EARLY ADOPTERS OF THE ACCOUNTABLE CARE MODEL

A FIELD REPORT ON IMPROVEMENTS IN HEALTH CARE DELIVERY

Sharon Silow-Carroll and Jennifer N. Edwards
Health Management Associates

MARCH 2013

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Abstract: Based on interviews with clinical and administrative leaders, this report describes the experiences of seven accountable care organizations (ACOs). Despite gaps in readiness and infrastructure, most of the ACOs are moving ahead with risk-based contracts, under which the ACO shares in savings achieved; a few are beginning to accept "downside risk" as well. Recruiting physicians and changing health care delivery are critical to the success of ACOs—and represent the most difficult challenges. ACO leaders are relying on physicians to design clinical standards, quality measures, and financial incentives, while also promoting team-based care and offering care management and quality improvement tools to help providers identify and manage high-risk patients. The most advanced ACOs are seeing reductions or slower growth in health care costs and have anecdotal evidence of care improvements. Some of the ACOs studied have begun or are planning to share savings with providers if quality benchmarks are met.

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OVERVIEW

In the continuing drive toward a higher-performing health system, and to reposition themselves in a changing health care marketplace, hospitals and physicians are forming accountable care organizations (ACOs). In so doing, they are forging contractual relationships with payers that reward achievement of shared goals for health care quality and efficiency.

The Affordable Care Act established ACOs—initially a private-sector innovation—as a delivery system option for Medicare. As of January 2013, more than 250 ACOs have contracted with the Centers for Medicare and Medicaid Services (CMS) to cover more than 4 million Medicare beneficiaries.[1] A small but growing number of state Medicaid programs are also implementing or exploring ACO-type arrangements, to coordinate care and restrain cost growth as they prepare to expand eligibility under the health reform law.[2] Though the total number of ACO arrangements in the private and public sectors is difficult to estimate, recent findings from surveys and evaluations suggest that the U.S. health care system is at the beginning of the ACO adoption curve.[3]

While specific arrangements vary, the basic ACO model involves a provider-led entity that contracts with payers, with financial incentives to encourage providers to deliver care in ways that reduce overall costs while meeting quality standards. ACOs rely on assignment of enrollees to primary care medical homes, communication among providers, strong management of high-risk patients across the continuum of care, and extensive monitoring of performance measures.[4]

Although ACOs are in their infancy, early results suggest modest savings and significant promise. Health care researchers and planners are therefore stressing the importance of learning from early adopters—particularly how they are transforming the delivery of care, designing incentives and sharing rewards with providers, and tackling a multitude of challenges.[5]

This report describes the experiences of seven hospital–physician organizations that have created ACO-type entities and begun risk-sharing arrangements with public and private payers, or will soon start them. Covered populations include formerly fee-for-service Medicare patients, a health system's own employees, enrollees in commercial health plans, Medicaid beneficiaries, or a combination.

Based on interviews with leaders of hospitals and physician groups, we explore the changes in health care delivery and payments that ACOs have pursued, the challenges they face, and their expectations for next steps. We describe the strategies for clinical integration and practice management that ACO administrators view as most promising, and present some early results. We also identify lessons for other organizations considering embarking on an ACO. Finally, we suggest insights for policymakers seeking to learn how public policies and incentives can spur hospitals and physician groups to participate in accountable care programs.

OUR METHODOLOGY

We selected ACOs for this study based on responses to the Health Research and Educational Trust (HRET) 2011 Care Coordination Survey.[6] (HRET is a division of the American Hospital Association.) Among the 1,672 hospitals that responded to the survey, 3.2 percent (53) reported that they were participating in an ACO.

HRET contacted these early ACO adopters and asked permission to share their contact information and survey responses with Health Management Associates for in-depth interviews. Eight hospitals (about 15%) replied that they would be willing to participate in a follow-up study. Two of these hospitals participate in the same ACO, so our study included seven separate ACO-type entities (Exhibit 1).

Health Management Associates completed semistructured interviews with individuals associated with the seven ACOs, including clinical and administrative leaders and board members, clinical and administrative leaders at participating hospitals, and physicians with practices participating in the ACOs. Because the selection was based on hospitals' self-reported participation in an ACO (and the survey did not strictly define an ACO), the organizations encompass a wide range of programs, payer arrangements, providers, and stages of development. However, all are

EXHIBIT 1. ACCOUNTABLE CARE ORGANIZATIONS AND AFFILIATED HOSPITALS AND HEALTH SYSTEMS

ACO	Hospital or Health System	Location
Accountable Care Alliance	Nebraska Medical Center and Nebraska Methodist Hospital	Omaha, Neb.
Arizona Connected Care	TMC Healthcare	Tucson, Ariz.
Cheyenne ACO	Cheyenne Regional Medical Center	Cheyenne, Wyo.
Mount Auburn Cambridge IPA Pioneer ACO	Mount Auburn Hospital and Mount Auburn Cambridge IPA (MACIPA)	Cambridge, Mass.
NewHealth Collaborative	Summa Health System	Akron, Ohio
Population Health Management*	North Shore-Long Island Jewish Health System (North Shore-LIJ)	Great Neck, N.Y.
University Hospitals ACO	University Hospital Case Medical Center	Cleveland, Ohio

* This organization is not an ACO per se, but models patients' health care risks, handles contracting, and administers North Shore-LIJ's full-risk employee health plan. For simplicity, we include the North Shore-LIJ risk arrangements when we refer to ACOs.

physician–hospital partnerships (that is, the sample does not include physician-only ACOs). (For profiles of the seven ACOs, see the appendix on page 23.)

The small sample size precludes us from generalizing our findings. However, we present common lessons and promising strategies for overcoming barriers to creating ACOs. These lessons and strategies may be helpful to hospitals, physician practices, and others embarking on or contemplating accountable care arrangements.

THE EXPERIENCES OF EARLY ADOPTERS

Of the seven organizations we studied, five have entered into risk-based contracts with Medicare or private payers. Three are or soon will serve as the ACO for their own health system's employees. And two are planning to enter into risk-based contracts. Cheyenne ACO, which does not yet have any risk-based contracts, is beginning a pilot involving patient-centered medical homes with wraparound services, to build infrastructure and experience for potential future ACO contracts.

All seven organizations are still building their capacity to fulfill key ACO functions. These include modeling the health care risks of patient populations, contracting with payers, developing data-based tools and health information technology, recruiting physician practices, helping them become medical homes, and building networks and relationships with other service providers.

Some of these ACOs also meet the requirements for participating in the CMS Medicare Shared Savings Program (SSP). These include the ability to share savings on health care costs (upside risk), share losses (downside risk, when that component of Medicare SSP begins), and establish, report on, and comply with criteria for health care quality. Most of the ACOs are building internal capacity through a clinical arm or a separate management services organization that is developing clinical standards, offering care management and disease management programs, and developing other tools and supports for providers.

Despite being at different places on the path to becoming fully functioning ACOs, the seven organizations reveal commonalities as well as differences in their efforts to build a foundation and develop strategies to reduce costs and improve quality. As they move into the unfamiliar territory—for most—of tying payments to better outcomes, the ACOs are taking incremental steps toward riskier financial futures.

The next section summarizes the payment models of these ACOs: how they structure risk-based contracts with payers and then distribute savings to participating providers. We discuss a key management focus on attracting and retaining a qualified cadre of

providers who buy into this risk and performance-improvement environment. We then describe the range of services and supports these ACOs are using to transform the delivery of care in hospitals and physician practices (Exhibit 2).

Payment Models: Slowly Increasing Risk

ACOs entail two levels of risk and incentives. The first involves the contract defining how a payer reimburses the ACO for care provided to a covered population, with the ACO accepting some degree of risk for the cost and/or quality of that care. The second level concerns how the ACO reimburses providers, particularly physicians. The latter type of risk-based payments is in earlier stages of development.

Risk Arrangements with Payers

The most common approach with payers is a shared-savings model, in which ACOs receive fee-for-service payments plus a portion of the savings if total spending on the covered population is below a target. This model has only upside risk: the payer is responsible for any costs in excess of the target.

Although the incentives to reduce overall costs can be modest, these arrangements allow ACOs to develop their systems for managing patients and coordinating care, and to invest in infrastructure, without risk of financial loss. After some experience with upside risk, some more mature ACOs are adding downside risk, which entails financial penalties for failing to meet an overall spending target.

The ACOs are now contracting with a variety of public and private payers and health plans, each with unique risk arrangements, or are planning to do so. These payers include:

- **Medicare Shared Savings Program:** Three of the ACOs—NewHealth, Arizona Connected Care, and University Hospitals ACO—are participating in the Medicare SSP, and two others are exploring this program. It reimburses an ACO on a fee-for-service basis, plus awards shared savings if the ACO meets cost goals and 33 quality goals related to patient and caregiver experience, care coordination and patient safety, preventive health, and at-risk populations.[7]

  Under an upside risk option, NewHealth could receive up to 50 percent of savings (capped at 10 percent of total reimbursements). Arizona Connected Care, now with upside risk, expects to add downside risk after gaining experience.

- **Pioneer ACOs:** Mount Auburn Hospital and Mount Auburn Cambridge IPA (MACIPA) participate in a Medicare Pioneer ACO, which entails higher rewards and risks than Medicare SSP. MACIPA (and Mount Auburn Hospital, through a contract with MACIPA) has 12,000 Pioneer ACO patients.

  Both organizations earn a bonus if they can meet a savings target of 2.7 percent. The Pioneer program is a five-year initiative. If the ACO achieves early savings, payment in year three shifts toward capitation or partial capitation. An ACO may also move from upside risk only to both upside and downside risk (with greater potential rewards) in 2013, which would be consistent with MACIPA's commercial contracts.

- **Medicare Advantage plans:** Four of the ACOs studied—NewHealth, North Shore-Long Island Jewish Health System (North Shore-LIJ), Arizona Connected Care, and Mount Auburn Hospital/MACIPA—are part of Medicare Advantage plans or provide care through contracts with such plans. These private health plans receive capitated payments from CMS to provide medical and hospital services, and sometimes pharmaceuticals, vision services, and other benefits, to enrollees. NewHealth has an arrangement with SummaCare Medicare Advantage plan to receive 60 percent of any cost reductions, based on spending targets reflecting past experience.

  ACOs expect to take on elements that many Medicare Advantage plans have been implementing for years, such as care management, management of provider networks, preventive care, and financial

EXHIBIT 2. KEY CHARACTERISTICS AND ACTIVITIES OF THE SEVEN ACOS

ACO Hospital/ Health System	Structure/ Governance	Programs and Payers	Payment Model with Payer	Compensation Model with Physicians	ACO-Level Activities	Key Physician Practice Transformations
Accountable Care Alliance Nebraska Medical Center and Nebraska Methodist Hospital, Omaha, Neb.	Limited liability organization created by two hospital systems and three physician groups	Commercial (under negotiation)	Anticipate only shared savings (upside risk) at first	Exploring three models: full employment, contracts with performance standards, and independent physicians with common protocols and performance monitoring	Population health management program with screening and early diagnosis; home medication management	Standardization of selected care practices
Arizona Connected Care TMC Healthcare, Tucson, Ariz.	Physician-led limited liability corporation, partnered with TMC Healthcare system	Medicare Advantage, Medicare Shared Savings Program (SSP), commercial plans; Medicaid health plan under negotiation	Shared savings; expects to adopt downside risk after gaining experience	75 percent of savings shared with primary care physicians, specialists, and hospital, based on number of patients and quality and efficiency metrics	Predictive modeling tool; targeting of patients with congestive heart failure, COPD, or acute myocardial infarction; care coordination; nurse care managers, educators, and coders working with clinics; EHR interface; sharing of best practices	Evidence-based guidelines; team-based patient management
Cheyenne ACO Cheyenne Regional Medical Center (CRMC), Cheyenne, Wyo.	Limited liability company—a 50–50 partnership between CRMC and physician group; managed by CRMC's Wyoming Institute of Population Health	Delaying application to Medicare SSP one year; beginning patient-centered medical home pilot	Considering Medicare risk models, others	Not yet determined	Implementing EHR in medical practices; helping them become medical homes; partnering with community services; pursuing care and EHR integration across state	EHR adoption; patient-centered medical homes; team-based care
MACIPA Pioneer ACO Mount Auburn Hospital and Mount Auburn Cambridge IPA, Cambridge, Mass.	IPA and hospital negotiate payer contracts jointly, but do not have a joint legal structure	Medicare Advantage and other capitated-risk contracts, commercial plans, Medicare Pioneer	Upside and downside risk arrangements	Physicians receive fee-for-service	Health information exchange providing a shared community record; home visits by nurse practitioners and pharmacists; nurse case managers in physician practices	Embedded nurse case managers; "pod leaders" spread information and data; medical homes; high-risk patients (those with physical and behavioral challenges) targeted
NewHealth Collaborative Summa Health System, Akron, Ohio	Physician-led limited liability company, part of Summa Health System	Medicare Advantage, health system employee plan, Medicare SSP; may add commercial plans and Medicaid	Shared savings; self-insured	Surplus savings distributed to physicians—50 percent based on financial performance, 50 percent on quality measures	Helping PCPs become medical homes; heart failure clinical model; disease registries/ data repositories; reports on high-risk patients, robust call center	Becoming patient-centered medical homes; EHR adoption; clinical guidelines and disease management programs; receive reports on high-risk patients and inpatients; report Medicare SSP measures; care teams

EXHIBIT 2. KEY CHARACTERISTICS AND ACTIVITIES OF THE SEVEN ACOS, CONTINUED

ACO Hospital/ Health System	Structure/ Governance	Programs and Payers	Payment Model with Payer	Compensation Model with Physicians	ACO-Level Activities	Key Physician Practice Transformations
Population Health Management North Shore-Long Island Jewish Health System, Great Neck, N.Y.	Limited liability company, wholly owned subsidiary of North Shore-LIJ	Health system employee plan; Medicare Advantage; Medicaid managed-care organization; Medicaid Health Home; bundled payments; exploring commercial plans	Self-insured; upside and downside risk; bundled payments; anticipating additional risk arrangements	Will vary to include fee-for-service, partial risk, full risk, and population management	Care management protocol; coordinated inpatient, postacute, and long-term care management; telemedicine, outpatient interdisciplinary team; population stratification data analysis	Care managers in large practices; virtual patient-centered medical homes; EHRs
University Hospitals ACO University Hospital Case Medical Center, Cleveland, Ohio	Legal entity under University Hospitals health system	Health system employee plan; applied for Medicare SSP	Self-insured; shared savings if approved for Medicare SSP	No payment incentives for practitioners at this time		

risk. Not surprisingly, many early ACOs emerge from or are providing these services for such plans.

- **Bundled payments:** CMS approved North Shore-LIJ to bundle payments for entire episodes of care, including inpatient and postacute or outpatient services, for six diagnoses.
- **Private payers, including self-insured companies, commercial managed care organizations, and employers:** Three ACOs that are part of integrated systems that self-insure—NewHealth, North Shore-LIJ, and University Hospitals ACO—are providing care for employees of the systems and their families. NewHealth receives 50 percent of any savings it achieves.

  Nearly all the seven ACOs have contracts with commercial insurers and managed care organizations (MCOs), or are negotiating or exploring such contracts, and two ACOs are planning to contract directly with large employers.

  Mount Auburn Hospital/MACIPA have nearly 23,000 covered lives in commercial, capitated-risk contracts similar to but predating ACOs. An "alternative quality contract" with Blue Cross Blue Shield of Massachusetts includes both upside and downside risk based on extensive quality indicators. The risk portion of the contract provides a global payment for each patient based on his or her age, sex, and health status, adjusted for inflation annually. That payment covers primary, specialty, hospital, and subacute care that Mount Auburn and the IPA provide to Blues members. All providers are part of the same risk pool, and the hospital/IPA partnership has been very successful in bending the cost curve.[8]
- **Medicaid:** The more established ACOs are now providing care for Medicaid populations, or are exploring ways to do so, by contracting with Medicaid MCOs or the state directly. North Shore-LIJ has begun a state Medicaid Health Home program that will incorporate risk-sharing in 2014.[9]

Sharing Savings and Risks with Providers

The second level of incentives concerns how an ACO compensates physicians and other providers. ACOs provide base reimbursements and some offer "gain-sharing"—paying a portion of the savings the ACOs earned (after covering their own costs) to hospitals and physicians that meet cost or quality benchmarks. ACOs may also require providers to contribute to ACO expenses or a bonus pool, thereby accepting some downside risk as well.

The ACOs we studied are cautious, however. Given that they need to recruit physicians, and that

many physicians are averse to accepting financial risks, ACO administrators are wary of overburdening physicians or reducing their income during a transitional phase, when care coordination and quality reporting may add to practices' workload. These ACOs are still mostly reimbursing physicians and other providers on a fee-for-service basis, and beginning to incorporate quality bonuses for agreed-upon performance measures. (Physicians employed by partner hospitals are paid on a salary basis.) However, these ACOs plan to move toward greater risk-sharing with practitioners.

Arizona Connected Care keeps 25 percent of savings earned through its Medicare SSP to fund its management services organization, which provides case management, coding, and other support services to practices. The remaining 75 percent is placed in a pool for distribution to participating primary care, specialty care, and hospital providers, based on the number of patients they handle and quality and efficiency metrics. Clinics and practices, in turn, distribute the savings to individual physicians. Specialists and hospitals similarly distribute funds to individual practitioners.

At Mount Auburn Hospital/MACIPA, primary care physicians (PCPs) and specialists are eligible for bonuses based on quality. PCPs must show that they manage care—for example, when the ACO sends a list of patients needing follow-up, physicians respond—and meet performance targets. Specialists must implement a quality-improvement project. Contracts include downside risk: if the IPA loses money, it can pay physicians less. However, the MACIPA would tap reserves before doing so, and has not yet reduced provider payments because of a loss.

Physicians participating in the NewHealth Collaborative contribute 2 percent (Medicare Advantage) or 1 percent (Medicare SSP) of their fee-for-service rates to help cover ACO expenses. NewHealth distributes surplus savings to providers after covering its costs, including new investments, such as creating a call center. Half of the distribution reflects financial performance, and half reflects quality.

Quality goals for NewHealth Collaborative PCPs include HEDIS (Healthcare Effectiveness Data and Information Set) measures, patient satisfaction, adherence to a care model, completion of health risk assessments, and physician participation in educational programs. Specialists have similar quality goals, and must also follow up with PCPs within seven days after seeing a patient. Hospital quality goals are also similar, and they must further aim to reduce readmissions. Based on an actuarial model, the distribution also rewards more reliance on primary and specialty care, and less reliance on hospital and pharmacy services.

Nebraska Medical Center is exploring various options for paying providers, including full employment (salaried), contracts with physicians that include performance standards, and sharing data and practice standards with independent physicians.

The ACOs are still working on their incentive programs for providers. Challenges include the time lag between their work and incentive payments, which can be as long as two years, and the difficulty of attributing care to a particular doctor among patients who see an array of providers. Finally, ACOs are concerned that incentive payments may be too small to get the attention of providers.

Workforce and Culture: Addressing Shortages and Emphasizing Shared Goals

The early-adopter ACOs are actively working to build their staff and networks of providers. Some are facing shortages of primary care and other key providers, as well as apprehension among physicians about changing the way they practice and accepting financial risk.

Creatively Tackling Workforce Shortages

Some of the ACOs face shortages of PCPs and care managers equipped to serve complex cases—two critical components of effective ACOs. These organizations are finding creative ways to stretch capacity, such as using nurse practitioners as primary care "extenders."

Arizona Connected Care is implementing a team-based model in one hospital-owned clinic, wherein nurse practitioners and clerical staff perform clinical and administrative tasks previously done by physicians. These role changes, which allow personnel

to work at the "top of their license," require a shift in physicians' mind-set, but interviewees report that most physicians are ultimately relieved to let go of certain tasks. "Team huddles" occur daily, and plans are under way to roll out this approach to another facility along with lessons learned. Arizona Connected Care is also pursuing multiple strategies to expand its PCP base, such as by helping physicians form private clinics and join larger multispecialty clinics.

Cheyenne ACO and hospital leaders are tackling workforce challenges by shifting more physicians to salaried status. These leaders find it easier to transform health care practices and culture among employed physicians. They are introducing team-based care to both stretch physician capacity and improve care. The teams may include a nurse practitioner or physician assistant, health coach, dietitian, and specialist in behavioral health.

ACOs' emphasis on actively managing the care of high-risk patients spurs demand for care managers with expertise in both behavioral and physical health and their interplay. One ACO leader cited the need to hire more specially trained nurse practitioners for specific mental health and substance abuse cases. Initially lacking such capacity in-house, the ACOs are partnering with community-based care management services, and developing curricula to train their own staff to manage specialized care. North Shore-LIJ's Center for Learning and Innovation, for example, has developed curricula for training and certifying care managers, and is considering an externship program to enable new RNs to develop those skills.

The ACOs are also stretching capacity by sharing resources. Population Health Management is assigning one case manager to two or three participating practices, for example. (See below for more on shared services.) Finally, some ACOs have found care management software an important tool for maximizing the capacity and effectiveness of such work.

Strategies for Changing Physician Culture

Recruiting physicians and changing care delivery are the most critical requirements and difficult challenges of the ACO model, according to early adopters. An ACO must nurture trust and a sense of shared goals between physicians and ACO administrators while emphasizing the need to adjust clinical practice. This is a slow process, as physicians often begin with the view that—as with traditional health plans—their priorities differ from those of management.

According to these early-adopter ACOs, culture change requires: 1) a consistent message from physician leaders that "this is the right thing to do"; 2) education, training, and tools; 3) financial incentives (only upside rather than downside risk in early stages); and 4) minimizing new burdens. All the ACOs also underscore that providers—specifically physicians—should drive the design of the ACO and its health care delivery and payment protocols, to ensure that quality and cost go hand in hand, and to promote that message. The ACOs therefore emphasize physician-majority leadership on their boards, steering committees, and operating committees, and allow physicians to shape clinical standards, quality measures, financial incentives, and other components of the model.

The ACOs vary in the degree to which they are encouraging or requiring physician offices and clinics to change the way they deliver care. NewHealth's approach is to identify a leader in each practice (office manager, physician, or other, depending on the dynamics of the practice). The ACO then teaches that leader about health risk assessments, care management resources, clinical standards, patient education, and new electronic tools. The ACO also instructs that leader on how to teach his or her office colleagues, although NewHealth leaders noted that this approach can yield inconsistent behavior among those colleagues. NewHealth plans to increase its own staff to allow it to train all employees at participating practices.

The ACOs have found that monitoring health care quality and cost and providing feedback to providers are essential to managing incentive payments and encouraging changes in care delivery. While most physicians in large group practices are already measuring performance, the ACOs can offer resources such as user-friendly reporting software to help them comply

with new requirements. For physicians in smaller practices or remote settings, measuring performance requires a mind-set shift, as well as new tools and rules such as clinical standards, electronic health records (EHRs), reports on quality measures, and feedback on performance.

ACOs' emphasis on engaging patients also requires a culture change among most physicians. The ACOs have found that they must enlist physician leaders who can convince their colleagues that better, patient-centered care means giving up a little individualism to adopt clinical guidelines and share decision-making with patients.

Transforming Care Delivery: Centralized and Onsite Supports

All seven ACOs cited ways in which they are transforming the patient and provider experience, either through centralized support services (the ACO level) or at care sites (the hospital or practice level). Many ACO-level interventions focus on using information technology to identify and manage high-risk patients and improve communication, and on engaging patients in their care.

Centralized ACO Activities

Centralized, management-level ACO initiatives and priorities include:

- **Shared care management, coding, and support services:** The ACOs have or plan to build their capacity to provide the services of nurse care managers, social workers, coders, technical experts, and others to participating practices. Some ACOs place a care manager in each outpatient setting, or enable a few small practices to share a care manager.

  For example, Arizona Connected Care sends a nurse care manager to clinics to review with a provider or office manager a list of high-risk patients to recruit to disease management or health education programs. Population Health Management is creating an interdisciplinary team to assist PCPs with complex patients. The team includes nurses, a social worker, resource specialist, navigator/outreach coordinator, behavior specialist, and psychiatrist, and offers in-person and virtual meetings with providers.
- **Practice standardization:** With significant provider input, ACOs determine best practices and create guidelines for inpatient and outpatient settings.
- **Community partnerships:** The ACOs forge relationships with community-based organizations—such as agencies serving people with developmental disabilities, and those providing housing—to increase patients' posthospitalization stability and reduce readmissions.
- **Enhanced medication management:** The ACOs use generics and formularies, review medication lists for contraindications and avoidable side effects, and educate patients about medication use and when side effects should trigger a visit to a PCP. At least one ACO has added a pharmacist to care teams.
- **Investigation of nursing home transfers:** After discovering significant variation in hospital readmission rates among nursing homes and other postacute–care facilities, one ACO is identifying and addressing contributing factors.

Using Information Systems to Identify High-Risk Patients and Alert Physicians

Most of these early-adopter ACOs have developed data-mining tools—through their EHR or claims databases—to identify patients at risk of high health care costs, and therefore good candidates for early intervention. The ACOs also encourage physicians to refer patients they believe would benefit from such outreach.

The ACOs expect that connecting these patients with case management and other targeted interventions will help avoid emergency room (ER) visits, and hospital admissions and readmissions. The ACOs are using several tools for these efforts:

- **Adoption of EHRs:** The first step for many physician practices joining ACOs is to switch from paper records to EHRs, and to improve connectivity

among providers. However, information-sharing across inpatient and outpatient settings is evolving. None of the ACOs has a comprehensive EHR for all inpatient and outpatient settings. Most are transmitting information on an inpatient stay to the PCP in a static format such as a PDF. The ACOs are working to expand EHRs and interface software to improve communication across care sites, and between PCPs and care managers.

- **Alerts on high-risk patients:** Electronic data collection combined with software tools allow the ACOs to identify patients with chronic conditions or at high risk of hospitalization, and alert their physicians and care managers. Arizona Connected Care uses ImpactPro[10] and data from health care claims for this work; NewHealth uses algorithms based on past claims. These patients are then referred to disease management programs, education, or counseling. The most common targeted diseases are congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes, and acute myocardial infarction.

  At Arizona Connected Care, the information system also identifies patients not complying with treatment, and alerts PCPs about support services appropriate for particular patients, although the PCP has discretion on next steps. At Mount Auburn Cambridge IPA, sophisticated algorithms use health records to identify patients in need of more support services and case management.
- **Disease registries and data repositories:** NewHealth uses the EHR and claims data to track patients with hypertension, cardiovascular disease, diabetes, tobacco use, and cancer screenings; create reports on those high-risk patients; and alert physicians and patients (see more below).
- **Inpatient updates for PCPs:** NewHealth uses electronic alerts to inform PCPs when patients have been admitted to the hospital, and provide status updates. This information—often not otherwise available to PCPs—allows the practice to contact the patient and arrange postdischarge care.
- **Quality reporting:** Besides helping to identify high-risk patients, some electronic systems can report on quality measures required by CMS.
- **Building on state health information exchanges:** Cheyenne ACO and Arizona Connected Care are tracking the progress of state information exchanges, and expect to tap them to share data with pharmacists, labs, and physician offices.

Engaging Patients in Their Care

Some ACOs are trying to educate patients and engage them in their care by helping them adopt a medical home and understand their disease, treatment plan, and medications. For other ACOs, patient engagement is a longer-term goal. Strategies include:

- **Financial incentives:** The Accountable Care Alliance pays members to complete a comprehensive health risk assessment (a paper form and physical screening), or to improve their score. The assessments enable the ACO to identify patient needs, inform the PCP of opportunities for care management, and contact patients before a condition worsens. Patients in the family plan of the University Hospitals ACO can earn up to $600 when they identify a PCP, and up to $600 more for participating in health screenings.
- **Postdischarge follow-up:** Some ACOs send health care professionals to postacute–care facilities and patients' homes after hospital discharge, to review follow-up plans, answer questions, and discuss any concerns. At Arizona Connected Care, a transition nurse sees patients both in the hospital and at home after discharge, reviews medications and diet, answers questions, interfaces with the PCP if necessary, and identifies extra needed services.

  At Population Health Management, an outpatient care manager visits patients approved by CMS for bundled care before they are discharged from the ER or an inpatient floor. The manager develops a care plan with the inpatient care manager, and conducts home visits after discharge, followed by telephone outreach.

- **Community education:** Arizona Connected Care sends nurse educators to clinics and senior centers to teach patients with diabetes about self-care.
- **Telemedicine:** North Shore-LIJ plans to use a Skype-type mechanism to provide physical, occupational, or speech therapy and exercises to bundled-payment patients who have had strokes or joint replacements. If this reduces the need for subacute care, the ACO will expand the strategy to other populations.
- **Patient Engagement Committee:** Arizona Connected Care has an active Patient Engagement Committee that works with a community relations expert on outreach to enrollees, including Web design.
- **Personal health records, patient portals, and Web access:** Some ACOs provide extensive clinical information to patients electronically, including educational materials and personal health records, which offer guidance and allow enrollees to track their health. Mount Auburn Hospital/MACIPA has a patient portal, and plans to educate patients about services and encourage them to actively engage in their care. NewHealth is developing a patient portal. And North Shore-LIJ employees have online access to a confidential personal health record, as well as tools for managing prescriptions, claims, and medical conditions.
- **Call centers:** NewHealth is launching a robust call center to answer patient questions and help triage concerns. The Accountable Care Alliance's nurse call center is heavily used by enrollees.
- **Benefit design focused on health and wellness:** The North Shore-LIJ full-risk employee health plan offers free or discounted supports and resources to enrollees. These include full reimbursement for completing WeightWatchers at Work if a member achieves weight-loss goals; discounts at fitness centers or gyms; free, customized tobacco cessation programs and medications; and an onsite employee health and wellness center offering annual health assessments, screenings, and immunizations.

The ACOs do not yet have a mechanism for soliciting feedback from enrollees. Leaders of Arizona Connected Care are assuming that enrollees will notice that PCPs are more actively engaged in their health, but will not necessarily recognize the ACO as the change agent.

Transforming Care in Physician Offices

The ACOs are working to standardize common clinical practices and provide physicians with better information, care coordination, and other supports in their offices and clinics. ACO leaders are sensitive to keeping the "hassle factor" low. However, they felt that most practices have begun to change their culture, and that most physicians are motivated to adopt best practices. Changes in the delivery of care in physician offices and clinics promoted by the ACOs include:

- **EHRs and interconnectivity:** ACOs are supporting the adoption of EHRs by physician practices, or trying to connect existing EHRs to care managers and other providers. NewHealth is rolling out EHRs to all practices.
- **Standardized guidelines:** Clinical guidelines and treatment alerts from ACOs are enabling and encouraging physicians to move their practices toward standardized, recommended care.
- **Care management and supports:** Practices may use the care management, social work, coding, information technology, and other services offered by some ACOs. As noted, for example, Arizona Connected Care places nurse care managers in clinics or enables small practices to share a care manager. University Hospitals ACO helps physicians meet goals for diabetes management and cancer screening.

  Mount Auburn Hospital and MACIPA jointly fund case management services for patients with diabetes and other chronic diseases. A pharmacy team tracks patients with multiple medications, intervening to prevent drug interactions and other adverse events. Under a new program, registered nurses will visit patients in nursing homes or at home to ensure that their needs are met.

- **Efficiency of patient flow:** NewHealth helps practices create front-office "care teams," which prepare patient information, medication lists, and standard orders for physicians, streamlining each visit.
- **Medical homes:** NewHealth's goal is to have all 60 participating practices qualify as patient-centered medical homes in the next two years. Cheyenne ACO is working to transform practices into medical homes and to create a "patient-centered medical home neighborhood"—a platform supporting coordinated care in the community. Population Health Management is linking two or three practices and assigning one case manager to form a virtual medical home.[11]

  The efforts of ACOs to help practices become patient-centered medical homes are particularly beneficial in regions where physicians can earn bonus payments for achieving medical home standards.

Transforming Hospital Care

The hospitals we examined are pursuing a range of initiatives to improve the quality and efficiency of care and reduce readmissions. For example, most hospitals identify high-risk patients for early care management, to assure safer transitions after discharge and reduce readmissions.

However, hospital interviewees could not fully distinguish efforts introduced or facilitated through ACOs from those that were already under way. One hospital leader noted that numerous changes in hospital practice are part of the health system's evolution toward a risk-based and population health management model. Even hospitals that could identify ACO-inspired strategies usually apply them to all patients, not just ACO members.

One exception is Arizona Connected Care's transition nurses, who work solely with ACO members to discuss follow-up care and connect them with their PCP. This effort produced an unintended consequence: the work of the transition nurses overlapped with that of hospital discharge planners, and patients complained that too many people were calling and visiting.

"We're working with hospital and other services to stop duplication for some patients, and find those patients who fall through the cracks," said Richard Johnson, M.D., medical director for Arizona Connected Care. This has led to a much closer working relationship between the ACO's transition nurses and the hospital's case managers, and reportedly improved patient care.

PROMISING EARLY RESULTS

The ACOs that have been at financial risk long enough to see results have cut costs, primarily from reduced hospitalizations, lower spending per hospitalization, and reduced spending on specialty and ancillary care. Newer ACOs lack enough financial data to cite concrete results, but some have seen improvements in utilization rates, such as fewer inpatient days, lower length of stay, and greater patient engagement.

- NewHealth Collaborative (Summa Health System), for example, lowered its costs by 8.4 percent in its first year as a Medicare Advantage ACO, largely because of reduced hospital use, including a 10 percent reduction in readmissions.
- Growth in health care costs for North Shore-LIJ employees under a full risk, self-insured plan dropped to less than 2 percent in 2011; they anticipate similar slow growth for 2012.
- Mount Auburn Hospital and MACIPA report that care management programs for enrollees in Tufts Medical Plan—their Medicare Advantage plan—may have had an impact. In 2012, for example, Tufts reported 252 inpatient admissions per 1,000 enrollees, compared with 390 admissions for Medicare fee-for-service patients. And Tufts enrollees had nearly 50 percent fewer inpatient days: 1,146 per 1,000 enrollees, compared with 2,027 per 1,000 Medicare fee-for-service patients. Admissions to skilled nursing facilities improved somewhat: Tufts reported 120 admissions per 1,000

enrollees, compared with 130 admissions among Medicare fee-for-service patients.

- The Accountable Care Alliance and Nebraska Medical Center found that costs for enrollees in their population management program rose just 4.2 percent over the past five years, compared with 27.4 percent nationally. The number of patients whose health care costs exceeded $30,000 a year also fell. The partnership between Nebraska Medical Center and Nebraska Methodist Hospital also allowed each to save $5 million the first year after they began contracting jointly for dialysis, insurance, and pharmacy services.
- University Hospital Case Medical Center changed management companies after its first year in an ACO, delaying the availability of information on costs. However, the medical center reported a drop in ER use and length of hospital stay its first year, as well as more attention to wellness. Data from the first quarter of 2012 will soon be available.

Information on improvements in health care quality is limited at this point, and some interviewees noted that where patients received care before joining an ACO can affect such outcomes. Still, some ACOs shared quality improvement highlights:

- At University Hospitals ACO, 70 percent of enrollees have designated a PCP. The pre-ACO figure is not available, but was "quite low," because employees and their families could seek care anywhere in the system. Ensuring that all patients choose a PCP was a high priority because that step allows better patient management and communication between PCPs and specialists. The ACO's leaders also believe that a physician–patient relationship is essential to spur patients to change health behaviors.
- One ACO reported improvements in rates of health care screening, though not yet in clinical outcomes, such as glycated hemoglobin (HbA1c) and low-density lipoprotein (LDL) levels.
- Patients in the Accountable Care Alliance have improved their health scores and are in closer touch with their PCP. Of 120,000 in the program, 90,000 are in regular contact with the health management process, including the call center, educational videos, or their provider.
- One ACO representative noted that the ACO is seeing slow changes in health care culture. Each meeting on care transitions starts with a story of how providers helped someone navigate the health system.

NEXT STEPS: BUILDING CAPACITY, NETWORKS, CONTRACTS, AND RISK

Though the ACOs are at very different places, they have similar agendas for the coming months and years: to build contracts, capacity, and risk. They are not waiting to have all elements fully in place before they begin their ACO contracts, but plan to learn, expand, and evolve over time.

Only one of the seven (Cheyenne) is still weighing the value of moving forward with ACO implementation. That organization is working with consultants to determine the actual cost of care for Medicare beneficiaries based on a 5 percent sample—and thus whether to develop a Medicare SSP model.

Next steps for these ACOs include:

- **Add contracts:** The ACOs are aggressively pursuing arrangements with commercial health plans, and in some cases Medicaid and Medicare. One hospital expects its ACO business to grow from about 10 percent in 2012 to about 50 percent by the end of 2013. Another expects to have 100,000 to 200,000 patients under risk contracts by next year.
- **Expand the provider network:** The ACOs are building and solidifying their network of primary care practices, specialists and subspecialists, and other providers across the care continuum, such as nursing homes and home health agencies.
- **Enhance tools and services for coordinating care:** The ACOs will continue to hire and train case managers/care coordinators (nurses or social workers, depending on the patient population),

or contract with community-based services. They will also continue to purchase case management software and implement and improve health risk assessments and risk stratification tools. NewHealth Collaborative is launching a call center with access to medical records to conduct triage, reduce the burden on PCPs, and help coordinate patient care. Arizona Connected Care plans to use volunteers to assist with outreach to patients.

- **Expand EHR use and connectivity:** The ACOs will be adding EHRs to ambulatory sites that are still using paper records and vet vendors that can provide interoperability across providers. Cheyenne Regional is using a $14 million Health Care Innovations Award from CMS to build a statewide EHR network to promote care coordination and integration. It is first linking hospital-employed physicians and then rolling out the EHR to the rest of the state, while pursuing telehealth for large rural regions.
- **Pursue performance measurement and standardization:** The ACOs are developing uniform metrics to measure performance across the continuum of care, developing clinical guidelines and incorporating them into EHRs, and standardizing processes as they develop primary care patient-centered medical homes.
- **Take on more risk:** The ACOs are developing capabilities to evolve toward downside as well as upside risk, and away from fee-for-service toward population-based payments, such as bundled payments and capitation.

One challenge to ACO expansion is the time lag in gaining access to reports on cost savings and quality improvements. As noted, one leader cited a time lag of six months to see outcomes based on medical claims data, and about 18 months until it could reward providers. The ACOs need such information to promote contracts with both commercial payers and providers.

POLICY RECOMMENDATIONS

Differences in market dynamics and culture across regions suggest the need for more than one ACO "model." For example, health care planners in Wyoming said they had difficulty integrating care because of a sparse population spread across a large geographic area, and little history of managing quality or chronic care. These leaders also cited a conservative anti–managed-care culture, a lack of competition among providers, and low Medicare spending and reimbursement that leaves little room to cut costs as barriers to change.

Yet these planners realize if they do not coordinate care more effectively and change incentives, they will lack the resources to provide health care to the entire population. Understanding differences in environment and resources across the state, they are exploring a shared-savings ACO approach in the Cheyenne region and an advance-payment ACO model for rural physicians and critical-access hospitals in western Wyoming. The advance payment model would provide front-end capital and extra operating funds for coordinating care and implementing health information systems.

Despite our small sample size, the experiences of these ACOs have implications for public policy. Among the ACOs participating in Medicare programs, Pioneer and bundled-payment enrollees are not restricted to the ACO system that is ostensibly managing their care. Interviewees noted that this open access reduces their ability to control—and therefore improve—patients' care. CMS has been responsive to feedback as Medicare ACOs have developed. The agency's continued consideration of concerns that arise as early ACOs gain experience should help foster success and encourage more organizations to pursue risk-based arrangements.

Other challenges have implications for state and local policies on behavioral health. ACOs serving patients with such challenges face "overly bureaucratic" mental health agencies, and uncoordinated rules on coverage and benefits. ACOs are also finding duplication of some services across programs and barriers to efficient and timely care, exacerbated by a lack of communication

between behavioral health and physical health providers. These challenges exist outside of ACOs, of course, but the ACO focus on population health highlights the urgent need to address them.

ACOs' emphasis on assessing patient risk, ensuring access to a continuum of services, and promoting communication across providers and care managers suggests that the Medicaid population may do well under the ACO model. One of the ACOs we studied has contracted with federally qualified health centers, and notes that these centers' experience with low-income populations has made them valuable partners in serving Medicaid beneficiaries.

Although only a handful of states are now implementing ACO-like contracts for Medicaid clients, many more could examine these models as they continue to face budget constraints while seeking to ensure quality and accountability. Such efforts could build on state leadership in developing patient-centered medical homes, especially as many states shift Medicaid beneficiaries into traditional MCOs, and expand Medicaid eligibility under federal health reform.

CONCLUSION

The seven early-adopter ACOs we examined vary in the populations they cover, payers, risk and payment arrangements, capacity, and stage of development. Yet we found striking similarities in the challenges they face, the strategies they are using to transform their delivery systems, and the lessons that are emerging.

These hospitals and health systems understand that the health care market and environment are changing and demanding value. These forward-thinking organizations are seeking to survive and thrive by improving efficiency; focusing on best practices, high-risk patients, and care management; and integrating rather than competing with outpatient providers.

By forming ACOs, these organizations expect to recoup some revenue losses from reduced hospital use by sharing in overall savings. They also see forming ACOs as a way to improve care—enabling them to attract both physicians and payers and increase their market share. "Risk-based care is the future, and we must respond now to be prepared—otherwise, we'll be left behind," said Eric Bieber, M.D., chief medical officer for University Hospital Case Medical Center.

Among the entities we studied, ACO readiness appears to depend primarily on leadership, culture shifts, and financial resources. The needed investments in health information technology and data analysis are costly, and planning, managing, and administering ACOs and recruiting providers takes time.

Integrated systems of hospitals, physician groups, and other providers have easier access to capital for starting an ACO, and a network of providers across at least part of the continuum of care. One leader reported that his ACO does not yet have the resources to coordinate care—it hopes to build that capacity in year two. Other interviewees noted that providers can forge relationships to provide a continuum of care even without a corporate umbrella.

With mounting pressure from payers and consumers to improve health care quality and contain spending growth, we anticipate experimentation and variation in risk-sharing arrangements to accelerate. As ACOs gain experience, evaluating the impact of the reforms in care delivery and payment at the practice, hospital, and ACO levels—and sharing lessons and best practices with providers and policymakers—will be critical.

APPENDIX. PROFILES OF EARLY–ADOPTER ACOS

Accountable Care Alliance **Nebraska Medical Center and Nebraska Methodist Hospital, Omaha, Neb.**	
Structure/ governance	Limited liability company created by two hospital systems and three physician groups. Board is composed of five physicians and the chief financial officer of each hospital system.
Program, payers, and size	Blue Cross Blue Shield Nebraska "narrow network" expected to serve patients by end of 2012. Discussions among providers initiated in January 2010. 10,000 to 20,000 enrollees expected.
Participating providers	Two hospital systems, each with three hospitals. Three physician groups: one at each hospital, and academic physicians affiliated with Nebraska Medical Center.
Payment/risk model between ACO and payer	Not yet decided, but anticipate only upside risk at first. Even before the ACO starts, providers have incentives to use generic drugs and reduce readmissions. However, payments are modest and made two years later.
Compensation and shared savings with physicians	Exploring three models: full employment, contracts with performance standards, and independent physicians with common protocols and performance monitoring.
ACO-level activities	Population health management program with screening and early diagnosis (program is also an add-on benefit sold to insurance plans). Patient must complete a health risk assessment, including an onsite exam and blood work. A personal health record is created. Educational videos, email reminders, and online communication to encourage engagement. Patients can earn a financial incentive to improve their health score. Of 120,000, 90,000 are in touch weekly with population health management process (e.g., nurse call center, educational videos). Program is passive for physicians. The program sends information to PCPs, or they can use a login to view it. Home medication management. Kaufman Hall is providing ACO management services. Hiring an executive director, medical director, and others.
Changes in care delivered by physician practices	Standardizing selected care practices.
Changes in care delivered by hospitals	Standardizing and automating order sets. Consolidating vendors. Nurse practitioner evaluates patients before discharge to reduce quick readmissions from nursing homes.
Challenges	Buy-in from physicians. Integrating information. Costs of reporting on quality (self-measurement). Time required for planning/management/administrative functions. Exchange of information between inpatient and outpatient settings. (EPIC, an EHR, launched for one health system's inpatients on August 4, 2012, but the other system is not buying it, and outpatient providers can choose.)
Results	Use of population management led to cost increase of just 4.2 percent per patient over five years, compared with national average of 27.4 percent. Fewer patients with expenses exceeding $30,000 than national average. Anticipate better patient outcomes, though too soon to report. Collaboration with Nebraska Methodist has saved each hospital $5 million through joint contracting for dialysis, insurance, and joint/bulk pharmacy purchases. Employer-sponsored medical home staffed by one physician group has lowered costs by 12.5 percent.
Next steps	Launch ACO.

Sources: Glenn Fosdick, CEO, Nebraska Medical Center; Jim Canedy, vice chair, Nebraska Medical Center.

Arizona Connected Care TMC Healthcare, Tucson, Ariz.	
Structure/ governance	Physician-led limited liability company, partnered with TMC Healthcare system. Board of directors includes physician majority, plus representatives from hospitals, community, and technology provider. Contracts with Innovative Practices and Optum for day-to-day ACO activities, including building networks, contracting, coordinating care, analyzing data. Was a Brookings-Dartmouth ACO pilot site.
Programs, payers, and size	Medicare Advantage (United Healthcare), began January 2012. Medicare Shared Savings Program (SSP), began April 2012. About 15,000 enrollees (only 7,200 with a PCP) as of July 2012. At least 20,000 expected by end of contract in 2015. Commercial MCO/insurer: multiple under negotiation, one with January 2013 start. Medicaid: negotiating with a Medicaid health plan.
Participating providers	Hospital: Tucson Medical Center. Clinics: three large federally qualified health centers (FQHCs). Primary care providers: about 180, some hospital-employed, others in FQHCs, large group practices, or small independent practices (one or two physicians). "Active equity members": surgeons, hospitalists, pediatricians. Specialists: cardiologists, cardiac surgeons, orthopedists, and neurologists partner with hospital and participate in Arizona Connected Care. Referral services: various community providers. Pursuing agreements with broader range of providers and services.
Payment/risk model between ACO and payer	Medicare Advantage: shared-savings arrangement with United Health plan. Medicare SSP: Shared savings; expect to add downside risk after gaining experience.
Compensation and shared savings with physicians	ACO keeps 25 percent of Medicare savings to pay for management services (Innovative Practices) and administrative costs; 75 percent distributed to equity partners, including primary care, specialists, and hospital. Clinics and practices distribute primary care fund to individual physicians, based on number of patients and quality and efficiency metrics. Specialist and hospital funds similarly distributed to individual practitioners.
ACO-level activities	Use Impact Pro predictive modeling tool and claims data to identify high-risk Medicare Advantage and Medicare SSP patients and sort by provider or clinic; contact providers to discuss services that could help those patients. Target patients with congestive heart failure, COPD, acute myocardial infarction in past year; also target patients with any of nine diseases in past two years, and those not complying with treatment. ACO plans to analyze data on claims and diagnoses. Contract with Innovative Practices includes contracting, practice transformation services, care coordination for patients at highest risk who are transitioning from acute-care facility to skilled-nursing facility or home, data analytics, quality reporting; funded by 25 percent of savings. Nurse case manager review list of high-risk patients with provider or office manager; practice helps diabetic patients enroll in chronic disease management program, take classes, or meet with educators; planning similar activities for patients with COPD and heart failure, and a chest pain clinic. Patients identified by risk score and provider knowledge. Nurse educators go to clinics and senior centers to provide education on diabetes self-care. Coders teach how to code for "risk adjustment factor" to obtain maximum reimbursement, and to use EHR problem lists. ACO works closely with state health information exchange to achieve EHR interface across practices, hospitals, and other providers statewide. Shares best practices. Efforts to transform practices include promoting "lean" principles, working with prototype hospital-owned clinic to achieve high efficiency through low variability; having all staff at practices work at top of license to relieve physicians of administrative tasks, improve quality, and reduce costs; planning to train trainers to spread these approaches to other sites. Examining ways to combine small physician practices for economies of scale.

Changes in care delivered by physician practices	Use of agreed-upon evidence-based guidelines to reduce variation. Team-based approach to managing patients: medical assistants track health maintenance and chronic-disease patients and known interventions, freeing providers to work with patients on challenges requiring their expertise. Physicians treat all Medicare patients as if they are in the ACO.
Changes in care delivered by hospitals	ACO transition nurse sees high-risk patients in hospitals and homes after discharge, reviews medications and diet, answers questions, interfaces with PCP if necessary, identifies other needed services or ensures that family can provide. Hospital does not differentiate ACO patients, except that it provides transition care only for patients with physicians participating in the ACO.
Challenges	Lack of EHR interface across providers. Not enough PCPs. Medicare SSP expected to begin with 12,000 enrollees, but CMS attributes only 7,200. Costly startup. Concern about overburdening practices with reporting and complying with new government programs. Culture change: physicians need to delegate so all can work at top of license, and move away from defensive medicine.
Results	Medicare Advantage: per member per month rate has increased because of efforts to code more correctly.
Next steps	Negotiate with self-insured employers and create specialty contracts such as Medicaid plans. Build primary care foundation, and expand network to subspecialists and providers across continuum of care, including home health nurses, social workers, and volunteers.

Sources: Richard Johnson, M.D., medical director, Arizona Connected Care, TMC Healthcare; Michael Goran, M.D., managing director, OptumInsight, Optum; Jeff Selwyn, M.D., New Pueblo Medicine, board president, Arizona Connected Care, TMC Healthcare.

Cheyenne ACO **Cheyenne Regional Medical Center, Cheyenne, Wyo.**	
Structure/ governance	Cheyenne ACO is a limited liability company. Managed by Wyoming Institute of Population Health, a division of Cheyenne Regional Medical Center (CRMC). Focus on to developing patient-centered medical homes and technology infrastructure, and expanding network to cover continuum of care. CRMC and WINHealth Partners (HMO) participate in Premier Partnership for Care Transformation (PACT) ACO Readiness Collaborative.[12]
Programs, payers, and size	Submitted letter of interest to Medicare SSP; delaying application by one year to build components to support ACO and determine whether to pursue Medicare SSP or Pioneer ACO. Beginning patient-centered medical home pilot; plan to provide broader continuum of care for potential ACO, including nursing homes, other long-term care, nutrition counseling, and social services. Institute of Population Health is advising state on developing ACO model for Medicaid.
Participating providers	Cheyenne Regional Medical Center. Southeast Wyoming Preferred Physicians—includes some 60 physicians employed by the hospital, plus 100 community-based physicians. Hospital has home health, is negotiating with a nursing home, and plans to partner with social services for ACO continuum.
Payment/risk model between ACO and payer	Not yet determined; first building medical homes among CRMC's employed physician practices. Considering Medicare risk programs, others.
Compensation and shared savings with physicians	Not yet determined.
ACO preparation activities	Completing implementation of EHR (EPIC) in practices. Helping practices become medical homes with team-based care. Partnering with community services to support continuum of care. With federal grant, pursuing integration and information technology statewide.
Changes in care delivered by physician practices	Adopting EHRs. Using TransforMed[13] to build primary care practices into patient-centered medical homes; implementing EHR to exchange data between (future) case managers and providers; introducing team-based care.
Changes in care delivered by hospitals	None associated solely with ACO. However, hospital is adopting elements of accountable care: care managers coordinate care for high-risk patients, manage medication; make follow-up appointments before discharge and call all patients within 24 hours after discharge; call every former ER patient to check on medications and follow up with physicians; identify frequent ER visitors.

Challenges	Lack infrastructure for ACO to succeed; sparse population and large geographic area make care integration and coordination difficult. Poor coordination and follow-up after hospital discharge; no history of managing quality and chronic care. Changing culture of hospitals and physician practices: younger and salaried providers more apt to adopt new technologies and practices; community-based physicians generally older, averse to changes that may increase workload; recruiting for patient-centered medical homes and ACO is challenging. Conservative anti–managed-care culture among public and state government. Care "leaks out" to border states; if care not coordinated within state, it will lack resources to care for population. Little competition, low utilization, and low Medicare spending and reimbursement levels, so not much room to cut costs.
Results	n/a
Next steps	Develop elements needed for ACOs: medical homes (team-based care, EHR, patient portal, patient registries, case management), information systems, physician engagement, and data analytics for 33 ACO quality measures. Developing tightly managed network anchored by 10 certified patient-centered medical homes; will evaluate potential for converting to ACO for commercial, Medicare, and Medicaid members. Working with Premier and Milliman to determine cost of care for 5 percent sample of Medicare beneficiaries, to decide whether to proceed with Medicare SSP. Using $14 million CMS Health Care Innovations Award to build statewide EHR network to coordinate care; starting with employed physicians and rolling out to rest of state; also pursuing EPIC Connect telehealth to promote medication management by rural physicians. Wyoming Integrated Care Network: 17-member hospital network integrating physicians, coordinating care, and fostering quality and efficiency; constantly recruiting and engaging physicians, talking with other hospitals about ACO-like risk pools, and providing opportunities to share savings by reducing unnecessary use of care.

Sources: John Lucas, M.D., CEO, Cheyenne Regional Medical Center; Stephen Goldstone, vice president for accountable care, Cheyenne ACO.

Mount Auburn Cambridge IPA Pioneer ACO **Mount Auburn Hospital and Mount Auburn Cambridge IPA, Cambridge, Mass.**	
Structure/ governance	IPA and hospital jointly negotiate payer contracts, but do not have a joint legal structure. Medicare ACO contract is with Mount Auburn Cambridge IPA (MACIPA).
Program, payers, and size	Medicare Pioneer ACO (12,000 patients). Capitated-risk contracts are similar to ACOs but not called ACOs (and predated ACOs). Medicare Advantage (3,700 patients). Most commercial plans in region, including Blue Cross Blue Shield of Massachusetts (BCBSM), Harvard Pilgrim Health Care, and Tufts (22,763). Mount Auburn Hospital and MACIPA have cosigned risk contracts for 20 years. BCBSM Alternative Quality Contract helped prepare for Pioneer contract.
Participating providers	Mount Auburn Hospital. MACIPA; majority of PCPs' patients are in ACO/risk plans; probably fewer than half of specialists' patients are in such plans. Cambridge Health Alliance.
Payment/risk model between ACO and payer	Pioneer: first-dollar savings shared if ACO achieves 2.7 percent savings or more; downside risk starts in second year; Pioneer allows only one signer, so contract is with MACIPA, and MACIPA and the hospital have separate agreement; high degree of trust. BCBSM, Harvard, and Tufts have both upside and downside risk linked to extensive quality measurement; for BCBSM, all providers are in same incentive pool; Harvard and Tufts have separate risk pools for hospital, physician, and pharmacy services.
Compensation and shared savings with physicians	Risks taken at practice level, not physician level; physicians paid fee-for-service.
ACO-level activities (also apply to risk contracts)	Developing a health information exchange that provides a "community record" for providers to share. Compass Program: nurse practitioners provide support in nursing homes and patient homes to reduce risk of readmission. Pharmacists may also go to patient homes after discharge to assist with medication management. Generics substituted for name-brand drugs. Nurse case managers go to practices to assist with psychosocial needs. Nurse case managers work with larger primary care practices to identify patients who would benefit from care management; precise model (such as number of patients per nurse) still evolving.
Changes in care delivered by physician practices	Embedded case managers (registered nurses) in larger practices help manage sickest patients. PCPs belong to a pod of 8–12 physicians; pod leader participates in meeting of physician organization and spreads info and data to PCPs in pod. Rolling out medical homes in several larger practices. Helping physicians identify high-risk/high-cost patients through data analysis, and supporting them in population management (including outreach for appointments and follow-up care). Identifying patients with depression and other mental health challenges to provide support services.
Changes in care delivered by hospitals	Embedded nurse case managers. Infection control for all patients as part of longstanding strategies to reduce hospital stays and costs; central line infections are rare; private rooms for all patients help reduce infections; aggressive flu campaign.

Challenges	Difficult to achieve patient-centered medical home among small practices and those without EHR. Open access for Pioneer patients reduces control over care. Multiple EHRs across the system. Concern about overloading physicians by constantly asking them to do more. Time lag between changes in health care delivery and financial rewards.
Results	MACIPA's Tufts patients had 252 admissions per 1,000 patients in 2012, compared with 390 for Medicare fee-for-service. MACIPA Tufts patients had 1,146 inpatient days in 2012, compared with 2,027 for Medicare fee-for-service. No financial results ready to share.
Next steps	Certification of patient-centered medical homes. Rollout of behavioral health program. Patient education and engagement.

Sources: Jeanette Clough, M.H.A., R.N., president and CEO, Mount Auburn Hospital; Barbara Spivak, M.D., president, Mount Auburn Cambridge IPA; Maggie Custodio, senior director, Mount Auburn Cambridge IPA.

NewHealth Collaborative Summa Health System, Akron, Ohio	
Structure/ governance	Physician-led limited liability company, part of Summa Health System. Participates in national Premier ACO Collaborative.
Programs, payers, and size	SummaCare Medicare Advantage plan: began January 2011, 12,000 members. Self-insured: SummaCare (provider-sponsored health plan, part of Summa Health System) began January 2012, 7,000 Summa employees/dependents. Medicare SSP: began July 2012 with 22,000+ members. Examining/pursuing arrangements with other commercial plans and Medicaid.
Participating providers	Hospitals: seven owned by or in joint venture with Summa Health System. Primary care providers: 75 employed physicians; 120 community-based PCPs. Specialty physicians: 200 specialists, about half employed directly by Summa Health System, half in affiliated medical groups. System has access to home health and other services that SummaCare already owns or has contracts with; pursuing agreements with nursing home and other community-based services.
Payment/risk model between ACO and payer	NewHealth receives fee-for-service plus shared savings, with targets based on past experience. Medicare Advantage: 60 percent savings to NewHealth, 40 percent to payer. Employee plan: 50/50 split.
Compensation and shared savings with physicians	Physicians contribute 2 percent (Medicare Advantage) or 1 percent (Medicare SSP) of fee-for-service rates to cover NewHealth costs and services. NewHealth distributes savings to providers after covering its costs, including those for new investments (e.g., call center); 50 percent based on financial performance, 50 percent on quality; pool for each type of provider based on actuarial model, with shift in some funds from inpatient and pharmacy to primary and specialty care. Primary care has four categories of quality: HEDIS measures and implementation of care model; patient satisfaction; health risk assessments for each Medicare patient; education/good citizenship (physicians attend educational sessions and conferences). Specialists: similar; must also report back to referring PCP within seven days of seeing a patient. Hospitals: similar; plus measure of readmissions rates. Other providers: no financial incentives yet.
ACO-level activities	Helping PCPs become medical homes. First year focused on clinical model for treating heart failure (standard guidelines and patient education, developed by NewHealth cardiologist based on national guidelines); year two focusing on diabetes, call center, and care coordination. Disease registries/data repositories tied to EMR and claims: hypertension, cardiovascular disease, diabetes, tobacco use, cancer screenings; physicians receive alerts on disease-specific tests and programs; provides better data than claims alone. Creating high-risk reports, collecting and reviewing data. Launching robust call center.
Changes in care delivered by physician practices	PCPs are becoming patient-centered medical homes. Participating practices must have or be adopting EHR (many different types are in use). Practices must adopt clinical guidelines for treating heart failure. Heart failure, hypertension, and other disease management programs offered by SummaCare health plan now available to physicians and patients. Physicians receive EHR alerts for tests due, programs for patients with certain conditions, daily inpatient reports, reports on high-risk patients (at risk of admission within 12 months based on claims; physicians refer patients to disease management programs). Medicare SSP requires practices to report on 33 measures (many were already reporting on some measures). Developing care teams: front office prepares patient info, medical checklist, and standing orders for tests, and readies patients for physicians on all visits.

Changes in care delivered by hospitals	First year focused on heart failure program and discharge planning. Daily inpatient reports sent to PCPs. At admission, PCP is contacted to allow scheduling of follow-up appointment. Care manager gets to know patients; after discharge can do home assessment and be contacted if problems occur, until patients return to physicians.
Challenges	Developing care teams requires practices to shift roles. Establishing mechanisms for coordinating care without reimbursement/funding. Different practices and hospitals have different EHRs, so unable to share information and coordinate care. ACO trying to add other commercial payers, but six months needed to show outcomes based on claims, and about 18 months to reward providers. Developing trust and shared goals: physicians traditionally view health plans as having different goals; address by being transparent and putting physicians in charge: board chair, 75 percent of board and committees; progress slow. Payers formerly were gatekeepers and controlled data; need to recognize that providers are getting into this arena; some payers responding by buying hospitals, primary care groups, and other provider organizations. Hospitals and practices have a variety of EHRs, so developing a plan for each patient that allows interface is challenging. Limited resources for case management; adding case managers but working on how to deploy them—to assist ACO patients only, or all patients in a practice? Even among employed physicians and within one practice, physicians lack a single goal and culture. ACO has limited staff to teach office managers and physicians new approaches, such as health risk assessments and how to educate patients; staff at each practice teach colleagues, but too much inconsistency.
Results	First-year results from Medicare Advantage: *Financial:* 8.4 percent savings, mainly because of reduced hospital use and costs; primary care costs rose, those for specialty and ancillary care declined slightly. *Quality:* Readmissions fell by about 10 percent. Blood pressure screening rates rose (attributed to outreach program and disease registry report). Greater physician engagement, attributed to financial incentives, education, supports, understanding of value of participation, especially EHR. No changes in patients' HbA1c, LDL cholesterol levels. ACO refunded physicians' 2 percent investment after first year, but nearly half of ACO savings geared to physicians not distributed; those who did not meet all goals received partial payments.
Next steps	In development: internal health information exchange to provide data on patients at point of care; robust call center with access to patient medical records, used to conduct triage, reduce burden on PCPs on call—viewed as step toward care coordination. Continue rolling out practice changes: having all practices adopt EHR, and all 60 practices certified as patient-centered medical homes. Examining/pursuing arrangements with other commercial plans, employers, and Medicaid. ACO expects to evolve toward downside as well as upside risk, and from fee-for-service to population-based payments, over 10 years. Hospital business now accounts for about 10 percent of ACO revenue; expected to increase to about 50 percent by end of 2013.

Sources: Charles Vignos, CEO, NewHealth Collaborative; Mike Bankovich, operations director, NewHealth Collaborative; Rodney Ison, M.D., board chair and participating physician, NewHealth Collaborative.

Population Health Management North Shore-Long Island Jewish Health System, Great Neck , N.Y.	
Structure/ governance	Population Health Management (PHM), LLC, a wholly owned subsidiary of North Shore-LIJ, was created to conduct risk modeling and contracting, develop database management tools, and provide analytic, administrative, and operational resources for multiple health system initiatives. The latter includes Group Health Management (the health system's care/case management entity), Clinical Integration Network IPA, Montefiore's Pioneer ACO, Health Home; PHM also managed contracts for long-term care, risk, and self-insured employers, unions, and government agencies. PHM also administers North Shore-LIJ's full-risk employee health plan. North Shore-LIJ will be obtaining insurance licenses to facilitate various risk and other types of contracts.
Programs, payers, and size	Health system self-insured full-risk employee plan with 46,000–50,000 members. Oxford PHO Medicare Advantage with some 4,500 patients, began in 1999. Partnership with Montefiore Medical Center to extend Pioneer ACO into Long Island and Staten Island in January 2013. HealthFirst (Medicaid MCO and Medicare Advantage plan): some 4,000 Medicare and 25,000 Medicaid patients, with North Shore-LIJ at full risk. Medicaid Health Home began in January 2013; about 15,000 members expected; will incorporate risk sharing in 2014. Bundled payments (models 2 and 4) for about 48 diagnostic categories approved by CMS for January 2013; now building infrastructure to administer. Shared savings and pay-for-performance commercial/Medicare programs based on quality metrics. Expect to have approximately 100,000 at-risk patients by early 2013. Application pending for managed long-term care plan (HMO license). United Health Care–North Shore-LIJ Advantage Plan.
Participating providers	Clinical Integration Network IPA (CIIPA) has 7,500 providers, including 2,400+ employed physicians. Premium IPA (new model for care integration) includes employed physicians and selected voluntary physicians who agree to certain quality measures, data-sharing, and use of North Shore-LIJ facilities (where clinically and geographically appropriate). All North Shore-LIJ facilities.
Payment/risk model between ACO and payer	Oxford Medicare Advantage plan: North Shore-LIJ receives partial premium from insurer and is at risk for actual costs, network maintenance, quality initiatives, and aspects of care management. HealthFirst plans: all functions performed by HealthFirst; PHM will supplement care management for at-risk members of North Shore-LIJ.[14] Medicaid Health Home (state Medicaid coordinated-care initiative): system will assume some risk-sharing in 2014. Bundled payments for inpatient and outpatient care for designated diagnoses. Anticipate more kinds of risk-sharing arrangements, including shared savings with providers if quality and other metrics are achieved.
Compensation and shared savings with physicians	As risk models evolve, compensation for practitioners will vary to include fee-for-service, partial risk, full risk, and population management.

ACO-level activities	North Shore-LIJ is implementing numerous changes as it evolves toward a risk-based and population health management model; all patients are and will be treated the same regardless of payer or contract or no insurance. Extensive clinical information is available electronically to guide PHM, which is establishing protocols for care management. For bundled-payment initiative, implementing coordinated inpatient, postacute, and long-term care management for designated diagnoses. Now in limited use: telemedicine to increase access to care, provide physical, occupational, and speech therapy for stroke patients and joint replacement patients via Skype-type mechanism. If successful and reduces need for subacute care in select cases, will expand to other populations. Developing outpatient interdisciplinary team with care/case managers, physicians, nurses, social workers, resource specialists, navigator/outreach coordinators, behavioral health specialists, and pharmacists; team and intervention depends on disease severity; in-person or virtual meetings. North Shore-LIJ's Center for Learning and Innovation has created curricula for training and certifying care managers, and the system is considering an externship program for new RNs. New initiatives: daily inpatient rounds by multidisciplinary team, including physician, RN, case manager, pharmacologist; hospital-based transition coaches to work with postacute care providers to ensure discharge protocols are met; palliative and compassionate care programs; medication management and reconciliation programs to coordinate patient therapies and avoid conflicting drug interactions. Focus on total integration of care delivery and the continuum of care: care coordination effort will start by using specific population stratification data analytics to identify high-risk patients.
Changes in care delivered by physician practices	Placing continuum of care managers in large practices to assist providers and help patients navigate system. Linking two to three practices and assigning case manager to form virtual patient-centered medical homes. Implementing EHRs in offices.
Challenges	Culture change: getting everyone to adopt a new way of doing business. Ensuring health system support at highest levels for both employed and other providers. Developing quality standards across the spectrum of care. Integrating data on clinical initiatives, including hospital and outpatient information. Continuing to implement EHR. Expanding primary care provider network. Facilitating patient-directed goals for care and ensuring satisfaction. Ensuring physician input on care coordination, patient-directed care, clinical outcomes, and satisfaction. Ensuring care manager capacity with broad and specific experience for various clinical situations, such as behavioral health, substance abuse, mental health, and HIV care. Embracing patients with behavioral health needs, and coordinating all needs under Medicaid Health Home, Managed Long-Term Care Plans, new Medicaid initiatives.
Results	For North Shore LIJ's self-insured plan, employee health care costs grew by less than 2 percent in 2011; similar low rate expected for 2012.
Next steps	Standardizing processes. Developing uniform metrics to measure performance across continuum of care. Expanding network/partnerships to more PCPs and continuum of care; forging relationships with community-based organizations. Vetting vendors to allow existing EHRs to communicate, implementing EHRs in facilities that still use paper, and developing portals for community-based physicians; looking at ALL Scripts case management software to enable tracking, reporting, and interface among care managers, physicians, and a local or regional health information organization. Examining outpatient risk-stratification tool. Considering a contractor to review data across inpatient and outpatient continuum, including failed transfers to skilled nursing facilities, to identify opportunities for improvement. Analyzing potential for bundled payments that include postacute care; data are difficult to decipher now.

Sources: Gerri Randazzo, vice president, case management, North Shore-LIJ; Nick Fitterman, M.D., medical director, group health management, North Shore-LIJ; Irina Mitzner, R.N., vice president, group health management, North Shore-LIJ; James J. La Rosa, M.D., vice president, managed care organization development, population health management, North Shore-LIJ.

University Hospitals ACO **University Hospital Case Medical Center, Cleveland, Ohio**	
Structure/ governance	University Hospitals ACO incorporated as legal entity.
Participating providers	Two critical-access hospitals, six community hospitals, cancer center, children's hospital, and women's hospital. 1,400 employed physicians provide 74 percent of the ambulatory care in the ACO. 1,700 to 1,800 additional providers.
Participating payers	Just themselves as self-insured employers (24,000 employees and family members), began 2011. Applied to CMS to be part of Medicare SSP.
Payment/risk model between ACO and payer	As a self-insured entity, no external risk. Success in managing care could mean losing hospital revenue. Medicare SSP would be a shared-savings model.
Compensation and shared savings with physicians	No payment incentives for practitioners at this time.
ACO-level activities	Hired third-party administrator (APEX, part of SummaCare) to help change health care delivery systems and reduce costs. Hired care managers, outreach coordinators, and physician liaison. Working on bundling care and managing population health (e.g., through diabetes screening and colorectal health). Driving patients to select a PCP and engage in their care; family can earn $400 by identifying PCPs, and another $600 by participating in screenings. Focusing on high-cost claimants, frequent ER users, care transitions, and care gaps (such as enrollees not screened for cancer or getting flu shots). Cannot embed care navigators in practices because health system is geographically dispersed, but lack of face-to-face contact has not been a problem.
Changes in care delivered by physician practices	Physicians are working to achieve a "diabetes bundle" (whereby they receive credit for completing nine components of recommended diabetes care) and perform cancer screening—the first two initiatives. Encouraging providers to use checklists to focus on highest-priority patient needs. Considering team-based approaches.
Challenges	ACO switched third-party administrator in 2012, slowing data collection and analysis, so impact of initiatives is difficult to report definitively.
Results	ER use and length of hospital stay declining, and attention to wellness increasing; figures for first-quarter 2012 forthcoming, delayed by transition to new third-party administrator. 70 percent of enrollees have designated a PCP (baseline is unavailable, but was "quite low"); allows ACO to provide information to providers, helps them manage patients, and motivates patients (for example, smoking cessation takes many months; without such a relationship it is nearly impossible).
Next steps	Expanding contracts with payers. Implementing EMRs at all ambulatory sites. Coordinating with health system to reduce readmissions.

Sources: Eric Bieber, M.D., chief medical officer, University Hospital Case Medical Center; Armand Kirkorian, M.D., endocrinologist, associate medical director, University Hospitals ACO.

NOTES

[1] These include 222 ACOs in the Medicare Shared Savings Program, 32 ACOs in the Pioneer ACO pilot program, and the six Physician Group Practice Transition Demonstration organizations. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html.

[2] See S. Silow-Carroll, J. N. Edwards, and D. Rodin, *Aligning Incentives in Medicaid: How Colorado, Minnesota, and Vermont Are Reforming Care Delivery and Payment to Improve Health and Lower Costs* (New York: The Commonwealth Fund, March 2013).

[3] A.-M. J. Audet, K. Kenward, S. Patel et al., *Hospitals on the Path to Accountable Care: Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization* (New York: The Commonwealth Fund, Aug. 2012).

[4] A recent evaluation of ACOs participating in the Premier Health Care Alliance's Accountable Care Collaborative identified six core components of an ACO, but noted that no existing ACO had deployed all of them. The components were patient engagement, health homes, an integrated network of providers, population health management with data use, an innovative management structure, and partnerships with payers. See A. J. Forster, B. G. Childs, J. F. Damore et al., *Accountable Care Strategies: Lessons from the Premier Health Care Alliance's Accountable Care Collaborative* (New York: The Commonwealth Fund, Aug. 2012).

[5] See C. H. Colla, D. E. Wennberg, E. Meara et al., "Spending Differences Associated with the Medicare Physician Group Practice Demonstration," *Journal of the American Medical Association,* Sept. 12, 2012, 308(10):1015–23; and D. M. Berwick, "ACOs: Promise, Not Panacea," *Journal of the American Medical Association,* Sept. 12, 2012, 308(10):1038–39.

[6] Audet, Kenward, Patel et al., *Hospitals on the Path to Accountable Care,* 2012.

[7] Participating ACOs may elect to contract with Medicare for one-sided or two-sided risk-sharing. The latter would start in the second year, and earn the ACO a higher percentage of savings if achieved. Each ACO must have a plan to lower growth in expenditures for the beneficiaries it serves. ACOs are encouraged to adopt EHRs, engage patients, promote evidence-based medicine, and manage the care of high-risk patients with multiple chronic conditions. ACOs must also meet targets for 33 quality measures in the second or third year to receive a bonus payment.

[8] See http://www.hfma.org/Templates/Print.aspx?id=18693.

[9] Section 2703 of the Affordable Care Act created an optional Medicaid State Plan. Under that approach, states establish health homes to coordinate and integrate all primary, acute, behavioral health, and long-term services for Medicaid clients with chronic conditions. See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html.

[10] Impact Pro™ is an episode-based predictive modeling tool designed to help care management teams use clinical, risk, and member profile information to target health care services to high-risk patients. For more information, see http://www.optuminsight.com/content/attachments/ImpactProforCareManagement.pdf.

[11] For more information, see http://www.guidedcare.org/.

[12] The Premier Alliance was created and owned by some 200 hospitals and health systems. Its ACO Readiness Collaborative, launched in 2010, works to develop the organization, skills, team, and tools needed to pursue a coordinated-care delivery model, and ultimately to implement that model.

[13] A subsidiary of the American Academy of Family Physicians, TransforMed helps practices become patient-centered medical homes by providing online tools and resources, best practices, training, audits, gap analysis, workflow guidance, and other services. For more information, see http://www.transformed.com/index.cfm.

[14] Healthfirst is a not-for-profit managed care organization participating in government-sponsored health insurance programs, including New York State's Child Health Plus and Family Health Plus programs, Medicaid, and Medicare Advantage. Healthfirst uses a hospital-sponsored business model, returning savings from operating efficiencies to its hospital sponsors, including North Shore-LIJ. For more information, see http://www.northshorelij.com/NSLIJ/Insurance+-+Healthfirst+(PHSP).

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