup> these exceptions need to be further defined for ACOs. Current federal antitrust policy provides safe harbor to groups of providers who jointly achieve financial

<sup>v</sup> “Federal antitrust” encompasses a vast body of laws, including the Sherman Act, 15 U.S.C. § 1; the Clayton Act, 15 U.S.C. § 12, and the Robinson-Patman Act, 15 U.S.C. § 13; and the Federal Trade Commission Act, 15 U.S.C §§ 41-58. Some states have their own antitrust laws as well, *see, e.g.*, California’s Cartwright Act, Cal. Bus. & Prof. Code § 16720.

<sup>vi</sup> E.g., California’s Medical Practice Act, Cal. Bus. & Prof. Code §§ 2052 and 2400.

<sup>vii</sup> The Medicare and Medicaid Patient Protection Act of 1987, 42 U.S.C. § 1320a-7b.

<sup>viii</sup> 42 U.S.C. § 1395nn.

<sup>ix</sup> 42 U.S.C. § 1320a-7a.

integration, i.e., share “substantial” financial risk, and thus are unlikely to have excessive market power, and provides a rule of reason analysis standard to those provider groups who achieve clinical integration. The key question, however, is whether a particular ACO or type of ACO actually qualifies for protection from antitrust prosecution. Revision of DOJ and FTC antitrust enforcement policy, specifically as applied to ACOs seeking incentive payments and certification under the new healthcare law, would provide more certainty to ACOs and avoid case-by-case examinations under the financial integration or clinical integration standards. More predictability in the form of clearer guidelines is essential to the healthy creation, growth, and spread of ACOs.

A second legal issue to be addressed involves the corporate practice of medicine doctrine (operating in California, Colorado, Illinois, Iowa, New York, New Jersey, and Texas) which prevents hospitals from employing physicians in the provision of out-patient services. Such laws will constrain the forms that ACOs may take in these states. In addition, scope of practice laws will require examination. State laws are an important consideration in the new federal healthcare law and should receive significant attention as ACOs evolve.

Third, while section 3022 of the Patient Protection and Affordable Care Act of 2010 gives the HSS Secretary statutory authority to waive the requirements of the anti-kickback statute, the Stark law, and the civil monetary penalties law, the scope and nature of these waivers remains to be seen. More definitive statements regarding permissible forms of ACOs—specifically permissible gainsharing and referral arrangements—are necessary from CMS in order to allow ACOs to begin forming and operating in large numbers. For example, without a regulatory exception or a waiver, the anti-kickback statute potentially prohibits any payment allocation arrangement that induces the referrals of Medicare reimbursable business or rewards them for such referrals.<sup>32</sup> The Stark law, which prohibits certain referral relationships between hospitals and physicians, is another area in which clarification would benefit ACO formation. Payment-sharing and compensation arrangements between a hospital and a physician group, such as sharing achieved cost savings, may not pass muster under the Stark law as the arrangement does not fit squarely within any of the current Stark exceptions.<sup>33</sup> Finally, without a waiver, the civil monetary penalties statute prohibits a hospital participating in an ACO or [bundled payment](#) arrangement from making payments to physicians that result in reducing or limiting service to Medicare beneficiaries, even if the purpose of the payment arrangement is to contain costs or increase efficiencies in service provision.<sup>34</sup>

New regulations clearly delineating permissible referral arrangements, incentive gainsharing arrangements, and cost-reduction mechanisms are essential.

Currently, the primary mechanism HHS employs to allow ACOs and other innovative service delivery and payment systems to operate under exceptions to the anti-kickback statute and other laws is issuing Office of the Inspector General (OIG) Advisory Opinions that state OIG’s enforcement position. This must change as ACOs begin operating in large numbers because Advisory Opinions only protect the persons or groups requesting the opinions and may not be relied upon by others, even those in similar arrangements.<sup>35</sup> New regulations clearly delineating permissible referral arrangements, incentive gainsharing arrangements, and cost-reduction mechanisms are essential.



### Recommendations: Legal Barriers

- HHS should form a taskforce involving experts from the Federal Trade Commission, legal and regulatory scholars, and others to examine the legal and regulatory barriers to ACO formation including but not limited to anti-gainsharing legislation, anti-kickback laws, civil monetary penalties laws under Medicare, antitrust legislation, corporate practice of medicine acts, and scope of practice laws.

### Accountability

Establishing organizational qualifications and patient linkage criteria, providing technical assistance and aligning payment and incentives to co-evolve with practice organizations must also be accompanied by accountability for the total cost and quality of care provided. For Medicare and Medicaid, we recommend establishment of an independent entity responsible for reviewing cost and quality of patient experience data of all ACOs and providers treating CMS patients. As previously noted, the measures should be based on the best available data as recommended by the [Institute of Medicine](#) and updated with advances in measurement over time.

Three categories of measures might be considered. The first would be measures with known reliability, validity, and feasibility of data collection ready for “prime time” use. For example, improving age and gender appropriate use of preventive services and reducing population-adjusted per capita costs below projected levels. A second set of measures would be those with generally established reliability and validity but that may require additional testing before being widely used, for example, increasing the percent of diabetic patients with blood sugar levels under control and increasing selected patient experience scores. The third set would be measures under development: that is, potentially promising but requiring further evidence to determine their reliability, validity and feasibility. For example, condition-specific risk-adjusted mortality and functional health status scores, alignment of care with patient preferences, and lowering condition-specific and episode specific costs. The data generated from well-established measures should be made publicly available in user-friendly formats for patients, providers, and the public at large. The measures should be aggregated from the local to the regional to the national levels, and should be benchmarked against the quality of care, patient experience, and cost performance targets set on an annual basis for beneficiaries of the CMS programs. Where feasible, the data should be displayed by gender, socio-economic status, race and ethnicity categories to chart progress toward eliminating inequalities in quality and outcomes of care.

The data should be publicly displayed and made available to patients, providers, payers and the public at large, and also be available on the insurance exchanges along with health insurance benefit, coverage, and premium data.

In a similar fashion, the Secretary of Health and Human Services should either delegate to CMS or another established separate entity within HHS (such as [AHRQ](#) or [NCHS](#)) the review of cost, quality, and patient experience data for all patients, providers, and health plans in the United States using the same metrics as those established for the CMS programs. These data should be publicly displayed and made available to patients, providers,

payers and the public at large. The data should also be available on the insurance exchanges along with the health insurance benefit, coverage, and premium data. Individuals and employers can then select insurance plans based not only on coverage and premium data but also the cost, quality and patient experience performance of the ACOs and other providers associated with the relevant health plan.

All of the above would be greatly facilitated by the development of two portals that would provide access to the data necessary for ACO operations: a multi-provider portal that would house security-protected patient health and medical data. It would be accessible through a single website to all of the patient's current providers and potentially to future providers as well and, as needed, to local health departments. Similarly, a multi-payer portal could be used to determine eligibility and benefits, and conduct claims administration. Together, the implementation of both portals would not only save millions—if not billions of dollars—over time but also significantly improve the coordination and communication of patient information among providers. We recommend that HHS form a public-private sector task force of all relevant stakeholders to develop these portals.

Implementation of the above accountability mechanisms would provide: 1) relevant information and knowledge for people to select health plans and providers; 2) national, regional, and local data on performance at various levels of aggregation; 3) information and knowledge for continuous improvement on cost and quality dimensions; and 4) a basis for further population health research.

**Recommendations: Accountability**

- HHS should form a taskforce of representatives from the [Agency for Healthcare Research and Quality \(AHRQ\)](#), private sector organizations, and professional associations to provide ongoing review of new measures of costs, quality, outcomes, and patient experience for purposes of updating the accountability criteria by which to assess ACO performance.
- AHRQ or a similar agency within HHS should report on cost, quality, outcome, and patient experience performance for the country at large for all providers including ACOs.
- Data on the cost, quality, outcome, and patient experience performance of ACOs should be made publicly available to patients, providers, payers, the general public, and on the insurance exchanges.

## CONCLUSION

Promoting the successful implementation of ACOs will require determining qualification standards and mechanisms for linking patients; providing technical assistance; aligning payment and incentives; and instituting accountability. The current entrenched fee-for-service payment system; largely independent physicians; lack of accessible, organized data; lack of practice infrastructure; and an acute shortage of primary care providers will all pose challenges to such implementation. The rate of growth in healthcare costs is cause to move with deliberate speed, and to learn quickly what works and what does not work in different parts of the country under varying local and regional circumstances.

Given the failure to date to slow the rate of increase in healthcare spending, delivery system reform proposals elicit much skepticism and even some cynicism that these efforts are doomed to failure. The Medicare Physician Group Practice (PGP) demonstration provides some basis for optimism. Across diverse sites, the program yielded quality of care improvements on a number of dimensions with generally no increase in costs or actual decrease in costs.<sup>36</sup>

History also offers a supportive example suggesting that governmental leadership to jumpstart ACOs can succeed. Like healthcare today, at the beginning of the 20<sup>th</sup> century, American agriculture was in crisis, hampered by small scale, inefficient and labor intensive farm production, resulting in the price of food consuming more than 40% of the average family's budget.<sup>37</sup> The government's response was to start a pilot program now known as the Agriculture Extension Service to assist farmers in using new technologies. Over time, this resulted in significant increases in crop yields and overall productivity. The transformation was not without its costs, both in terms of consolidations and of farm closures, but American society as a whole reaped the net benefit.

In like fashion, not all providers will benefit equally from the changes in the healthcare system we advocate, and which the 2010 health reform law embraces. In fact, some will not benefit at all. But the American healthcare system as a whole will. With considered attention paid to implementation and learning, all providers will be given the opportunity to succeed and to improve over time. What is clear is that a new platform of healthcare delivery is needed to meet both the demand and needs of the increased number of Americans with insurance coverage and the equally compelling challenge of sustaining the affordability of such coverage over time.

## GLOSSARY

**Administrative Data:** Data in the form of computerized records, such as claims and billing data, gathered for administrative purposes but that also contains information that can be used for a variety of research and evaluation purposes. Examples of administrative data include birth records, which are maintained as a matter of public record and have long been available in electronic, easily searchable form. Computerized hospital discharge data used primarily for electronic bill paying for both government (Medicare and Medicaid) and commercial payers are another example. By contrast with clinical data (obtained from medical records), administrative data may be obtained in relatively inexpensively in uniform format at a population level.

**AHRQ:** The Agency for Healthcare Research and Quality (AHRQ) is located within the U.S. Department of Health and Human Services (HHS). AHRQ is charged with conducting research and evaluation relating to quality, safety, efficiency, and effectiveness of healthcare in the United States.

**AMI:** Acute myocardial infarction (AMI) is another term for a heart attack.

**Bundled Payment (also known as Payment Bundling or episode-based payments):** A payment method by which health care service providers, typically physicians and hospitals, receive a single payment for all care provided during an episode of illness. Bundled payments are used in lieu of per service payments. Depending on the type of payment bundling used, a bundled payment may include acute and post-acute care as well as related tests.

**CABGS:** Coronary Artery Bypass Graft Surgery (CABGS) is a treatment used to treat Coronary Artery Disease (CAD).

**Capitation (full or global):** Under a capitation arrangement, payers pay the providers an upfront, flat payment per member/per month (pm/pm). In exchange for this monthly capitation payment, the provider agrees to provide each member all of the required medical services as defined in the provider agreement. Capitation contracts reverse the typical incentive arrangements in provider arrangements. Rather than being paid for the number and type of services provided, the providers are paid based upon the number of members enrolled in their practice regardless of the nature or intensity of service utilization.

**Capitation (partial):** A payment system in which some services are prepaid through capitation but some remain fee-for-service. This can be a way of controlling risk while allowing for flexibility.

**Center for Medicare and Medicaid Innovation (CMI).** The 2010 healthcare reform bill, the Patient Protection and Affordable Care Act (Public Law 111-148), creates within the Centers for Medicare & Medicaid Services (CMS), a new center charged with testing innovative payment and service delivery models to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care provided.

**Centers for Medicare & Medicaid Services (CMS):** An agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, Medicaid, and the Children's Health Insurance Program

**Council of Accountable Physician Practices (CAPP):** A joint undertaking by physician practices to promote a healthcare system that is more accountable to patients, consumers, and purchasers.

**Electronic Health Records (EHRs):** A longitudinal computerized record of a patient's health information and history. EHRs contain demographic, medical, and administrative information. EHRs are generated and maintained, generally speaking, within a single institution but, if their format is standardized could be shared and used in a variety of institutions and settings.

**Episode-of-Care Based Payment:** Another term for a bundled payment.

**Federally Qualified Health Center (FQHC):** A community-based primary care organization that provides health services to individuals regardless of their ability to pay.

**Fee-for-Service:** By contrast with a bundled payment, fee-for-service is a traditional method of paying for medical services under which doctors and hospitals are paid for each service (test, procedure, etc.) they provide.

**Health Maintenance Organization (HMO):** An organization that provides comprehensive healthcare to enrollees in a specific geographic area using a network of contracted physicians with capitated payments and limits on referrals outside the network.

**Independent Practice Association (IPA):** An IPA consists of a network of physicians who jointly contract with HMOs and other managed care plans. Even though physicians continue to own and administer their practices and offices, the IPA provides a corporate structure through which HMO contracts can be negotiated and administered. IPA groups are particularly prominent in western states, especially California. In the rest of the United States, "two-tier" managed care structures, where HMOs contract directly with individual physicians, remain the norm.

**Institute of Medicine (IOM):** The Institute of Medicine (IOM) is an independent, nonprofit organization that provides unbiased and authoritative advice to decision makers and the public. It was established in 1970 and is the health arm of the National Academy of Sciences.

**Integrated or Organized Delivery System (IDS or ODS):** Networks of organizations that provide or arrange to provide a coordinated continuum of services to a defined population and are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served. They may be established through direct ownership or through contractual alliances and partnerships.<sup>38</sup>

**Lean Production:** A production practice that targets for elimination all expenditures for goals other than value creation for the end-user.

**Multi-Specialty Group Practice (MSGP):** An organization providing care from physicians in multiple specialties. They may be owned either by physicians or by hospitals and other entities

**National Center for Health Statistics (NCHS):** An agency within the U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC) that is the principal health statistics agency for the federal government. NCHS compiles statistical information to guide actions and policies to improve the health of Americans.

**National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS):** The NCQA is a private, nonprofit organization dedicated to improving healthcare quality. NCQA generates information about healthcare quality to help inform consumer and employer choice and provide feedback that helps physicians, health plans, and others identify opportunities for quality improvement. HEDIS is a tool consisting of 71 measures across 8 domains of care with data drawn from multiple health plans to permit inter-plan comparison. More than 90 percent of health plans in the United States use HEDIS data to measure performance.

**National Quality Forum (NQF):** A nonprofit organization that strives to improve the quality of healthcare for all Americans by setting national performance improvement priorities and goals, endorsing standards for measuring and publicly reporting on performance, and conducting education and outreach. NQF's membership includes consumer organizations, public and private purchasers, physicians, nurses, hospitals, accrediting and certifying bodies, supporting industries, and healthcare research and quality improvement organizations.

**Office of the National Coordinator for Health Information Technology (ONC):** Housed within the U.S. Department of Health and Human Services (HHS), ONC is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

**Physician-Hospital Organization (PHO):** Jointly owned organizations that include a hospital and a subset of the hospital's medical staff members. Physician-hospital organizations typically include medical staff members whose economic interests are most aligned with the hospital's and who can provide the hospital with sufficient geographic coverage for health plan contracting. There are approximately 1,000 PHOs in the United States. Most are loosely governed organizations, but under comprehensive healthcare reform the PHO model could evolve into an entity that would actively manage the quality and cost of care.<sup>39</sup>

**Plan, Do, Study, Act (PDSA) Cycle:** A series of activities aimed at achieving process or system improvements. A PDSA cycle typically consists of these elements in this order: *Plan*: Problem analysis and solution planning. *Do*: Implement or test out the problem solving plan, preferably as a pilot project to avoid significant time, money, or labor costs if efforts are unsuccessful. *Study*: Evaluate the plan implementation efforts to determine whether the

plan as implemented successfully solved the problem. If it failed to solve the problem, either in whole or in part, collect data on the plan's shortcomings and create a new or modified plan of action. *Act*: Choose to either completely abandon the plan or modify it, using information gained from the previous cycle, and run it again to attempt to solve the problem. No matter what the final action is, the PDSA cycle continues, either with the same problem or a new one.

**Quality Improvement Organizations (QIOs):** Organizations with which CMS contracts, as required under Sections 1152-1154 of the Social Security Act, to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. CMS contracts with one QIO organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. QIOs are private, mostly nonprofit organizations, staffed by professionals, mostly doctors and other healthcare professionals.

**Relational Coordination:** A teamwork model used in a study conducted with the Harvard Business School involving multiple medical centers. The model includes communication that is frequent, timely, and accurate, as well as provider relationships characterized by problem solving, shared goals, shared knowledge, and mutual respect.<sup>40</sup>

**Run Chart:** A graph representing the average or median quality measure of the outcome of a particular process in which high quality runs are plotted above the median quality line while low quality runs are plotted below the line. These graphs can be used to convey important information and, if sufficient runs are plotted, permit the use of statistical analyses and other analytical techniques to look for trends in runs that might provide useful information as to how to best improve quality overall.

**Six Sigma Technique:** A technique used perfect a process or product by targeting a defect rate of 3.4 per million, or six standard deviations from the population average (the statistical symbol for standard deviation is the Greek letter sigma). The Six Sigma technique differs from the PDSA cycle approach, which aims for incremental increases in performance and quality control. Six Sigma aims for rapid and substantial performance improvements and requires significant organizational change and large labor and time investments.

**Targeted Expenditure Cap:** An amount of money allotted for all services provided within the year. Strict caps have stringent spending limits and require service reduction or denial to avoid cost overruns. Expenditure targets provide more flexibility with, for example, the ability to make up overruns by reducing payments in subsequent years.

## REFERENCES

- <sup>1</sup> Devers, Kelly and Robert Berenson. 2009. “Can Accountable Care Organizations Improve the Value of Healthcare by Solving the Cost and Quality Quandaries?” Washington, DC: The Urban Institute.
- <sup>2</sup> Jeff Goldsmith. 2009. “The Accountable Care Organization: Not Ready for Prime Time.” Health Affairs Blog. ([healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time](http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time) [August 17, 2009]).
- <sup>3</sup> Fisher, Elliott S., and others. 2009. “Fostering Accountable Healthcare: Moving Forward in Medicare.” *Health Affairs* 28 (2): w219-31. ([content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w219v1](http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w219v1) [January 27, 2009]).
- <sup>4</sup> *Patient Protection and Affordable Care Act, Medicare Shared Savings Program*, section 3022. H. Res. 3590, 111 Cong. 2 sess. Library of Congress, 2010.
- <sup>5</sup> Id. at section §§ 2706 and 3129.
- <sup>6</sup> Shortell, Stephen M. and Lawrence P. Casalino. 2008. “Health Care Reform Requires Accountable Care Systems.” *JAMA* 300 (1): 95-97.
- <sup>7</sup> Shortell Stephen M., Lawrence P. Casalino LP, and Elliott S. Fisher. 2010. “Achieving the Vision: Structural Change.” In F.J. Crosson and L.A. Tollen, eds., *Partners in Health: How Physicians and Hospitals can be Accountable Together*. San Francisco: Jossey-Bass.
- <sup>8</sup> Medicare Payment Advisory Commission. 2009. “Improving Incentives in the Medicare Program.” Chapter 2, Accountable Care Organizations ([www.medpac.gov/documents/jun09\\_entirereport.pdf](http://www.medpac.gov/documents/jun09_entirereport.pdf) [June 2009]).
- <sup>9</sup> Shortell, Stephen M. and Lawrence P. Casalino. 2010. “Implementing Qualifications Criteria and Technical Assistance for Accountable care Organizations.” *JAMA* 302 (17): 1747-1748.
- <sup>10</sup> McClellan, Mark, and others. 2010. “A National Strategy to Put Accountable Care into Practice.” *Health Affairs* 29 (5): 982-990.
- <sup>11</sup> Federal Trade Commission and U.S. Department of Justice. 2006. “Statements of Antitrust Enforcement Policy in Health Care.” Washington, DC.
- <sup>12</sup> Rittenhouse, Diane R., and others. 2008. “Measuring the Medical Home Infrastructure in Large Medical Groups.” *Health Affairs* (27) 5: 1246-1258.
- <sup>13</sup> Audet, Anne-Marie J., Michelle M. Doty, Jamil Shamasdin, and Stephen C. Schoenbaum. 2005. “Measure, Learn, and Improve: Physicians’ Involvement in Quality Improvement.” *Health Affairs* 24 (3): 843-853.
- <sup>14</sup> Rittenhouse, Diane R., and others. “Improving Chronic Illness Care: Findings from a National Study of Care Management Processes in Large Physician Practices.” *Medical Care Research and Review OnlineFirst* ([mcr.sagepub.com/cgi/content/abstract/1077558709353324v1](http://mcr.sagepub.com/cgi/content/abstract/1077558709353324v1) [January 6, 2010]).
- <sup>15</sup> Gittel, Jody Hoffer. 2000. “Organizing Work to Support Relational Coordination.” *International Journal of Human Resource Management* 11 (3): 517-539.
- <sup>16</sup> Fried, Bruce J., Sharon Topping, and Amy C. Edmondson. 2006. “Groups and Teams.” In S.M. Shortell and Arnold D. Kaluzny, eds., *Health Care Management: Organization Design and Behavior*, 5th ed. Albany: Delmar.
- <sup>17</sup> National Center for Healthcare Leadership. 2004. “Competency Model 2.0” Chicago.
- <sup>18</sup> Institute of Medicine. 2006. “Medicare’s Quality Improvement Organization Program: Maximizing Potential.” National Academy of Sciences. Washington, DC.
- <sup>19</sup> Nyweide, David J., and others. 2009. “Relationship of Primary Care Physicians’ Patient Caseload with Measurement of Quality and Cost Performance.” *JAMA* 302 (22): 2444-2450.
- <sup>20</sup> Institute of Medicine. 2005. “Performance Measurement: Accelerating Improvement Report.” National Academy of Sciences. Washington, DC.
- <sup>21</sup> National Quality Forum. 2008. “National Quality Forum National Voluntary Consensus Standards for Ambulatory Care.” ([www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=1262](http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=1262) [April 26, 2010]).
- <sup>22</sup> National Committee for Quality Assurance. “HEDIS 2010 Summary Table of Measures, Product Lines and Changes.” ([http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010\\_Measures.pdf](http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2010/2010_Measures.pdf) [April 26, 2010]).
- <sup>23</sup> Rosenthal, Meredith B. 2009. “Beyond Pay for Performance: Emerging Models of Provider Payment Reform.” *New England Journal of Medicine* 359 (12): 1197-1200.



- <sup>24</sup> Miller, Harold D. 2009. "How to Create Accountable Care Organizations." Pittsburgh, PA: Center for Healthcare Quality and Payment Reform.
- <sup>25</sup> Casalino, Lawrence P. 2006. "The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice." *Journal of Health Politics, Politics and Law* 31 (3): 569-585.
- <sup>26</sup> Currier, Maria T. and Morris H. Miller. 2010. "Medicare Payment Reform: Accelerating the Transformation of the U.S. Healthcare Delivery System and Need for New Strategic Provider Alliances." *Health Lawyer* 22 (3): 1-14.
- <sup>27</sup> Belfort, Robert. 2010. "Provider Participation in ACOs May Hinge on HHS Regulations." *BNA Health Law Reporter* 19 (15): 1-3.
- <sup>28</sup> Berenson, Robert A., Paul B. Ginsburg, and Nicole Kemper. 2010. "Unchecked Provider Clout in California Foreshadows Challenges to Health Reform." *Health Affairs* 29 (4): 1-7.
- <sup>29</sup> Casalino, Lawrence P. 2006. "The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice." *Journal of Health Politics, Politics and Law* 31 (3): 569-585.
- <sup>30</sup> Burke, Taylor and Sara Rosenbaum. 2010. "Accountable Care Organizations: Implications for Antitrust Policy." *BNA Health Law Reporter* 19 (10): 1-11.
- <sup>31</sup> Federal Trade Commission and U.S. Department of Justice. 2006. "Statements of Antitrust Enforcement Policy in Health Care." Washington, DC.
- <sup>32</sup> Currier, Maria T. and Morris H. Miller. 2010. "Medicare Payment Reform: Accelerating the Transformation of the U.S. Healthcare Delivery System and Need for New Strategic Provider Alliances." *Health Lawyer* 22 (3): 1-14.
- <sup>33</sup> Ibid.
- <sup>34</sup> Ibid.
- <sup>35</sup> Ibid.
- <sup>36</sup> Trisolini, Michael, and others. 2008. "The Medicare Physician Group Practice Demonstration: Lessons Learned on Improving Quality and Efficiency in Health Care." RTI International, Research Triangle Park, NC.
- <sup>37</sup> Gawande, Atul. 2009. "Testing, Testing." *The New Yorker*. December 14, pp. 34-41.
- <sup>38</sup> Shortell, Stephen M., Robin R. Gillies, and David A. Anderson. 1994. "The New World of Managed Care: Creating Organized Delivery Systems." *Health Affairs* 13 (5): 46-64.
- <sup>39</sup> Shortell, Stephen M. and Lawrence P. Casalino. 2008. "Health Care Reform Requires Accountable Care Systems." *JAMA* 300 (1): 95-97.
- <sup>40</sup> Gittel, Jody Hoffer and others. 2000. "Impact of Relational Coordination on Quality of Care, Postoperative Pain and Functioning, and Length of Stay: A Nine-Hospital Study of Surgical Patients." *Medical Care* 38 (8): 807-19.

## APPENDIX 1

**California Association of Physician Groups, Accountable Care Organization “Owner’s Manual”:** A primer on how to form and operate high quality, efficient Accountable Care Organizations (Table of Contents).

*Used with permission from CAPG ([www.capg.org](http://www.capg.org)).*

## ACCOUNTABLE CARE ORGANIZATION

### “OWNER’S MANUAL”

*A primer on how to form and operate high quality, efficient,  
Accountable Care Organizations*

#### Introduction

The California Association of Physician Groups (“CAPG”) is a California based professional association comprised of 150 Accountable Care Organizations (ACOs) physician groups, most of which have been operating for over two decades. Most, if not all, of CAPG’s members currently meet the criteria for Accountable Care Organizations (“ACOs”) set out in the House and Senate Health Care Reform bills. ACOs are owned and operated by physicians that have voluntarily come together to provide health care services to their communities, and to be accountable for the cost and quality of that care. These CAPG members employ or contract with approximately 59,000 physicians, about two thirds of the practicing physicians in the state of California. They provide services to approximately 12 million patients in HMO products, and another approximate 5 million patients in various fee-for-service products.

Through experimentation, evolution, trial and error -- and with considerable success -- these CAPG ACOs have developed a model of care in California that produces some of the highest quality, most efficient, and most affordable health care in the nation.

What follows is the Table of Contents for a primer regarding the development, ownership, and operation of an ACO. This primer represents a collection of “best practices” that can facilitate and expedite the development and expansion of the ACO model across the United States. We prepared this primer to assist those wishing to develop the ACO model, including the Centers for Medicare and Medicaid Services (CMS).

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- IV. Criteria for Qualifying as an ACO
  - a. What organizations can be an ACO (e.g., IPA, PHO, IDS, Large multi-specialty group, partnerships)?
  - b. What are minimum enrollment levels?
  - c. What core capabilities are required?
    - i. Installed HIT: EMR, CPOE, PACS
    - ii. Meet clinical integration requirements
    - iii. Financial systems
    - iv. Quality achievements
  - d. Specifications around other items in final law
  - e. Must an ACO offer a full continuum of care (e.g., SNF, Hospital, home health)
  
- V. Organizational structure
  - a. Legal entity options and guidelines, organizational and ownership structure
  - b. Governance and authority (e.g., how an ACO makes joint decisions)
  - c. Leadership and management structure
    - i. Physician
    - ii. Lay

- d. Committee structure
- e. Critical processes/functions required
  - i. Management services
  - ii. IT
  - iii. Clinical Decision support
  - iv. Care management, quality, utilization review
  - v. Financial controls
- f. Potential pitfalls/risks
- g. Minimum financial strength requirements (e.g., cash on hand, audited financial statements, tangible net equity, years in operation, experience of management?)

#### VI. Network development and management

- a. Including the full-continuum to serve scope of services
  - i. Physician
  - ii. Hospital
  - iii. Long-term care
  - iv. Outpatient and ancillary services
  - v. Behavioral health
  - vi. Home care
- b. Inclusive or exclusive physician membership to the ACO
- c. Partners vs. contractors
- d. Method/criteria for selecting providers (e.g., computer in office, submit data electronically, performance metrics)
- e. Criteria for remaining in the network (e.g., meet metrics, quality, cost, volume, board certification, licensed, adherence to practice protocols, plans of care?)
- f. If ACO is facility based, must facilities be:
  - i. Licensed
  - ii. Accredited by appropriate agency
  - iii. Certified
  - iv. Medicare approved

#### VII. Defining new care delivery models

- a. Models for primary care (e.g., medical home)
- b. Integration of primary care and specialty services: chronic care, centers of excellence
- c. Partnering with patients in their health
- d. Use of tools to increase coordination
  - i. Along continuum of care
  - ii. With patients
- e. Coordination within care team
- f. Referral process
- g. Effective hand-offs and coordination between levels of care
- h. Timely access

- i. New methods to have appropriate care in appropriate setting
  - i. Home based monitoring
  - ii. E-visits
  - iii. Protocols
  - iv. Telemedicine
  - v. Home based caregivers

VIII. Achieving quality for the population

- a. Use of data to measure outcomes
- b. Metrics and standards
- c. Proactive measures to manage health/wellness
- d. Use of tools to increase consistency of quality care (e.g., evidence based protocols)
- e. Access
- f. Care management and coordination (see VI)
- g. System for review, evaluation and remedy of problems related with access, continuity and outcomes
- h. Process for grievances and appeals
- i. Monitoring

IX. Managing cost and utilization

- a. Identifying high-risk, high-cost patients
- b. Models to assist and engage high-risk, high-cost patients with complex health issues
- c. Concurrent utilization review/case management
- d. Management of acute episodes
- e. Predictive modeling: population management/trends

X. Building required infrastructure

- a. IT capabilities (e.g., disease registries, EMR, data warehousing)
- b. Data interface/coordination
  - i. along continuum
  - ii. integration between financial and clinical systems
- c. Ability to turn data into information
- d. Key personnel and their roles
- e. Key processes (care management, risk management, provider performance review)
- f. Key functions (e.g., decision support, care management, UR, claims and AR management)
- g. Training and education

XI. Internal and external communication

- a. Name/brand
- b. Communication with patients (e.g., print, portal, other)

- c. Communication between providers (e.g., print, portal, other)
  - d. Role of CMS?
- XII. Compensation and incentives
- a. How payments flow: from CMS to ACO; from ACO to providers
  - b. Provider compensation models
  - c. Incentive structures
  - d. Weighing the risks, advantages and disadvantages
- XIII. Performance, benchmarking and reporting tools
- a. Real time reporting
  - b. Public reporting
  - c. Internal reporting and feedback
- XIV. Financial requirements
- a. Capital
  - b. Financial projections
  - c. Cash reserves
  - d. If ACO is not risk bearing, assume no RBO or related regulation
- XV. Transition process/plan
- a. Components
  - b. Phasing
  - c. Risks
  - d. Critical success factors
- XVI. Protections
- a. Patient protections (e.g., marketing, grievances, appeals)
  - b. Financial (e.g., reserve requirements)
- XVII. Mitigating risk
- a. Reinsurance
  - b. Reserves
  - c. Critical mass/minimum threshold
  - d. Grievance process, agreement between ACO and CMS (e.g., arbitration, litigation)
- XVIII. Legal and compliance issues
- a. State regulatory issues, if any
  - b. CMS oversight/audits

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## Berkeley Center on Health, Economic & Family Security

The Berkeley Center on Health, Economic & Family Security (Berkeley CHEFS) is a research and policy center at the University of California, Berkeley, School of Law and the first of its kind to develop integrated and interdisciplinary policy solutions to problems faced by workers and families in the United States. Berkeley CHEFS works on increasing access to health care, improving protections for workers on leave from their jobs, supporting workers in flexible workplaces, and ensuring that seniors are secure during retirement.



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