



**HIGH PERFORMANCE ACCOUNTABLE CARE:  
BUILDING ON SUCCESS AND LEARNING FROM EXPERIENCE**

Stuart Guterman, Stephen C. Schoenbaum, Karen Davis, Cathy Schoen,  
Anne-Marie J. Audet, Kristof Stremikis, and Mark A. Zezza

April 2011

**ABSTRACT:** A key provision of the Affordable Care Act is the establishment of the Medicare Shared Savings Program, which provides incentives for improved quality and efficiency to a new category of provider—the accountable care organization (ACO). The program, slated to begin in January 2012, rewards groups of providers who agree to collaborate to offer more accountable, effective, and efficient care with a share of the savings they achieve. While the prospect of participating in this initiative has generated a groundswell of interest and activity among providers, many issues need to be addressed about the methods that will be used to determine how that accountability is to be achieved, assessed, and rewarded. This report provides recommendations for ensuring the successful implementation and spread of ACOs to achieve the goals of a high performance health system.

Support for this research was provided by The Commonwealth Fund. This and other Fund publications are available online at [www.commonwealthfund.org](http://www.commonwealthfund.org). To learn more about new publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 1494.

**THE COMMONWEALTH FUND**  
**COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM**

**James J. Mongan, M.D. (Chair)**

Professor  
Department of Health Care Policy  
Harvard Medical School

**Maureen Bisognano, M.Sc.**

President and Chief Executive Officer  
Institute for Healthcare Improvement

**Sandra Bruce, M.S.**

President and Chief Executive Officer  
Resurrection Health Care

**Christine K. Cassel, M.D.**

President and Chief Executive Officer  
American Board of Internal Medicine  
and ABIM Foundation

**Michael Chernew, Ph.D.**

Professor  
Department of Health Care Policy  
Harvard Medical School

**John M. Colmers, M.P.H.**

Vice President  
Health Care Transformation and  
Strategic Planning  
Johns Hopkins Medicine

**Patricia Gabow, M.D.**

Chief Executive Officer  
Denver Health

**Glenn M. Hackbarth, J.D.**

Consultant

**George C. Halvorson**

Chairman and Chief Executive Officer  
Kaiser Foundation Health Plan Inc.

**Jon M. Kingsdale, Ph.D.**

Consultant

**Gregory P. Poulsen, M.B.A.**

Senior Vice President  
Intermountain Health Care

**Neil R. Powe, M.D., M.P.H., M.B.A.**

Chief, Medical Services  
San Francisco General Hospital  
Constance B. Wofsy Distinguished  
Professor and Vice-Chair of Medicine  
University of California, San Francisco

**Louise Y. Probst, R.N., M.B.A.**

Executive Director  
St. Louis Area Business Health Coalition

**Martín J. Sepúlveda, M.D., FACP**

IBM Fellow and Vice President  
Integrated Health Services  
IBM Corporation

**David A. Share, M.D., M.P.H.**

Vice President  
Value Partnerships  
Blue Cross Blue Shield of Michigan

**Glenn D. Steele, Jr., M.D., Ph.D.**

President and Chief Executive Officer  
Geisinger Health System

**Alan R. Weil, J.D., M.P.P.**

Executive Director  
National Academy for State Health Policy

## CONTENTS

List of Exhibits.....	iv
Preface.....	v
About the Authors.....	vi
Executive Summary.....	ix
Introduction.....	1
Rationale for Creating ACOs.....	3
Promising Organizational and Payment Models.....	8
Primary Care Medical Home Fees.....	11
Bundled Acute Case Rates.....	13
Global Fees.....	14
Shared Savings.....	16
A Diversity of Organizational Models Fit Within the ACO Concept.....	17
Policy Recommendations.....	18
Strong Primary Care Foundation.....	19
Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs.....	21
Informed and Engaged Patients.....	22
Commitment to Serving the Community.....	24
Criteria for Entry and Continued Participation That Emphasize Accountability and Performance.....	24
Multipayer Alignment to Provide Appropriate and Consistent Incentives.....	26
Payment That Reinforces and Rewards High Performance.....	28
Innovative Payment Methods and Organizational Models.....	30
Balanced Physician Compensation Incentives.....	32
Timely Monitoring, Data Feedback, and Technical Support for Improvement.....	33
Conclusion.....	35
Notes.....	37

**LIST OF EXHIBITS**

Exhibit ES-1 Commission Recommendations..... xiii

Exhibit 1 Statutory Requirements for Medicare ACOs .....2

Exhibit 2 Poor Coordination of Care Is Common,  
Especially if Multiple Doctors Are Involved.....4

Exhibit 3 Majority Support More Accessible, Coordinated,  
and Well-Informed Care .....4

Exhibit 4 Relationship Between Payment Methods and  
Organizational Models.....6

Exhibit 5 Some Promising Organizational Models for ACOs.....10

Exhibit 6 Physician Group Practice Demonstration Sites .....16

## PREFACE

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) enacted several key changes intended to help achieve a high performance health system. Such a system includes affordable coverage for all; alignment of incentives to promote quality, efficiency, and cost control; increased accountability for the quality and cost of care; improved coordination; and effective leadership in developing and implementing policies to improve system performance. These objectives have been laid out by the Commission on a High Performance Health System in a series of reports, beginning in August 2006 with a *Framework for a High Performance Health System for the United States* and continuing with *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* in November 2007. The Commission's February 2009 report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, contained an explicit set of recommendations, many of which appeared in the health reform legislation.

A key provision of the Affordable Care Act is the establishment of the Medicare Shared Savings Program, which provides incentives for improved quality and efficiency to a new category of provider: the accountable care organization (ACO). The program, slated to begin in January 2012, rewards groups of providers with a share of the savings they achieve by collaborating to offer more accountable, effective, and efficient care. While the prospect of participating in this initiative has generated a groundswell of interest and activity among providers throughout the country, the requirements for the program have raised questions about what an ACO is, what it ought to be accountable for, and how that accountability is to be achieved, assessed, and rewarded.

This report sets forth the rationale for creating ACOs, describes several promising models that should be considered for use by ACOs, and contains a set of recommendations on what ought to be expected from ACOs and how to ensure their successful implementation and spread, both immediately and over time. Although the report's primary audience is the Centers for Medicare and Medicaid Services, which has responsibility for implementing the program, it is also intended to offer information and guidance to providers, payers, and patients who will be forming and interacting with ACOs.

**James J. Mongan, M.D.**  
Chairman

**Stuart Guterman**  
Executive Director

The Commonwealth Fund Commission on a High Performance Health System

## ABOUT THE AUTHORS

**Stuart Guterman** is vice president for Payment and System Reform at The Commonwealth Fund and executive director of the Commonwealth Fund Commission on a High Performance Health System. His prior positions include: director of the Office of Research, Development, and Information at the Centers for Medicare and Medicaid Services; senior analyst at the Congressional Budget Office; principal research associate in the Health Policy Center at the Urban Institute; deputy director of the Medicare Payment Advisory Commission (and its predecessor, the Prospective Payment Assessment Commission); and chief of institutional studies in the Health Care Financing Administration's Office of Research. He can be e-mailed at [sxg@cmwf.org](mailto:sxg@cmwf.org).

**Stephen C. Schoenbaum, M.D., M.P.H.**, was the executive vice president for Programs at The Commonwealth Fund from February 2000 to December 2010, and executive director of the Fund's Commission on a High Performance Health System. From 1993 to 1999, he was the medical director and then president of Harvard Pilgrim Health Care of New England. Prior to that, from 1981 to 1993, he was deputy medical director at Harvard Community Health Plan. Dr. Schoenbaum currently has an appointment as lecturer at Harvard Medical School in the Department of Population Medicine. He is the author of over 150 medical publications.

**Karen Davis, Ph.D.**, is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*.

**Cathy Schoen, M.S.**, is senior vice president for Policy, Research, and Evaluation at The Commonwealth Fund. Ms. Schoen is a member of the Fund's executive management team and research director of the Fund's Commission on a High Performance Health System. From 1998 through 2005, she directed the Fund's Task Force on the Future of Health Insurance. Prior to joining the Fund in 1995, Ms. Schoen taught health economics at the University of Massachusetts School of Public Health and directed special projects at the UMASS Labor Relations and Research Center. During the 1980s, she directed the Service Employees International Union's research and policy department. In the late 1970s, she was on the staff of President Carter's national health insurance task force. She has authored numerous publications on health policy issues, insurance, and national/international health system performance and coauthored the book, *Health and the War on Poverty*. She holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College.

**Anne-Marie J. Audet, M.D., M.Sc.**, is vice president for Health System Quality and Efficiency at The Commonwealth Fund. A leader in health care quality improvement for more than 20 years at the national, state, and provider levels, Dr. Audet has conducted policy analysis at the American College of Physicians, led the implementation of the Medicare Health Care Quality Improvement Program in Massachusetts while with the Massachusetts Peer Review Organization, and, more recently, worked with CareGroup, an integrated care system. She also has served as director of the Office for Clinical Effectiveness/Process Improvement at Beth Israel Deaconess Medical Center in Boston. Dr. Audet earned a medical degree and a master's degree in epidemiology from McGill University, as well as an S.M. in health policy and management from Harvard University.

**Kristof Stremikis, M.P.P.**, is senior research associate for the president of The Commonwealth Fund. Previously, he was a graduate student researcher in the School of Public Health at the University of California, Berkeley, where he evaluated various state, federal, and global health initiatives while providing economic and statistical support to faculty and postdoctoral fellows. He has also served as consultant in the director's office of the California Department of Healthcare Services, where he worked on recommendations for a pay-for-performance system in the Medi-Cal program. Mr. Stremikis holds three undergraduate degrees in economics, political science, and history from the University of Wisconsin at Madison. In May 2008, he received a Master of Public Policy degree from the Goldman School at the University of California, Berkeley.

**Mark A. Zezza, Ph.D.**, is a senior policy analyst for health care delivery policy at The Commonwealth Fund, for which he prepares policy analyses related to health care payment and delivery system reform and helps develop grants to support research in these areas. Dr. Zezza joined the Fund from the Engelberg Center for Health Reform at the Brookings Institution, where he was a research director responsible for provider payment and delivery system reform projects. Earlier, he was associate director in the State, Provider, and Payer Practice at the Lewin Group, contributing to analyses of the economic and coverage effects of reform proposals and the impact of Medicare payment policy. He has also worked in the Office of the Actuary, the Center for Medicare Management, and the Center for Beneficiary Choices at the Centers for Medicare and Medicaid Services in Baltimore. A graduate of Dickinson College, Dr. Zezza holds an M.A. in economic policy analysis and a Ph.D. in public policy from the University of Maryland.

---

*Editorial support was provided by Sarah Klein.*

## EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) establishes a new category of provider within the Medicare program—the accountable care organization (ACO)—with rules for provider participation and principles for sharing the savings that ensue from this new form of health care delivery. A broad framework is specified in the law and more details have been laid out in proposed rules released by the Centers for Medicare and Medicaid Services (CMS), but whether the promise of this new payment and delivery model is realized will depend both on the implementation decisions made over time by CMS and the willingness and ability of health care providers, other payers, and the general public to respond to this opportunity to improve the performance of the health care system.

This report by the Commonwealth Fund Commission on a High Performance Health System (Commission): 1) sets forth the rationale for creating ACOs; 2) describes several promising types of ACO models that should be considered and evaluated as part of an effort to facilitate adaptability and spread of accountability for quality and cost to as wide a segment of the U.S. health care delivery system as possible; and 3) concludes with a set of Commission recommendations on what ought to be expected from ACOs and how to ensure their successful implementation and spread, both immediately and over time. Although the Commission’s recommendations are addressed, for the most part, to CMS, the report also is intended to offer information and guidance to providers, payers, and patients who will be forming, and interacting with, ACOs.

### **RATIONALE**

Systematization and organization of care delivery would make it easier to provide the high-quality, coordinated care that the American public seeks and needs. Currently, even when individual services meet high standards of clinical quality, there is often insufficient coordination of care across settings and over time to meet the needs of patients. More highly developed primary care services, both in the United States and in other countries, are associated with better clinical outcomes and lower costs—which are major objectives of the Affordable Care Act. Indeed, nearly all patients—nine of 10—report that it is important to them to have one place or personal physician responsible for their primary care and for coordinating their care with other providers, that all physicians involved in their care have access to their medical information, and that they have a place—other than the emergency room—to go for care at night and on weekends.

Within the United States, we have evidence that reorganizing care around the patient with teams that are accountable to each other and to patients and are supported by information systems that guide and drive improvement, has the potential to eliminate waste, reduce medical errors, and improve outcomes—at lower total cost. Accomplishing this requires changing the incentives upon which the health care system is built. The fee-for-service payment that currently typifies the U.S. health system emphasizes the provision of health services by individual providers rather than coordinated teams of providers who collaborate to address patients’ needs. The current system also encourages the provision of more health services but not the achievement of better health outcomes, and tends to focus on acute care and complex services, rather than prevention, primary care, and serving the ongoing needs of the population.

### **PROMISING ORGANIZATIONAL AND PAYMENT MODELS**

Previous work by The Commonwealth Fund and this Commission has shown that organized and accountable health care delivery holds significant potential for transforming the U.S. health care system. In recognition of this potential, the Affordable Care Act provides incentives under the Medicare program for provider organizations to be accountable for the total care of patients, including population health outcomes, patient care experiences, and the cost per person. While CMS has substantial discretion to set the requirements for qualifying ACOs, the law establishes an ACO as a legally established *provider* organization that is directly responsible for providing many of the services covered by the Medicare program and can ensure that its patients have access to the rest. ACOs differ from health maintenance organizations in that they are explicitly health care delivery organizations, rather than insurers that contract with a network of providers.

Providers’ participation in an ACO is voluntary. The ACO is required to have sufficient primary care providers to care for Medicare beneficiaries and is held accountable for the quality and cost of care for the Medicare patients of those primary care providers. The law sets out several ACO models (including networks of individual practices, group practices, and hospitals partnering with providers or employing providers), and gives the secretary of Health and Human Services (HHS) further discretion to approve other groups of providers. The law also provides for Medicaid ACOs for pediatric patients, although that provision is not addressed in this report.

Many specific decisions about qualifying ACOs are left to the discretion of the secretary. In particular, the law does not restrict beneficiary choice of providers to those participating in or contracting with the ACO to which their primary care provider

belongs. Nor is there a requirement that the ACO include or contract with all of the providers who care for the patient: the ACO could consist of a network of primary care physicians, multispecialty physician group practices without hospitals or the full panoply of specialists, or hospitals that employ physicians or partner with physician groups.

The law does specify that there will be a mechanism to distribute shared savings achieved by the ACO, but many of the related details are not completely specified. Providers might be paid directly by Medicare as they are now or Medicare might choose to use new provider payment models. Providers could assign their payments to the ACO, which then would receive all Medicare payments, both for direct care and for shared savings, with the ACO responsible for compensating providers through salaries or another internally set remuneration and/or incentive system. Alternatively, the ACO could elect to receive a partial capitation payment from Medicare that includes both shared savings (on the fee-for-service portion of the payment) and financial risk (on the per-patient portion), or a global fee (with full financial risk).

When patients receive services from providers outside the ACO, Medicare might continue to pay for those services (e.g., hospital care, home health care, or non-ACO specialists) as it does now, while adjusting the partial capitation payments or global fee to the ACO for any “out-of-organization” care. Alternatively, the ACO might be required to contract with and pay out-of-organization providers to ensure access to a full range of coordinated care.

This report addresses how CMS might make important decisions about payment and delivery system design. It describes three organizational models that could be promising for ACOs: advanced primary care practice networks with infrastructure support and associated specialist referral networks; multispecialty physician group practices; and health care organizations with functionally integrated ambulatory, inpatient, and postacute care services. Correspondingly, several alternative options could be used in the ACO context, including:

- *Primary care medical home fees*, any of several methods for paying primary care providers that encourages them to coordinate their patients’ care. Blue Cross Blue Shield of Michigan and Community Care of North Carolina are two organizations that have used such payment methods with success.

- *Bundled acute case rates*, which cover a range of services related to treatment for a patient during a specified time interval around an acute care event, like a hospital admission. Geisinger Health System in Pennsylvania uses this method.
- *Global fees*, a payment rate that covers all the health care provided to an individual during a specified time interval. Examples of organizations using global fees include HealthPartners in Minnesota, Intermountain Healthcare in Utah, Blue Cross Blue Shield of Massachusetts, and Kaiser Permanente in eight regions around the country.

While ACOs receiving partial capitation or global fees share in both savings and financial risk, Medicare might mitigate the risk of being accountable for high-cost patients through reinsurance or stop-loss provisions, especially for cases in which the ACO does not directly provide the full range of services. This would be consistent with CMS's proposed rule for the Medicare Shared Savings Program, which in the first two years would cap potential losses for ACOs that opt to both receive a share of any savings and be responsible for a share of excess spending; in the third year, potential losses would be capped for all ACOs, which will be required to share in savings and be responsible for a share of excess spending.

## **POLICY RECOMMENDATIONS**

The Affordable Care Act builds on innovations already under way across the country and contains a number of requirements for extending successful ACO payment concepts to qualifying organizations. CMS can further support the success and spread of high-performing ACOs through its regulations and practices. The objective is to achieve a high performance health system that is organized to attain better health, better care, and lower costs. To facilitate this process, the Commission makes the following recommendations (Exhibit ES-1):

### **1. Strong Primary Care Foundation**

- 1a. CMS should ensure that all ACOs have a strong primary care foundation that builds on the concept of the patient-centered medical home.
- 1b. Although CMS may require that ACOs have certain structural characteristics (e.g., electronic medical records and availability of after-hours care) or have certain processes in place (e.g., quality improvement programs), the availability and accessibility to patients of a regular source of care and the ability of that provider to coordinate care received from all sources should be paramount.

## **Exhibit ES-1. Commission Recommendations**

**Overall goal: to achieve a high performance health system that is organized to attain better health, better care, and lower costs**

- 1. Strong Primary Care Foundation**
- 2. Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs**
- 3. Informed and Engaged Patients**
- 4. Commitment to Serving the Community**
- 5. Criteria for Entry and Continued Participation That Emphasize Accountability and Performance**
- 6. Multipayer Alignment to Provide Appropriate and Consistent Incentives**
- 7. Payment That Reinforces and Rewards High Performance**
- 8. Innovative Payment Methods and Organizational Models**
- 9. Balanced Physician Compensation Incentives**
- 10. Timely Monitoring, Data Feedback, and Technical Support for Improvement**

### **2. Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs**

- 2a. All participating ACOs should be required to agree to and be able to report measures of quality of care, patient care experiences, and outcomes, or have arrangements in place to enable such reporting.
- 2b. Shared savings should be distributed contingent on high quality and positive patient experiences.
- 2c. CMS (along with other participating payers) should work with each ACO to ensure that incentives for providers within the ACO are aligned and consistent with the aims of better health, better care, and lower costs.
- 2d. Regardless of which payers are involved in the ACO payment mechanism, the shared savings paid out by each payer or group of payers should, to the extent feasible, take into account the ability of the ACO to achieve overall savings on total costs, rather than just savings for individual payers.

### **3. Informed and Engaged Patients**

- 3a. Providers should notify all of their patients that the providers belong to a given ACO, along with its characteristics and what that will mean for the care that patients will receive.
- 3b. ACOs should encourage providers and patients to specify expectations and responsibilities, and engage providers and patients as partners in ensuring the best care and outcomes.
- 3c. CMS should test different approaches for encouraging patients to designate an ACO as the principal source of their care by providing positive incentives to do so (such as enhanced benefits or lower cost-sharing responsibility). Patients should retain the right to seek care from the providers of their choice, including those not participating in the ACO, unless they explicitly agree to receive care exclusively from the ACO's providers.

### **4. Commitment to Serving the Community**

CMS should make an explicit commitment to serving its community, including low-income and uninsured patients, an integral part of qualifying as an ACO.

### **5. Criteria for Entry and Continued Participation That Emphasize Accountability and Performance**

Entry criteria for ACOs should include, at a minimum, the availability of primary care and the capacity of the organization to ensure that patients have access to needed services across the continuum of care, as well as the ability to provide meaningful evidence of quality (including patient experiences and outcomes) and cost performance. Continued participation and financial rewards should be contingent on performance and accountability rather than structural characteristics. This should include public reporting of performance metrics.

### **6. Multipayer Alignment to Provide Appropriate and Consistent Incentives**

CMS should actively work with providers and payers in each major market to develop multipayer ACO arrangements—including Medicare, Medicaid, and private payers—whenever possible. Such arrangements should be designed to align incentives among payers, give a clear and consistent message to ACOs, and enable them to focus on achieving higher quality of care, better patient care experiences, improved population health outcomes, and lower costs for all their patients, as well as simplifying administrative processes.

## **7. Payment That Reinforces and Rewards High Performance**

- 7a. The threshold for attributing savings to ACOs should be set to reflect the predictability and reliability of each organization's cost trend, to protect against shared-savings payments that are generated by random fluctuations in year-to-year costs, while ensuring that organizations are rewarded for achieving actual cost reductions.
- 7b. The determination and payment of shared savings should be accomplished so that the reward for reducing costs while improving quality is received with as little delay as possible from the behavior that generates it. This can be supported by prospectively determining the patients whose costs are to be used to calculate shared savings and prospectively setting the spending target for each ACO.
- 7c. CMS (along with other participating payers) should make upfront support, possibly as low-cost loans against future shared savings, available to organizations that, because of certain circumstances, need it to offset the infrastructure investment expense required to redesign care processes and make other changes so they can become successful ACOs. Determination of the availability and extent of upfront support and the basis on which it is provided (e.g., loans vs. grants) may differ by whether it is a safety-net institution serving underserved populations, as well as by other defining characteristics of the organization, subject to the organization's potential for achieving the program's goals and its proposed plan for doing so.

## **8. Innovative Payment Methods and Organizational Models**

CMS should be prepared to apply different payment approaches that are suitable for different organizational configurations of ACOs in different geographic areas and different circumstances, as appropriate. These payment approaches could include primary care medical home fees or bundled acute case rates, along with shared savings, or risk-adjusted global fees with risk mitigation (e.g., stop-loss or reinsurance). All approaches should make payments contingent on reaching quality benchmarks.

## **9. Balanced Physician Compensation Incentives**

For ACOs receiving payment for direct care as well as shared savings, compensation of clinicians within the ACO should include incentives to deliver evidence-based care but ensure that appropriate care is not withheld.

## **10. Timely Monitoring, Data Feedback, and Technical Support for Improvement**

- 10a. CMS should provide baseline data as well as early and regular reports on total Medicare payments, utilization, and quality measures for the ACO patient population, and other data required to help ACOs be successful in achieving the aims of better health, better care, and lower costs; other payers should do the same. Trends should be tracked over time to assess the impact of alternative payment models and different configurations of ACOs and disseminate learning about the most effective strategies.
- 10b. CMS should work with other payers to develop robust information exchanges and standardized reports that can provide ACOs with timely feedback on comparative results, support rapid-cycle improvements in quality and cost performance, and develop new knowledge on effective and efficient clinical practices.
- 10c. The Department of Health and Human Services, through its Office of the National Coordinator for Health Information Technology, should provide technical assistance for implementing electronic information systems and exchanges to facilitate transfer of critical clinical information.
- 10d. CMS should create toolkits of interventions and practices that health care organizations have found effective in improving quality and lowering costs. All payers should collaborate to provide technical assistance to organizations to help them identify and adopt effective and efficient practices and to spread successful innovations in payment methods and organizational models.
- 10e. Every effort should be made by public and private payers, as well as providers, to ensure transparency of information and to minimize administrative complexity.

## **CONCLUSION**

To meet population health needs now and in the future, the U.S. health care delivery system has to become accountable for three things: delivering high-quality, effective, and safe care that contributes to the best possible population health outcomes; configuring itself for the benefit of patients to provide excellent patient experiences with care; and using resources efficiently and prudently. Substantial evidence exists that it is possible to improve the way health care is organized and delivered to slow the growth of health care costs while improving outcomes and patient experiences. By adopting these objectives as core values and achieving increasingly stringent goals in each area, it will be possible to provide affordable health care into the future with access for all and care that helps to prevent illness, restore health for those with acute conditions, and maintain health and

productivity for all, including the growing population of patients with one or more chronic conditions.

Holding the health care system accountable through new payment arrangements that support high value rather than high-volume care creates the promise of transforming the U.S. health system to achieve these aims. Yet, much work needs to be done to establish and spread ACOs and learn from innovative care systems. Success requires the development of trust among all the parties, as well as a willingness to test multiple approaches, measure results, and adapt rapidly to improve performance. Government leadership and flexibility are essential, as are activated and engaged clinicians and patients who embrace accountability for better care and health outcomes. If all this occurs, moving ACOs from concept to action can play an instrumental role in achieving a high performance U.S. health system over the coming decade.



# **HIGH PERFORMANCE ACCOUNTABLE CARE: BUILDING ON SUCCESS AND LEARNING FROM EXPERIENCE**

## **INTRODUCTION**

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) establishes a new category of provider within the Medicare program—the accountable care organization (ACO).<sup>1</sup> The law provides rules governing the types of providers that compose an ACO and the principles for sharing savings that result from this new form of health care delivery. A broad framework for ACOs is specified in the law, and more details have been laid out in proposed rules released by the Centers for Medicare and Medicaid Services (CMS);<sup>2</sup> but whether the promise of this new payment and delivery model is realized will depend not only on the implementation decisions made over time by CMS but also on the willingness and ability of health care providers, other payers, and the general public to respond to this opportunity to improve the performance of the health care system.

The law sets forth a number of requirements for participating ACOs (Exhibit 1). To be eligible, an ACO must have a mechanism for shared governance, and may include professionals in group practice arrangements, networks of individual practices of ACO professionals (i.e., physicians, physician assistants, nurse practitioners, or clinical nurse specialists), hospitals employing ACO professionals, or partnerships or joint venture arrangements between hospitals and ACO professionals. The ACO must include sufficient primary care providers to care for a defined population and be willing to be accountable for the quality, cost, and overall care of Medicare fee-for-service beneficiaries assigned to it for a period of at least three years. The organization must have a formal legal structure allowing it to distribute shared savings and have a leadership and management structure that includes clinical and administrative systems with the capacity to report information on participating professionals, quality of care, use and cost, and other information required for the determination of savings. The law further stipulates that ACOs define processes to promote evidence-based medicine and patient engagement, and meet various patient-centered criteria specified by the secretary of Health and Human Services (HHS).

---

## **Exhibit 1. Statutory Requirements for Medicare ACOs**

1. Groups of providers of services and suppliers, which can include:
    - a. Physicians and other practitioners (referred to as ACO professionals) in group practice arrangements;
    - b. Networks of individual practices of ACO professionals;
    - c. Partnerships or joint venture arrangements between hospitals and ACO professionals;
    - d. Hospitals employing ACO professionals; or
    - e. Other groups of providers of services and suppliers deemed appropriate by the secretary of Health and Human Services (HHS).
  2. Willingness to become accountable for the quality, costs, and overall care of Medicare fee-for-service beneficiaries assigned to it based on their utilization of primary care services.
  3. Agreement to participate in the program for a minimum of three years.
  4. A formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers.
  5. Inclusion of primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries (a minimum of 5,000) assigned to it.
  6. Provision to HHS of information necessary to determine the Medicare beneficiaries for which the organization is responsible, the implementation of quality and other reporting requirements, and determination of payments for shared savings.
    - a. Quality measures may include clinical processes and outcomes, patient and caregiver experience of care, and utilization measures such as hospital admissions for ambulatory care-sensitive conditions.
    - b. Additional quality measures may include care transitions, hospital discharge planning, and post-hospital discharge follow-up.
  7. A leadership and management structure that includes clinical and administrative systems.
  8. Processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.
  9. Demonstration that the organization meets patient-centeredness criteria specified by the secretary.
-

Under the new law, ACOs can participate in a shared-savings program, under which each ACO receives a portion of the savings it achieves on Medicare Part A and B expenditures for its patients relative to a spending target, contingent on quality standards specified by CMS. In addition, the law tasks the new CMS Center for Medicare and Medicaid Innovation (Innovation Center) with developing and testing alternative payment models for future use in paying ACOs.

This report by the Commonwealth Fund Commission on a High Performance Health System (Commission): 1) sets forth the rationale for creating ACOs; 2) describes several promising types of ACO models that should be considered and evaluated to facilitate the adaptability and spread of accountability for quality and cost to as wide a segment of the U.S. health care delivery system as possible; and 3) concludes with a set of Commission recommendations on how to ensure the successful implementation and spread of ACOs. Although the Commission's recommendations are addressed, for the most part, to CMS, the report also is intended to offer information and guidance to providers, payers, and patients who will be forming, and interacting with, ACOs.

## **RATIONALE FOR CREATING ACOS**

Increased organization of health care delivery should make it easier to provide high-quality, coordinated care—which often is not available to patients in the United States (Exhibit 2).<sup>3</sup> Currently, even when individual services meet high standards of clinical quality, there is often insufficient coordination of care across providers, services, and settings to efficiently and effectively meet the needs of patients. More highly developed primary care services, both in the United States and in other countries, are associated with better clinical outcomes and lower costs—both of which are major objectives of the Affordable Care Act. Nearly all patients—nine of 10—report that it is important to have one place or personal physician responsible for delivering their primary care and coordinating their care, that all physicians involved in their care have access to their medical information, and that they have a place—other than the emergency room—for care at night and on weekends (Exhibit 3). People do want choice of their personal physician and many want to be informed, active participants in decisions about their care—but few want to be on their own navigating our complex health care system.

## Exhibit 2. Poor Coordination of Care Is Common, Especially if Multiple Doctors Are Involved

Percent reporting in past two years:	Number of doctors seen		
	Any	1 to 2	3 or more
After medical test, no one called or wrote you about results, or you had to call repeatedly to get results	27	21	36
Doctors failed to provide important information about your medical history or test results to other doctors or nurses you think should have it	23	22	26
Test results or medical records were not available at the time of scheduled appointment	18	14	29
Your primary care physician did not receive a report back from a specialist you saw	15	11	24
Your specialist did not receive basic medical information from your primary care doctor	12	9	18
<i>Any of the above</i>	47	42	55

Source: K. Stremikis, C. Schoen, and A.-K. Fryer, *A Call for Change: The 2011 Commonwealth Fund Survey of Public Views of the U.S. Health System* (New York: The Commonwealth Fund, April 2011).

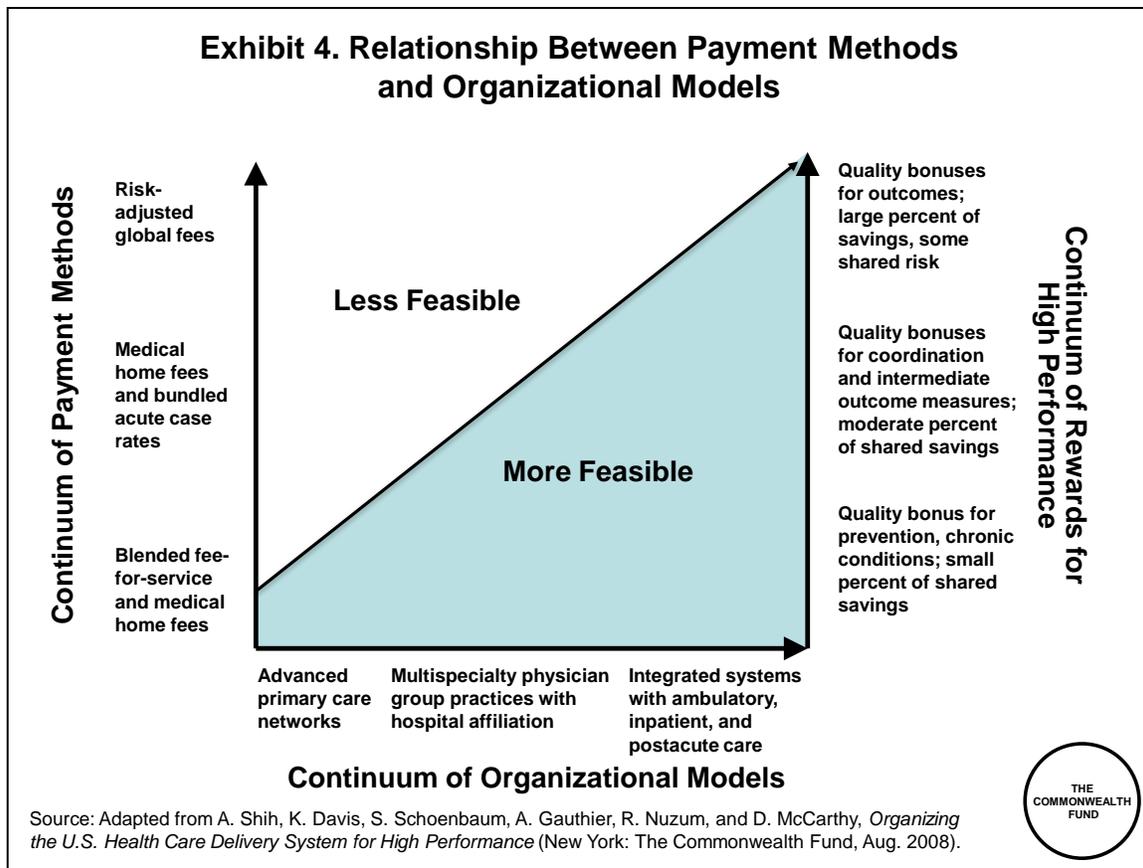
## Exhibit 3. Majority Support More Accessible, Coordinated, and Well-Informed Care

Percent reporting it is very important/important that:	Total: Very important or important	Very important	Important
You have one place/doctor responsible for primary care and coordinating care	93	64	29
On nights and weekends, you have a place to go other than the emergency room	85	54	31
All your doctors have easy access to your medical records	96	70	26
You have information about the quality of care provided by different doctors/hospitals	96	58	38
You have information about the costs to you of care before you actually get care	89	58	31

Source: K. Stremikis, C. Schoen, and A.-K. Fryer, *A Call for Change: The 2011 Commonwealth Fund Survey of Public Views of the U.S. Health System* (New York: The Commonwealth Fund, April 2011).

Within the United States, we have evidence that reorganizing care around the patient—using teams that are accountable to each other and to their patients for the effectiveness and efficiency of care and are supported by information systems that guide and drive improvement—has the potential to eliminate waste, reduce medical errors, and improve outcomes—at a lower total cost of care.<sup>4</sup> Accomplishing this requires changing the payment system that drives how health care is organized and provided. The fee-for-service payment that currently typifies the U.S. health system emphasizes the provision of health services by individual providers rather than coordinated teams that work across providers and settings to address the patient’s needs. The current system encourages the provision of more health services but not the achievement of better health outcomes. It also favors more complex services rather than prevention and primary care. Moreover, fee-for-service payment focuses on providing acute care, rather than serving the ongoing needs of the population.

Payment for health care and the organization of the delivery system that provides that care are interdependent. Payment incentives influence the organization of care and the use of resources and, in turn, the types of organizations in which providers practice affect their ability to respond appropriately to different types of payment incentives (Exhibit 4). As payment methods change, those who provide care will innovate in response to new incentives. Just as providers have responded to the incentives embedded in the current fee-for-service mechanism by steadily increasing the volume and intensity of services provided in a fragmented health care delivery system, new and different incentives can encourage providers to work together, either in formal organizations or in virtual systems of care. These new incentives will spur providers to take broader responsibility for the patients they treat and the resources they use—and benefit from doing so.



As organizational arrangements evolve, payment methods can be adjusted to encourage and reward increasing levels of accountability for cost and quality of care, leading to continuous improvement over time. To accomplish those aims, more innovative payment approaches can be offered to providers in organizational arrangements that are more capable of taking on and successfully responding to these new incentives and producing more favorable outcomes of care.

The challenge is to design both financial and nonfinancial incentives that will bring providers together in an ACO, keep them in an ACO, and enable the ACO to move progressively to increased levels of accountability for its performance that reflect the Triple Aim set forth by the Institute for Healthcare Improvement: enhanced experience of care, improved health of populations, and reduced per capita health care costs.<sup>5</sup> Given the diversity of existing provider systems and communities of patients and caregivers, one must consider the incentives that should be available to individual providers and small provider organizations, as well as to larger, integrated systems, to ensure that all move progressively from fragmented care to more accessible, coordinated, patient-centered care.

In the future, transparency will need to be an essential feature of the U.S. health care delivery system so that, as ACOs develop, patients are comfortable getting their care from providers in the various organizational arrangements that result. Organizing care with accountability to patients and the public will require providers to make positive care experiences and improved outcomes central goals. It will also require payers to align payment incentives with those goals.

The Commission's February 2009 report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, recommended changing the way we pay for health care to reward high quality and prudent stewardship of resources and to encourage more coordinated health care delivery.<sup>6</sup> The Commission's recommendations included the following payment reforms:

- Strengthen and reinforce primary care by revising the Medicare fee schedule to enhance payment for primary care services and ensure annual increases that keep pace with the cost of efficient practice;
- Institute new methods of paying for primary care that encourage adoption of the medical home model and promote more accessible, coordinated, patient-centered care, with a focus on health and disease prevention; and
- Promote more effective, efficient, and integrated health care delivery by adopting more bundled-payment approaches to paying for care over a period of time or for the duration of an illness, with rewards for quality, outcomes, and efficiency.

Those recommendations were reflected in several of the provisions incorporated in the Affordable Care Act.<sup>7</sup> Among the most important of these provisions are: the creation of the Innovation Center to develop and rapidly implement pilots of new methods of provider payment, a requirement to engage in value-based purchasing, and the establishment of the shared-savings program for ACOs. Together, they move the emphasis away from the current fee-for-service system and its adverse incentives and toward mechanisms meant to spur the reorganization and reorientation of the health care delivery system so that it becomes focused on more effective, efficient, patient-centered care and results in slower growth in national health spending.<sup>8</sup> Giving providers both the incentive and the means to reach benchmark levels of quality and efficiency is a key objective of a comprehensive health reform package that also puts in place public health measures to promote health and prevent disease.<sup>9</sup> All are essential for achieving the law's most important objective: ensuring affordable, sustainable insurance coverage for all.

Given the extent of the payment and delivery system changes that are required, a period of testing new models is sensible, so that the design, implementation, and impact of multiple options can be considered and the potential pitfalls associated with any major change can be avoided. A principal concern is that moving away from fee-for-service payment will create incentives for under-provision of needed care, just as the current system to the over-provision of services, including duplicative, unnecessary, and avoidable care. Finding the right balance of incentives and safeguards will require careful planning, monitoring, and examination. No one solution will fit every area of the country, provider, or patient. The size, scope, and structure of accountable care systems will need to be tailored to local circumstances. The promise of higher quality, better patient outcomes, and enhanced efficiency needs to be weighed against the prospect of greater consolidation that can lead to higher prices or less responsiveness to patient preferences. Yet, applying coordinated payment reforms not only to Medicare but also to Medicaid and private insurance plans is likely to be the key to broad dissemination of reforms throughout the health system. As experience is gained, learning quickly and continuously about the factors that lead to success and understanding the problems and pitfalls that need to be addressed will be critical to putting lessons into practice and achieving the success, sustainability, and rapid spread of ACOs. This is of paramount importance given the urgency arising out of the current health care system's shortcomings.

### **PROMISING ORGANIZATIONAL AND PAYMENT MODELS**

The ACO concept of care delivery holds significant potential for transforming the U.S. health care system, particularly when it is combined with complementary models like patient-centered medical homes. Work by the Commission has shown that encouraging the spread of more organized systems through the use of financial incentives, changes to the regulatory, professional, and educational context, and support for new infrastructure will help lower health care costs.<sup>10</sup> The Congressional Budget Office (CBO) estimated that providing ACOs with the incentive of shared savings would save Medicare \$4.9 billion over the 10-year period ending in 2019.<sup>11</sup> However, several factors indicate that the eventual impact of the program will be greater than that: first, the program will not begin until 2012; second, the CBO estimate does not attribute any savings to the program until 2013; and third, CBO's estimate indicates that by 2019, the last year of CBO's 10-year budget period, program savings will have increased to \$1.1 billion annually.

In recognition of this potential, the Affordable Care Act provides incentives under the Medicare program for provider organizations to be accountable for the total care of patients, including population health outcomes, patient care experiences, and the cost per

person. The law specifies that an ACO is a legally established *provider* organization that directly provides many of the services covered by the Medicare program, and ensures access for its patients to those covered services it does not directly provide. It differs from managed care plans that do not provide care directly, but rather serve as insurers that contract with networks of providers.

Provider participation in ACOs is voluntary. An ACO is required to have sufficient primary care providers to care for Medicare beneficiaries, but the nature or capabilities of the primary care providers are not defined by the law. The ACO is held accountable for the quality and cost of care provided to the fee-for-service Medicare patients of those primary care physicians. The law sets out several models of ACOs (networks of individual practices, group practices, and hospitals partnering with physicians or employing physicians), and gives the HHS secretary further discretion to approve other groups of providers.

Although the ACOs established under the law are specifically for Medicare fee-for-service beneficiaries and must legally be organizations of providers, there is nothing to preclude a commercial insurer from setting up an organization of participating providers or from developing contractual relationships with the same organization of participating providers for the care of commercially-insured patients or Medicare Advantage patients. Such arrangements could foster aligned payment incentives and facilitate the development of infrastructure support (administrative, leadership, analytic, information system, and care management system) for the provider organizations.

The Affordable Care Act specifies that each ACO will receive a distribution of the savings achieved, and the proposed rule released by CMS would provide ACOs with the option to receive a higher share of any savings if they also agree to be liable for a share of any excess spending in the first two years of the program—with all ACOs required to both share in savings and be liable for excess spending in the third year. In addition, other approaches could be used as the basis for ACO payments in pilots developed and implemented by the Innovation Center; for example, the ACO could receive a global fee, with the providers taking full risk, or a partial capitation payment, which is a blend of fee-for-service payment and a global fee.

Under either a global fee or a partial capitation approach, Medicare would have to decide how to pay for the services patients receive from providers outside the ACO. Medicare might continue to pay for those services (e.g., hospital care, home health care, or non-ACO specialists) as it does now, adjusting the global fee or partial capitation payment to

the ACO for “out-of-organization” care. Alternatively, the ACO might be required to enter into a formal agreement with and pay “out-of-organization” providers who are necessary to ensure accessible, coordinated care.

Three promising organizational models for ACOs are illustrated in Exhibit 4 and elaborated in Exhibit 5. These include: advanced primary care practice networks with infrastructure support and associated specialist referral networks; multispecialty physician group practices with hospital affiliation; and health care organizations with functionally integrated ambulatory, inpatient, and postacute care services.<sup>12</sup> The exhibits also illustrate different Medicare payment methods that could be used as an alternative to current fee-for-service payment, with Medicare paying the ACO for the services it provides using these new methods of payment, while continuing to pay for “out-of-organization” services directly as it does now, with any savings distributed to the ACO as an incentive for proper stewardship of the total resources required in the provision of care, either directly, as under a global fee; through shared savings, as in a fee-for-service model; or as a combination of the two, as under partial capitation.

**Exhibit 5. Some Promising Organizational Models for ACOs**

	<b>Advanced primary care networks</b>	<b>Multispecialty physician group practices with hospital affiliation</b>	<b>Integrated ambulatory, inpatient, and postacute care</b>
Criteria for Participation	<ul style="list-style-type: none"> <li>•Primary care:</li> <li>•24/7 access arrangements</li> <li>•Chronic condition registries: at least basic HIT</li> <li>•Teams</li> <li>•Contract entity</li> </ul>	<ul style="list-style-type: none"> <li>•Primary care foundation</li> <li>•HIT link across practices</li> <li>•Hospital able to accept bundled payment for select conditions</li> <li>•Contract entity</li> </ul>	<ul style="list-style-type: none"> <li>•Primary care foundation</li> <li>•HIT links across sites including hospital</li> <li>•Legal entity to contract and take financial risk</li> </ul>
Payment Mix	<ul style="list-style-type: none"> <li>•Blended FFS payment and medical home monthly fees</li> <li>•Shared savings</li> </ul>	<ul style="list-style-type: none"> <li>•Medical home monthly fees for primary care</li> <li>•Bundled acute case rates with 30-day warranty for at least two conditions</li> <li>•Shared savings</li> </ul>	<ul style="list-style-type: none"> <li>•Medical home monthly fee for primary care</li> <li>•Bundled acute case rates for multiple conditions</li> <li>•Moving toward risk-adjusted global fees</li> <li>•Reinsurance or other methods to mitigate insurance risk</li> </ul>
Tracking Metrics— Targets based on top 10% and starting point for each ACO	<ul style="list-style-type: none"> <li>•Patient survey</li> <li>•Admissions for ambulatory care-sensitive conditions; 30-day readmit rates; and emergency department use</li> <li>•Chronic care outcomes</li> <li>•Total costs of care for chronically ill, including Rx</li> <li>•Targets for each</li> </ul>	<ul style="list-style-type: none"> <li>•Patient survey</li> <li>•Admissions for ambulatory care-sensitive conditions; 30-day readmit rates; and emergency department use</li> <li>•Chronic care outcomes</li> <li>•Mortality for select acute conditions</li> <li>•Total costs of care, including Rx</li> <li>•Targets for each</li> </ul>	<ul style="list-style-type: none"> <li>•Patient survey</li> <li>•Admissions for ambulatory care-sensitive conditions; 30-day readmit rates; and emergency department use</li> <li>•Chronic care outcomes</li> <li>•Mortality for acute conditions</li> <li>•Total costs of care, including Rx and post-acute care</li> <li>•Targets for each</li> </ul>
Criteria to renew contract	<ul style="list-style-type: none"> <li>•High patient ratings</li> <li>•Meet quality targets</li> <li>•Slow cost growth</li> <li>•Reinvest savings in care system</li> </ul>	<ul style="list-style-type: none"> <li>•High patient ratings</li> <li>•Meet quality targets</li> <li>•Slow cost growth</li> <li>•Reinvest savings in care system</li> </ul>	<ul style="list-style-type: none"> <li>•High patient ratings</li> <li>•Meet quality targets</li> <li>•Slow cost growth</li> <li>•Reinvest savings in care system</li> </ul>

Alternative payment methods that could be used for ACOs include:

- Primary care medical home fees, such as those paid by Blue Cross Blue Shield of Michigan (BCBS-MI) and Community Care of North Carolina (CCNC);
- Bundled acute case rates, such as those used by the Geisinger Health System (Geisinger) in Pennsylvania; and
- Global fees, including those employed by HealthPartners in Minnesota (HealthPartners), Intermountain Healthcare (Intermountain) in Utah, Blue Cross Blue Shield of Massachusetts (BCBS-MA), and Kaiser Permanente in eight regions around the country.

Additional variants of each model of organization and payment could be developed, but any payment model used should ensure that ACOs are held accountable for the overall quality and total costs of care provided to their assigned patient population. Below is an examination of several basic payment approaches, including those listed above, in the context of alternative organizational models.

### **Primary Care Medical Home Fees**

Advanced primary care practices that build on the concept of a patient-centered medical home could be paid a per-patient fee for all primary care or a blended payment that is part fee-for-service and part per-patient fee. These fees would compensate primary care practices for providing timely access to care, including after-hours appointments, managing chronic conditions, and coordinating care. They would also support practices in the use of care teams, telephone and e-mail exchanges, registries and active patient panel management, and other enhanced clinical and patient information systems. Risk-adjustment may be required to account for additional time providers must devote to more-complex patients, to avoid punishing providers who treat those patients. The medical home is attracting interest from primary care providers, who are drawn to its team approach, and patients, who appreciate the benefits of medical homes, including prompt attention to medical issues as they arise, continuity of care, and additional support in managing chronic conditions.

Health systems like Group Health Cooperative in Seattle have found that the medical home model has many advantages. Primary care physicians using a team approach that involves nurses and medical assistants are encouraged to care for patients in new ways. This includes longer visits for sicker patients; phone and e-mail access; and support of patients in their homes for complex medication, nutritional, or counseling needs to

manage conditions and avoid complications. As a result, physician burnout has gone down, costs have declined, and patient satisfaction has increased as the medical home saves patients time and increases the attention and assistance they get from the entire team.<sup>13</sup>

BCBS-MI, in cooperation with the Michigan State Medical Society, has implemented a physician group incentive program (PGIP) to encourage adoption of the patient-centered medical home model. It has redirected a meaningful proportion of professional payment toward practice transformation and population-level performance. Over 8,600 physicians, including 5,600 primary care physicians, have developed associations with 39 physician organizations serving 2 million BCBS-MI members. Incentive payments to these physician organizations amount to approximately \$100 million a year, rewarding infrastructure development, including electronic health information systems and care process transformation, improvement and optimization of population level quality and cost performance, the implementation of provider-delivered disease management services, and clinical process reengineering support. In addition, primary care practices that implement a critical mass of medical home capabilities and have good outcomes on cost and quality measures receive increased fee-for-service payments for office-based, cognitive services, further supporting the model of comprehensive care provided by a physician-led medical home team. A Commonwealth Fund-supported evaluation of the PGIP by the University of Michigan is forthcoming.<sup>14</sup>

Another ACO model might involve state-created umbrella organizations providing support to independent physician practices. An example is CCNC, a public-private partnership between the state and 15 nonprofit community care networks to enable practices serving low-income adults and children enrolled in Medicaid and the Children's Health Insurance Program (CHIP) to function as medical homes for their patients. Evaluations have found a 40 percent decrease in hospitalizations for asthma, a 16 percent decrease in emergency room use, and total savings to the Medicaid and CHIP programs of \$535 million.<sup>15</sup> The payment model has a simple structure: each of the networks receives a payment of \$3.00 per member per month from the state's Medicaid program as an "enhanced care management fee." These fees are to be used to hire local case managers and pay for the resources necessary to manage Medicaid enrollees in the participating practices. Similarly, primary care physicians enrolled in the program receive an "enhanced case management fee" from Medicaid of \$2.50 per member per month, which helps ensure their participation in the network and its care management programs.<sup>16</sup> CCNC is currently engaged in disseminating information about the model to encourage replication in other states, and several states have expressed interest.<sup>17</sup>

Oklahoma recently received approval from CMS to test the model in up to two areas; and if successful, the model will be implemented statewide. Alabama is also seeking CMS's approval for replication of the Community Care model.

Other successful examples of enhancing patient-centered medical homes include new ways of working with specialists as consultants to primary care clinicians,<sup>18</sup> as well as developing referral networks in which there are specific service agreements for care coordination between primary care and specialty practices that specify the way services are delivered and integrated.<sup>19</sup>

Emerging evidence about several medical home projects attests to improved care results and reduced emergency department use, hospital admissions, and avoidable complications.<sup>20</sup> Several of the models include medical homes in more integrated care systems, such as Geisinger<sup>21</sup> and Intermountain.<sup>22</sup>

Although a medical home can exist independently of an ACO, there is enormous benefit to combining the two organizational concepts. A variety of support services provided through a medical home (e.g., care coordination, after-hours care, and health information exchange) are necessary for the primary care practice to be able to achieve significant results with respect to the quality and cost of care for the population served. The ACO can be thought of as providing a “medical neighborhood” that not only provides or arranges for the provision of those services, but also assures clinical integration between primary care practices that may share responsibility for managing patients (including after-hours coverage) and among primary care practices, specialists, hospitals, home health care, long-term care, and other settings of care. With either a blended fee-for-service payment and medical home fee or a global primary care fee, it should be possible for the primary care practice to supply or purchase enhanced services or enable networks of primary care practices to develop or collectively purchase shared services and become an ACO. Ideally, all of the primary care practices in an ACO would meet criteria for being medical homes for their patients.

### **Bundled Acute Case Rates**

Another approach is to pay a bundled acute case rate to hospitals for a given procedure, such as hip replacement or heart bypass surgery, that includes care after discharge. Everything is included in one fee: the hospital bill (and any care necessitated by complications that cause the patient to be readmitted to the hospital), the surgeon's fee, the anesthesiologist's fee, the rehabilitation facility fee, and the fees for the many other

providers that are typically involved in complex procedures and the subsequent period of recovery. Geisinger offers such a bundled fee for a number of procedures, including coronary artery bypass graft surgery, total hip replacement, and perinatal care.

A bundled acute case rate for a surgical, medical, or obstetrical procedure has many advantages. The most important is that it provides a significant incentive to hospitals, surgeons, and other hospital-based physicians to take joint responsibility for reducing complications and improving transitions in care after discharge. This, in turn, should stimulate providers to collaborate to organize care in a way that leads to excellent outcomes and eliminates waste and excess cost. Bundled payment also allows providers the flexibility to provide services that are not generally covered by health insurance but may improve outcomes and reduce costs; these include medical services such as remote diagnosis and nonmedical services such as nutrition or home-based help. The bundled-payment approach also encourages providers to use their time more efficiently and in a way that may be more convenient for their patients.<sup>23</sup>

### **Global Fees**

The current fee-for-service payment system rewards physicians for providing a greater volume of more costly services rather than for getting the best results for patients. While bundled case rates may partially address this issue, they create new issues such as how best to define the bundle and how to keep the number of bundles from growing in response to the payment incentive. An alternative is to pay each provider organization a global fee for all care—a fixed, per-person payment based on the patient’s health condition or a risk-adjusted capitation rate—and allow the provider organization the latitude of determining the care processes that are most appropriate for the population it serves.

Very successful examples of global payments exist. In the case of integrated delivery systems with their own health insurance plans, like HealthPartners, Intermountain, and Kaiser Permanente, patients enroll in the insurance plan and get their care through that health system of hospitals and physicians. The health system is effectively paid a global fee per patient, with some cost-sharing payments by patients for individual services. But if it manages patients’ diabetes well so that those patients aren’t hospitalized, or it begins using lower-cost imaging tests, those savings remain with the organization and can be reinvested in improved care or distributed to the health care providers who can then share in the savings.<sup>24</sup> Patients benefit from better outcomes and by avoiding hospitalization or unnecessary tests, and may also share in the savings in the form of lower premiums.

BCBS-MA has piloted a monthly, risk-adjusted global payment that covers all services delivered for members of its health maintenance organization (HMO) plan. The levels of shared savings in this Alternative Quality Contract (AQC) are contingent on quality improvements, including improved outcomes. Nine organizations now participate in these alternative quality contracts, including one-fourth of all primary care physicians in the BCBS-MA network and 13 affiliated hospitals, serving 31 percent of BCBS-MA's 1.2 million HMO members. A Commonwealth Fund-supported evaluation of the AQC by Harvard University is in progress.<sup>25</sup>

When global fees are being considered—particularly those that cover a significant amount of care that isn't within the direct control of the providers who constitute the ACO entity—there needs to be consideration of whether the providers are being asked to take on an appropriate level of risk. There are two categories of financial risk associated with health care delivery: “probability (or insurance) risk” and “technical risk.”<sup>26</sup> The former is the risk that some members of the population will develop unusually expensive problems or that some providers will systematically attract higher-cost patients, whereas the latter results from the provider's delivery of inappropriate care or inappropriately expensive care that overuses or wastes resources. Insurance risk can be mitigated for the provider; in contrast, it is appropriate that the provider be held responsible for delivering technically effective and efficient care.

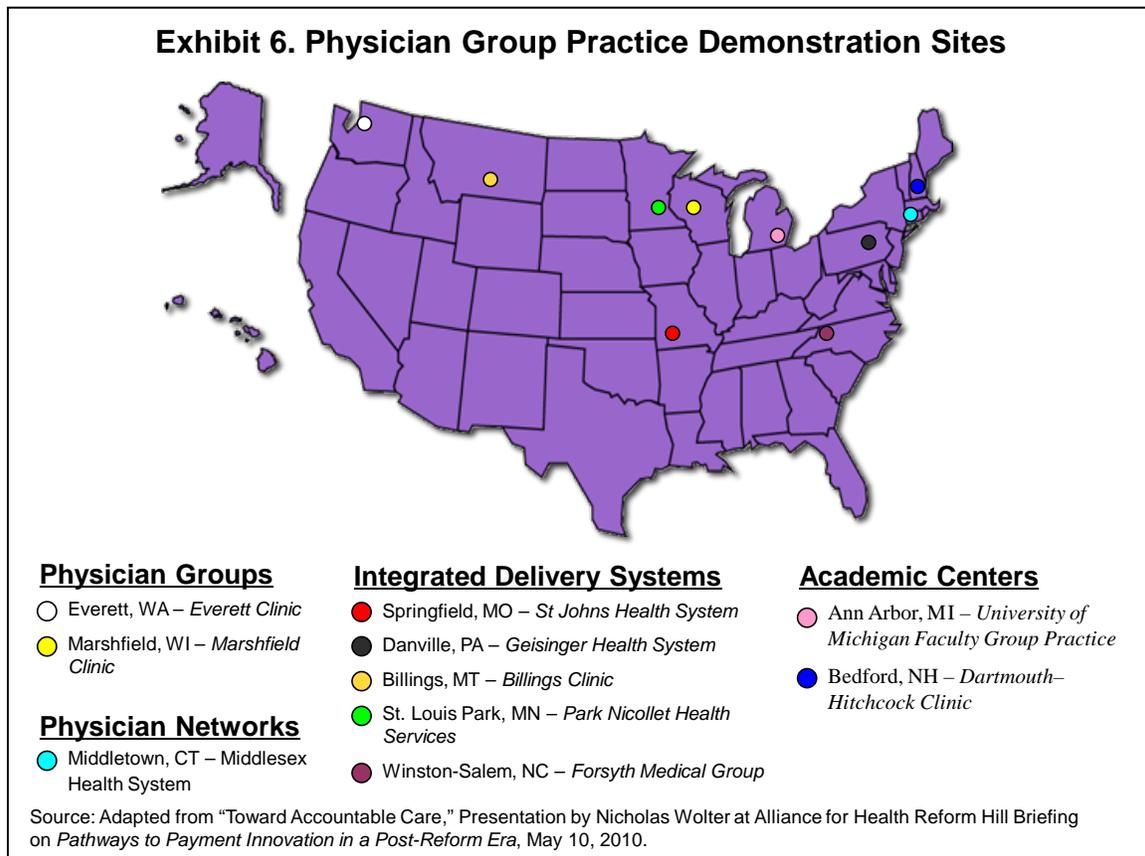
ACOs receiving global fees or partial capitation could experience savings or losses. When the ACO provides care to the population for which it receives global payments for less cost than the total payment received, it captures the savings. Alternatively, if it spends more than what it receives, it is at risk for the loss. The risk to the ACO of being accountable for high-cost patients (insurance risk) ought to be mitigated through risk-adjusted global payments and/or reinsurance or stop-loss provisions. Risk-adjusted payments would be provided directly by Medicare and other payers, while reinsurance and/or stop-loss protection could be either provided by payers or obtained by the ACO from a private reinsurer to which it pays premiums. Minimizing “technical risk” will be an important core function of ACOs, one that will require them to develop systems and processes to help their constituent providers manage care as effectively and efficiently as possible.

Overall, global payment arrangements are likely to be more appealing to, and better managed by, more functionally integrated care systems with an existing legal structure and financial structure to allocate resources across a continuum of care. Loosely integrated confederations of independent practices that are just in the process of developing ways to work together and share information across sites of care are less

likely to welcome such payment arrangements. However, offering attractive global payment models could be instrumental in encouraging emerging networks to develop more sophisticated organizations and care delivery systems, which offer increasingly integrated and coordinated care to the populations they serve.

### Shared Savings

Launched in 2005, the Medicare Physician Group Practice (PGP) demonstration gave 10 large, multispecialty group practices the opportunity to share savings earned by reducing the cost of health care delivered to the Medicare beneficiaries they treat—contingent on their ability to meet a set of quality improvement standards. The demonstration, the experience with which guided policymakers as they wrote the health reform law, offered each participating practice a portion of the savings it achieved relative to a target based on the local trend in per-beneficiary cost in the area it serves. The participating practices, distributed across the country, were chosen for their capacity to engage in system redesign (Exhibit 6). These practices encompass different organizational models: two are physician groups that have no formal affiliation with a hospital, five are integrated delivery systems, two are practices affiliated with an academic medical center, and one is a physician network.



While the payment model involved no downside risk to the practices in terms of payment, the participating practices were expected to spend their own resources up front in efforts to achieve savings. For each practice in each year, excess spending from prior years was accrued in determining if there were savings to be shared. Nonetheless, the prospect of shared savings provided what appears to have been an effective impetus to engage in practice improvement to increase quality and slow cost growth.

All 10 PGP practices achieved benchmark performance on almost all of the agreed-upon quality measures over the first four years of the demonstration, and in the third and fourth years, five practices received bonus payments by reducing by two percentage points or more the trend in Medicare outlays relative to the overall trend in the areas they serve.<sup>27</sup> Strategies for improving performance varied across sites—ranging from interventions focused on selected chronic conditions such as diabetes and heart failure to nurse case managers for patients at high risk of emergency department use, hospitalization, and rehospitalization.<sup>28</sup>

The payment method that CMS has proposed for the Medicare Shared Savings Program differs in several ways from the one used in the PGP demonstration. One major difference is that it provides ACOs with the option to reap a more substantial share of possible savings than in the PGP demonstration if they also agree to receive lower payments if their costs exceed their target rates; by the third year, all ACOs will be required to participate in a two-sided model. Another difference is that the ACO's spending target will be based on the historical national rate of increase, rather than the rate of increase actually experienced in the organization's own service area. An important similarity to the PGP demonstration, however, is that a large share of the distribution of shared savings would be based on the organization's performance on a set of specified quality performance standards.

### **A Diversity of Organizational Models Fit Within the ACO Concept**

Although functional integration is likely to be easier to achieve when a single organizational entity owns and operates an entire health care delivery system, encompassing ambulatory primary and specialty care, hospital care, ancillary services, and possibly long-term care, as well as an insurance mechanism, it can also be achieved by tight contractual arrangements between separately owned components, or even a set of highly aligned incentives that catalyze the development of shared information systems and care processes and permit a full spectrum of accountable care for a defined population. A Commonwealth Fund series of 15 case studies has shown how diverse types of organized

health care delivery systems promote higher performance through attributes such as information continuity, patient engagement, care coordination, team-oriented care delivery, continuous innovation and learning, and convenient access to care.<sup>29</sup> Developing these attributes ought to become objectives for the various models of ACO. When an organization has these attributes, it should be capable of providing demonstrable benefits to both patients and providers such as achieving the Triple Aim. Furthermore, using modern technology and shared services, it should be possible to achieve these results without necessarily requiring physicians to aggregate physically under one roof, allaying both the public's and physicians' concerns about large institutional practices.

For example, medical homes are compatible with any of the basic organizational models shown in Exhibit 4. Primary care practices could be organized in networks affiliated with a specialist referral network and an infrastructure support of shared services; organized as part of a multispecialty group practice; or organized as part of an integrated delivery system with a full continuum of care services. Geisinger, which both owns and has affiliations with sets of primary care practices, supplied care coordinators to both owned and affiliated practices as part of the PGP demonstration.

By exploring diverse models, the most effective strategies can be identified before communities, payers, and governments commit to one or more of them. An approach that fosters diversity in how ACOs are constituted and organized will allow them to be responsive to local cultures and circumstances. It will also be more likely to avoid the potential negative consequence of consolidation of providers into large, vertically integrated systems, which dominate their markets and are inclined to use their market dominance to undermine incentives that would otherwise drive them toward increased efficiency. Finally, by allowing and fostering the development of diverse ACO models, providers (physicians, hospitals, and community-based programs) will be supported in being fully engaged in their practices and will be animated by the values, purposes, and sense of ownership that inspire them in their professional work and service to the community.

## **POLICY RECOMMENDATIONS**

For ACOs to contribute significantly to improving the performance of the U.S. health system, it will be essential for the accountable care model to become widespread and able to operate in and adapt to a wide variety of local populations and health care environments. To provide a solid basis for the propagation of the model, it is important to build on

successful innovations already under way across the country, including those used at Medicare PGP demonstration sites, and ACO and medical home initiatives launched by state governments, private insurers, and providers.<sup>30</sup>

The Commission on a High Performance Health System offers here a series of recommendations intended primarily to inform CMS in the development of final rules for the Medicare Shared Savings Program but also to assist the Innovation Center as it considers alternative payment approaches and models of health care delivery. These considerations are, moreover, important for all parties—payers, providers, patients, and purchasers—interested in improving the performance of the U.S. health system through this approach. These recommendations are intended to describe a set of design features that are important to ensure that ACOs achieve the goals of health reform—the Triple Aim of better care, better health, and lower costs—while allowing enough flexibility to achieve success in different health care environments with various populations and configurations of providers and payers.

### **Strong Primary Care Foundation**

ACOs are specifically defined by the Affordable Care Act to be “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of [the fee-for-service] Medicare beneficiaries . . . who are assigned to it.”<sup>31</sup>

The statutory requirements for ACOs include having enough primary care providers to serve the Medicare beneficiaries in the group. This requirement reflects the fact that the goal is to improve access and coordinate care, with an emphasis on prevention and health. A strong primary care foundation is essential for accessible, well-coordinated care, especially for beneficiaries with chronic conditions, and is characteristic of high-performing health systems—ones that achieve better outcomes, lower costs, and greater equity in serving a population.<sup>32</sup> These results depend upon robustness of each of the dimensions of primary care: first contact, continuity, coordination, and comprehensiveness. Primary care practices should provide excellence in primary and secondary prevention; screening and early detection of illness; coordinated acute care with appropriate follow-up; and smooth transitions across clinicians, settings, and services.

Belief that the United States will benefit from more and better primary care services has led to the development of the patient-centered medical home. This model emphasizes patient-centered primary care that is available day and night and is the core of a system that delivers evidence-based, coordinated care. While 95 percent of American adults say

they would like a practice that is accessible and provides personal, coordinated care, only 50 percent can say they have all four of the following: 1) a regular doctor or place of care (90 percent); 2) the doctor or staff who knows important information about their history (82 percent—“always” or “often”); 3) a doctor who is easy to contact by phone during regular office hours (81 percent—“easy” or “somewhat easy”); and a doctor who helps coordinate care received from other doctors or sources of care (69 percent—“always” or “often”).<sup>33</sup> People who give an affirmative answer to all four of those questions tend to experience fewer errors in care or medication, less duplication of tests and delays in care, better chronic care management, and greater overall satisfaction with care.

There is reason to believe—and early evidence to indicate—that primary care practices, even ones that have adopted electronic medical records and several other important features, will best meet patient needs when they are an integral part of a supportive health care system with payment methods that encourage and reward working together to care for patients over time.<sup>34</sup> While medical homes are necessary, they will function best in medical neighborhoods that enhance clinical integration across physician practices (primary care and specialists) and between health care facilities that focus on effective and efficient care and improved outcomes.<sup>35</sup> ACOs should be able to provide these medical neighborhoods. Therefore, medical homes and ACOs should be complementary models of care delivery.<sup>36</sup>

The support that ACOs can provide would logically encompass or link all of the practices, primary care and specialty, and organizations such as hospitals that are providing services to a population of patients for which they are responsible. For example, they could provide or contract for after-hours care (e.g., telephone triage and centralized urgent care visits) to provide round-the-clock access. They could provide the equivalent of an “information technology department” for practices that could not otherwise support one and ensure that there is information exchange between providers. They could supply a variety of care coordination and disease management services to affiliated hospitals and practices. They could develop or contract with an information exchange to connect the organizational components. And they can—indeed, will be required to—provide a variety of administrative and analytic services that assemble performance information. This same set of capabilities also should facilitate the ACO’s offering, and perhaps require specific performance improvement activities such as regional improvement collaboratives or expertise in change management facilitation.

**Recommendation 1. Strong Primary Care Foundation**

- 1a. CMS should ensure that all ACOs have a strong primary care foundation that builds on the concept of the patient-centered medical home.
- 1b. Although CMS may require that ACOs have certain structural characteristics (e.g., electronic medical records and availability of after-hours care) or have certain processes in place (e.g., quality improvement programs), the availability and accessibility to patients of a regular source of care and the ability of that provider to coordinate care received from all sources should be paramount.

**Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs**

To stimulate the spread of patient-centered care systems that provide timely access to well-coordinated care and strive for continual improvement in outcomes, it will be important to ensure accountability for health care quality, patient experiences, and positive outcomes in addition to reduced costs—and to reward those results. ACOs will be held accountable for, and their payments will be tied to, meeting performance standards. For example, patient surveys will assess access and care experiences, and outcome and quality indicators will track and assess performance over time.

To gain public trust and to stimulate innovations that improve patient care, it is essential to link ACO accountability to a commitment to track and report performance. Such accountability was notably absent when the managed care movement was growing in the 1990s, giving rise to concerns that financial incentives were undermining rather than enhancing quality of care.<sup>37</sup> As illustrated in Exhibit 5, outcome metrics could vary depending on the level of integration and bundling of payments. All types of ACOs, however, would benefit from targeted surveys to obtain the patient perspective on access and care outcomes—including health and functional improvement after surgery. Within the United States and internationally, patient registries that are used to guide systematic outreach and follow-up, and to report on these activities, can also provide feedback to clinicians to help them improve care.<sup>38</sup> Holding emerging ACOs accountable for costs, quality of care, outcomes, and patient experiences has the potential to stimulate ongoing health system change focused on achieving better care at lower costs—and supported by the public.

It is axiomatic that ACOs should be accountable for achieving the Triple Aim. The question is: to whom are ACOs accountable? The answer is they must be accountable to multiple parties, including the population they serve, their payers, and the providers with whom they have regular relationships. In turn, it is particularly important that the

providers within each ACO understand their attendant responsibilities, which are broader than under the current delivery system and payment structure. For example, hospitals traditionally identify their population as persons to whom they are providing services. As a component of an ACO, it will be important for hospitals to understand that their contribution to accountability for patient experiences and outcomes extends into areas such as working with others to ensure excellent follow-up care and reduce or eliminate avoidable readmissions, helping other providers reduce or eliminate ambulatory care-sensitive admissions, and providing excellent experiences for patients and their family members, who may also be part of an ACO population even if they are not patients of the hospital themselves.

**Recommendation 2. Accountability for Quality of Care, Patient Care Experiences, Population Outcomes, and Total Costs**

- 2a. All participating ACOs should be required to agree to and be able to report measures of quality of care, patient care experiences, and outcomes, or have arrangements in place to enable such reporting.
- 2b. Shared savings should be distributed contingent on high quality and positive patient experiences.
- 2c. CMS (along with other participating payers) should work with each ACO to ensure that incentives for providers within the ACO are aligned and consistent with the aims of better health, better care, and lower costs.
- 2d. Regardless of which payers are involved in the ACO payment mechanism, the shared savings paid out by each payer or group of payers should, to the extent feasible, take into account the ability of the ACO to achieve overall savings on total costs, rather than just savings for individual payers.

**Informed and Engaged Patients**

Having physicians discuss with the patient the fact that the physician is part of an ACO and what that means about the kind of care the patient will be receiving can increase the levels of engagement of both providers and patients, enhance provider-patient relationships, and enable more coordinated care. It also would be to the advantage of all the parties involved to be able to: 1) assure patients that the physician and the organization of which he or she is a part are aiming to achieve a high level of performance; 2) explain how they plan to do so; and 3) convey what safeguards have been established to protect the patient's access to the care he or she needs and ensure the quality and effectiveness of that care. Ideally, physicians and their patients would reach agreement on their mutual expectations and responsibilities.

In the absence of effective communication of this sort, patients may infer that the physicians and others caring for them have an incentive to withhold necessary care and not have full trust in their providers, as happened in the late 1990s with respect to managed care organizations.

From the outset, there should be transparency about the how the ACO's performance is being measured and, over time, one would expect ACOs to provide evidence to patients of their performance. Patients should retain the right to receive care from the specialists of their choice. Indeed, if patients seek care outside the ACO because they perceive they are not getting the access they need or quality they believe they deserve, this may encourage providers to improve. Care outside the ACO, however, may not be as well coordinated—for example, if the providers inside and outside the ACO do not share an information exchange or the hospital outside the ACO does not know how best to arrange a care transition back to the providers inside the ACO. Patients will need to be informed about the benefits and pitfalls of seeking care outside the ACO; and the ACO should be monitoring not just the occurrence of care outside the ACO but also the reasons behind it. That monitoring should be considered part of their overall responsibility for the population.

Physicians often are concerned that their professional performance is subject to factors outside their control, such as whether the patient is adhering to a treatment or medication regimen. Yet, common reasons for nonadherence are cost and disagreement with or lack of understanding of a physician's recommendations.<sup>39</sup> Medicare beneficiaries not only have coverage, but will have increasingly comprehensive coverage for preventive care and prescription drugs under the Affordable Care Act, so cost should be less of a barrier. That said, physicians and other providers undoubtedly need assistance in doing a better job engaging patients in shared decision-making and using teach-back techniques to ensure that their recommendations are understood and mutually acceptable. A similar set of issues is involved in helping patients with chronic conditions understand those conditions and how they can help themselves in the management of them.

**Recommendation 3. Informed and Engaged Patients**

- 3a. Providers should notify all of their patients that the providers belong to a given ACO, along with its characteristics and what that will mean for the care that patients will receive.
- 3b. ACOs should encourage providers and patients to specify expectations and responsibilities, and engage providers and patients as partners in ensuring the best care and outcomes.
- 3c. CMS should test different approaches for encouraging patients to designate an ACO as the principal source of their care by providing positive incentives to do so (such as enhanced benefits or lower cost-sharing responsibility). Patients should retain the right to seek care from the providers of their choice, including those not participating in the ACO, unless they explicitly agree to receive care exclusively from the ACO's providers.

**Commitment to Serving the Community**

One of the major lessons of the 1990s managed care experience was that as the HMO market evolved from one comprising prepaid group practices concerned primarily with health care delivery to one dominated by organizations in which the insurance function was distinct from the health care delivery function, the focus of managed care shifted from providing care to paying for care. This led to a patient backlash, as HMOs—regardless of the motivations of individual organizations—increasingly were seen as attempting to pay lower prices and deny needed care, rather than coordinating care and providing it more efficiently and effectively. To safeguard against history repeating itself, ACOs should embrace a culture of putting the patient first, with a focus on providing access to the most appropriate care and a mission of serving the community. In particular, access to needed health care for low-income, uninsured, and other vulnerable populations must be ensured.

**Recommendation 4. Commitment to Serving the Community**

CMS should make an explicit commitment to serving their community, including low-income and uninsured patients, an integral part of qualifying as an ACO.

**Criteria for Entry and Continued Participation That Emphasize Accountability and Performance**

The Affordable Care Act includes several compliance requirements for ACOs, and more specific requirements are described in CMS's proposed rule for the Medicare Shared Savings Program. Meeting these requirements would best be ensured by developing clear entry criteria for these organizations, together with new payment arrangements. Continued participation should be contingent on performance.

Although there are a number of characteristics that may be associated with the potential success of the model, CMS must strike an appropriate balance between the need to ensure its success and the desire to be flexible enough to encourage its propagation. Some essential features of ACOs are specifically defined by the Affordable Care Act, including:

- Relationships with a group of providers either through direct involvement in the organization or through a contractual arrangement, so that the ACO can provide the full continuum of health care for the population it serves.
- An established mechanism for shared governance among those directly involved in the organization.
- A leadership and management structure that includes clinical and administrative systems that can provide information needed to assess patient experiences, outcomes, and costs. Such systems are essential for providing feedback to participating providers and patients and for informing efforts to learn and improve and to report performance to payers and the public.
- Agreement to survey patients about their access and care experiences and report patient outcomes.
- The financial and administrative stability necessary to be accountable for the quality, costs, and overall care of Medicare fee-for-service beneficiaries and others in the population served, as well as the ability to take on a three-year contract with Medicare for the quality, costs, and overall care of fee-for-service beneficiaries with minimum risk of default on the contract.
- An appropriate legal structure enabling the organization to receive and distribute payments for shared savings to the providers in the group.
- A process for ensuring the competence of providers—for example, structured annual review of physician performance.<sup>40</sup>
- A set of processes that meets the requirement for promoting evidence-based medicine and patient engagement.
- Capability of using “enabling technologies” for care coordination, such as telehealth and remote patient-monitoring.
- Appropriate mechanisms for providing patient-centered care, as documented by patient experiences.

The criteria an organization must meet to participate as an ACO should focus on functionality, as detailed above, rather than on structures per se. ACOs will need to be adaptable to a variety of health care markets, which may differ in terms of location, degree of competition, and other characteristics. All ACOs will need to include, or contract with, the appropriate providers to ensure they can be accountable for care across the continuum and ensure access to needed care for the population they serve. Even the minimum entry criteria for participation must not be overly prescriptive, while at the same time ensuring sufficient functional capacity for the provider organization to assume accountability for care.

It will challenge the creativity of all the major stakeholders in an ACO to determine how the requirements above and any others might best be met. Since participating ACOs would be required to report on performance metrics for quality and patient experiences and have arrangements with payers to report on total costs of care, it is reasonable to expect that continued participation in ACO payment arrangements would be contingent on performance on patient experiences and quality, not just costs.

Measuring and reporting on outcomes should also be part of the ongoing certification process to assure the public that ACOs are indeed accountable to patients. Patients are unlikely to be convinced they are receiving more effective and efficient care unless performance data are publicly available. Significant effort will be required to develop new performance measures and make them progressively more meaningful to the public and providers.

***Recommendation 5. Criteria for Entry and Continued Participation That Emphasize Accountability and Performance***

Entry criteria for ACOs should include, at a minimum, the availability of primary care and the capacity of the organization to ensure that patients have access to needed services across the continuum of care, as well as the ability to provide meaningful evidence of quality (including patient experiences and outcomes) and cost performance. Continued participation and financial rewards should be contingent on performance and accountability, rather than structural characteristics. This should include public reporting of performance metrics.

**Multipayer Alignment to Provide Appropriate and Consistent Incentives**

Most physician practices have both Medicare patients and privately insured patients. If these payers have different methods of payment, the incentives that are intended in the law to improve quality and control costs for Medicare patients will be less effective than

if all payers join together and pay ACOs in compatible ways. The greater scale that comes from participation of private insurers will also enable ACOs to establish the infrastructure required for success, as well as enable them to share in risks.

Fisher and colleagues calculated that one can have stable networks of care for a panel of 5,000 Medicare fee-for-service beneficiaries;<sup>41</sup> the Medicare Payment Advisory Commission has stated that it would take 5,000 beneficiaries to make it possible to “distinguish actual improvement from random variation on a reasonably consistent basis.”<sup>42</sup> While 5,000 Medicare patients in an ACO may meet the requirements set out in law, from the perspective of providers it may take a much larger degree of improvement from trend to generate a reasonable probability and amount of reward for that small a panel of patients. Thus, ACOs as entities are more likely to succeed if the majority of the patients cared for by their providers care are considered to be part of the ACO—and that is more likely to happen if multiple payers are providing consistent incentives.<sup>43</sup>

In some instances, this will involve CMS’s convening other payers to organize joint initiatives; in other instances, since ACO pilots are developing in some states that do not yet involve CMS, it will involve CMS’s joining those efforts. These approaches maximize the likelihood that the providers who are willing to become involved in an ACO that meets the statutory requirements will have similar care and cost objectives for the majority of patients they serve. This should not be taken to imply that Medicare, Medicaid, or other payers must delay their efforts to encourage the development of ACOs until multiple payers can be involved in the initiative, but that those efforts, where possible, should be coordinated to align incentives and maximize their impact. Over time, CMS and other payers can move toward higher degrees of coordination by using similar performance measures, payment models, and methods for sharing data, and by sharing best practices and lessons learned.

**Recommendation 6. Multipayer Alignment to Provide Appropriate and Consistent Incentives**

CMS should actively work with providers and payers in each major market to develop multipayer ACO arrangements—including Medicare, Medicaid, and private payers—whenever possible. Such arrangements should be designed to align incentives among payers, give a clear and consistent message to ACOs, and enable them to focus on higher quality of care, better patient care experiences, improved population health outcomes, and lower costs for all their patients, as well as simplifying administrative processes.

### **Payment That Reinforces and Rewards High Performance**

The Affordable Care Act specifies that ACOs shall share in savings as the growth in Medicare Part A and Part B outlays for their patients is reduced relative to the projected trend in per-beneficiary spending in traditional fee-for-service Medicare. The target used to calculate savings is to be based on the most recently available three years of cost data, with the precise methodology to be determined by the HHS secretary. This is a change from the PGP demonstration, in which the target for each participating practice was based, after the fact, on the actual increase in spending for other patients in the same local area during each year. The revised methodology has two major advantages over that used in the PGP demonstration: first, because the target can be prospectively specified, ACOs will be able to manage to a known benchmark; second, because the target is based on program-wide data, large ACOs will not be adversely affected by “spillover effects” in their community from adoption of their own improved practices by other local organizations.

Other improvements in the payment mechanism for ACOs under the shared-savings program are needed to ensure that the incentives provided have the desired impact. In the PGP demonstration, savings were only attributed to each participating practice after a threshold of 2 percent savings had been achieved relative to the cumulative target. From the perspective of CMS, the 2 percent threshold was necessary to avoid rewarding savings that might result from random improvement versus purposeful redesign and achievement of more efficient care.<sup>44</sup> A better strategy would be to set the threshold at a 95 percent confidence threshold that reflects both the size of the ACO’s patient population and the consistency of its actual cost trend, which would lead to lower thresholds for ACOs with more predictable costs over time.

In the PGP demonstration, there has been a substantial lag between provision of care that is being rewarded and the distribution of the corresponding rewards. This reflects the need to wait until the data for the performance period are collected to compute the level of spending for each practice’s service area, set the spending target, and identify the patients who are to be attributed to each practice so their costs can be determined. Maximizing the effectiveness of payment incentives for ACOs and the providers that compose them will require ensuring that shared savings are distributed more promptly.

The attribution of patients to an ACO for calculation of rewards in a shared-savings model will be an issue for ACOs, for several reasons. The retrospective attribution of patients to providers, as described above, contributes to the delay in the distribution of rewards. Retrospective attribution also means that it is difficult for providers to know for

which patients they will be held responsible. Moreover, it hinders the ability to engage patients as partners with their providers in managing their care, because they do not know at the time whether they are being included in the accounting of the ACO's performance. The latter two of these issues are also addressed in the discussion of informed and engaged patients above.

Another issue related to the determination of ACO payments is that, from the perspective of participating ACOs, upfront investments often are necessary to make the changes that will produce savings. Making those investments has required both financial stability and a leap of faith that the investments will pay off. Even if methods are adopted that make payment of shared savings more timely, some mechanism for upfront funding (which could be counted against any realized savings) may enable more potential ACOs to make the investments necessary to participate in the program. This funding could be targeted to providers that face particular challenges in accessing capital or that serve certain (vulnerable) populations or certain (rural, low-income, or underserved) areas, by restricting it to those groups of providers or by offering them more favorable terms.

As an alternative to upfront payments, or in combination with them, changing the basic provider payment method to a blended payment including monthly per-patient medical home fees would help motivate primary care physicians to participate in ACOs and enable investments in teams and information systems. Similarly, bundled global fees for hospital acute care, including care after discharge, can provide resources for hospitals to invest in transition care and foster relationships with providers in the community, while also helping providers assume broader accountability for care of a defined set of patients and helping to shift the orientation of physicians toward total population care.

Holding ACOs accountable to patients requires that savings be linked to positive patient care experiences and outcomes, not just costs. This will require financial agreements that make savings allocations contingent on quality and performance, as in the PGP demonstration.

### **Recommendation 7. Payment That Reinforces and Rewards High Performance**

- 7a. The threshold for attributing savings to ACOs should be set to reflect the predictability and reliability of each organization's cost trend, and protect against shared-savings payments that are generated by random fluctuations in year-to-year costs, while ensuring that organizations are rewarded for achieving actual cost reductions.
- 7b. The determination and payment of shared savings should be made with as little delay as possible, so that the reward for reducing costs while improving quality closely follows the actions that generate it. This can be supported by prospectively determining the patients whose costs are to be used to calculate shared savings and prospectively setting the spending target for each ACO.
- 7c. CMS (along with other participating payers) should make upfront support, possibly as low-cost loans against future shared savings, available to organizations that, because of certain circumstances, need it to offset the infrastructure investment expense required to redesign care processes and make other changes so they can become successful ACOs. Determination of the availability and extent of upfront support and the basis on which it is provided (e.g., loans vs. grants) may differ by whether it is a safety-net institution serving underserved populations, as well as by other defining characteristics of the organization, subject to the organization's potential for achieving the program's goals and its proposed plan for doing so.

### **Innovative Payment Methods and Organizational Models**

Although the Affordable Care Act requires the development of a shared-savings model in relation to ACOs, the responsibility for testing innovative payment and delivery system models has been assigned to CMS's Innovation Center, which "is to test innovative payment and delivery system models that show important promise for maintaining or improving the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while slowing the rate of program costs."<sup>45</sup> As described earlier, this should encourage voluntary participation in pilots of other payment models for ACOs besides shared savings.

Shortell and colleagues have proposed a three-tiered approach to paying ACOs, with qualifying conditions for each.<sup>46</sup> Tier 1 involves a shared-savings model with fee-for-service payments that could include primary care medical home fees with opportunities for bonuses and no downside risk. Tier 2 involves shared savings with the potential for more generous payments than in Tier 1, but it also adds a downside risk, with reduced payments if spending exceeds a preestablished target. Tier 3 would reimburse the ACOs through full capitation or extensive partial capitation and bundled payments; the opportunity for reward—as well as the risk—would be greater than in the second tier.

McClellan and colleagues also have proposed a three-level approach to classifying and paying ACOs.<sup>47</sup> In their proposal, Levels 1 and 2 are similar to Shortell and colleagues' Tiers 1 and 2, but their Level 3 involves risk-adjusted partial capitation payments with quality bonuses rather than full capitation. In this report, we have described a set of organizational models as well as a set of alternative payment approaches, and discussed how those combinations can be combined; all of these approaches should be among those considered for possible pilot-testing.

CMS is proposing to move more rapidly to a two-sided model of accountability by offering ACOs the option of taking responsibility for a share of any excess spending as well as receiving a share of savings, with a higher share of savings available for those who choose this arrangement. By year 3, all ACOs will be required to participate in this type of arrangement.

Some of the questions that merit consideration in designing and evaluating various payment models are:

- Will the addition of downside risk to shared-savings models (i.e., using the Shortell or McClellan frameworks, this would require comparing results of Tier/Level 2 and Tier/Level 1) improve performance or simply deter participation?
- What advantages, if any, does partial capitation offer over full capitation, and does the answer depend on the configuration, size, and other features of the organization?
- Will different types of organizations involving physicians (i.e., primary care network-based, multispecialty group practice-based, or fully integrated ambulatory and hospital provider-based ACOs) gravitate to or only succeed with certain payment models?
- Ultimately, how can ACOs be motivated to take on or move to the model/level/tier that is associated with the highest achievable levels of quality and lowest achievable levels of cost?

Another way to consider payment models for ACOs is that they are all based on some degree of shared savings with some including elements of shared risk; and they can be designed to provide a range of opportunities for risk or reward for the ACO. That said, the way payments are distributed can differ greatly in various models. Shared savings models generally involve continued fee-for-service payments to individual practitioners or hospitals (perhaps evolving to a model involving symmetric risk or partial capitation), with the potential of a lump-sum reward to the ACO, which could distribute the reward

(and, perhaps, total payments) to providers under a mechanism that would be specified to CMS by the organization. Capitation models generally involve payment of a lump sum to the ACO to cover expected per-person, per-month spending, with the ACO distributing those funds to providers as agreed upon internally within the organization.

Robinow has examined many of the issues involved in global payment or capitation in a series of structured interviews with experts who have substantial and lengthy experience with these models.<sup>48</sup> She found that tools that now exist can be used to address some past problems with this method of payment: for example, risk adjustment can help reduce the incentive for providers to avoid sicker patients, which was a major criticism of capitation in the heyday of managed care in the 1990s. Utilizing stop-loss or reinsurance for ACOs could also help mitigate insurance risk that would otherwise limit widespread provider participation. But other issues remain: for example, combining deductibles and coinsurance with global payment models requires claim adjudication and collection of the patient's share of cost, which increases administrative burden. Also, although the experts Robinow interviewed generally favored alternatives to fee-for-service such as salary or payment based on panel size and performance on quality and patient satisfaction, they note that, for physicians in independent practices, payment based on the services they provide, coupled with a bonus or higher fee levels based on individual and organizational performance, can have desirable effects.

**Recommendation 8. Innovative Payment Methods and Organizational Models**

CMS should be prepared to apply different payment models that are suitable for different configurations of ACOs in different geographic areas and different circumstances, as appropriate. These payment approaches could include primary care medical home fees or bundled acute case rates, along with shared savings, or risk-adjusted global fees with risk mitigation (e.g., stop-loss or reinsurance). All approaches should make payments contingent on reaching quality benchmarks.

**Balanced Physician Compensation Incentives**

While the ACO as an organization will share in savings generated by improved care and more efficient operation, the lessons of the managed care experience of the 1990s suggest that applying those incentives to individual physicians or small groups of physicians could expose them to financial instability and pressure to under-provide services.

In addition to aligning incentives for providers with the objectives of the organization and the health system, it is important that ACOs avoid entering into arrangements in which individual physicians have strong incentives to skimp on care or avoid sicker patients.

Collective rewards should be used to foster collective accountability for performance and be explainable to individual patients as minimizing the conflict a physician will have in making clinical decisions relating to the care of individual patients. Furthermore, requiring that the ACO meet performance standards based on quality before it is eligible for rewards based on cost also lessens the risk of skimping on necessary care for patients. Tying shared-savings payments to performance on quality improvement metrics, which was an important feature of the PGP demonstration, could strengthen the connection between the incentives to improve quality and reduce costs. In any case, the quality standards applied to ACOs must be based on or strongly related to better clinical outcomes and must be meaningful to patients in terms of both their outcomes and experiences with care.

**Recommendation 9. Balanced Physician Compensation Incentives**

For ACOs receiving payment for direct care as well as shared savings, compensation of clinicians within the ACO should include incentives to deliver evidence-based care but ensure that appropriate care is not withheld.

**Timely Monitoring, Data Feedback, and Technical Support for Improvement**

While the Affordable Care Act sets out requirements for organizations to qualify as ACOs, it is largely silent on what ACOs should or could do to achieve the goals of improved patient care, health outcomes, and greater efficiency. It does refer to the use of “a set of processes to promote evidence-based medicine and patient engagement, to report on quality and cost measures, and to coordinate care, such as through the use of telehealth, remote patient monitoring and other enabling technologies; the use of patient and caregiver assessments or individualized care plans among other tools, to make and document patient-centeredness as a focus; and the obligation to submit data to the Secretary of HHS on quality measures and other reporting measures . . . to assess the quality of care provided . . . as well as transitions across health care settings.”

CMS (and other payers) could enhance the success of ACOs by providing rapid and comparative performance feedback. This feedback could include monthly reports on utilization and expenditures of patient panels, as well as comparative data from Medicare, Medicaid, and private insurers on provider-reported quality performance. HHS and the Office of the National Coordinator for Health Information Technology (ONC) could also provide technical assistance on implementation of electronic information systems and exchanges. In fact, HHS and ONC currently have many technical assistance initiatives that CMS could build upon for ACO purposes.

In addition to helping ACOs operate more effectively and efficiently, timely monitoring could help enhance the evidence base on best clinical practice and effective organization. Despite enormous investments in scientific evidence and impressive results, the evidence base that can be applied to clinical practice to improve effective and efficient care is quite thin. ACOs could help in extending that evidence base, and the patients attributed to them need to play an important role. The central goal of a health care system is to help the population live longer, healthier, more productive lives. To gain better evidence about the effects of treatments on various subgroups of patients, it will be important to combine information obtained directly from patients with clinical data. And it will be important to develop the capability of analyzing these combined clinical databases to extract the evidence.

Further, CMS and the Quality Improvement Organizations with which it has a relationship could create toolkits of effective interventions and best practices that health care organizations have found effective in improving quality and lowering cost. At a minimum, this should include those strategies and best practices employed by successful participants in earlier demonstrations, such as tools to facilitate and/or use the following:

- Shared decision-making;
- Electronic decision-support systems including disease registries, reminders, and prompts;
- Electronic health information exchange;
- After-hours services;
- Telemonitoring and other remote monitoring systems;
- Care coordinators, individualized care plans, and ways of managing transitions from inpatient to ambulatory or long-term care;
- Patient and caregiver assessments;
- Advance directives;
- Predictive hospital readmission risk modeling and tailored interventions; and
- Management of extremely complex patients, including home visits.

Although financial incentives are very powerful, they are not enough by themselves to ensure the success of ACOs and should be supplemented by technical assistance to achieve the program's aims.

In past demonstrations, CMS has taken a hands-off approach to implementation, for fear of contaminating the evaluation of the initiative. The ACO program, however, is not a research project. It is a permanent part of the Medicare program, and all stakeholders should work together to support its success. CMS should take an active role in assisting ACOs to develop and implement effective strategies and best practices.

**Recommendation 10. Timely Monitoring, Data Feedback, and Technical Support for Improvement**

- 10a. CMS should provide baseline data as well as early and regular reports on total Medicare payments, utilization and quality measures for the ACO patient population, and other data required to help ACOs be successful in achieving the aims of better health, better care, and lower costs; other payers should do the same. Trends should be tracked over time to assess the impact of alternative payment models for different configurations of ACOs and to disseminate learning about the most effective strategies.
- 10b. CMS should work with other payers to develop robust information exchanges and standardized reports that can provide ACOs with timely feedback on comparative results, support rapid-cycle improvements in quality and cost performance, and develop new knowledge on effective and efficient clinical practices.
- 10c. The Department of Health and Human Services, through its Office of the National Coordinator for Health Information Technology, should provide technical assistance on implementation of electronic information systems and exchanges to facilitate transfer of critical clinical information.
- 10d. CMS should create toolkits of interventions and practices that health care organizations have found effective in improving quality and lowering costs. All payers should collaborate to provide technical assistance to organizations to help them identify and adopt effective and efficient practices and to spread successful innovations in payment methods and organizational models.
- 10e. Every effort should be made by public and private payers, as well as providers, to ensure transparency of information and to minimize administrative complexity.

**CONCLUSION**

The U.S. health care delivery system should be accountable for three things: delivering high-quality, effective, and safe care that contributes to the best possible population health outcomes; configuring itself for the benefit of patients and providing excellent patient experiences with care; and using resources as efficiently as possible. By adopting those as core values and achieving increasingly stringent goals in each area, it should be possible in the future to ensure that all Americans—including the growing population of patients with one or more chronic conditions—have access to affordable health care for

the prevention of illness, the restoration of health for those with acute conditions, and the maintenance of health and productivity.

To accomplish this, health care delivery in the United States will require new organizational structures. While those structures will vary depending on the local conditions, existing health care delivery elements, and population characteristics, each must be designed to be accountable for its performance. Since each organization will need to encompass many existing stakeholders, and since each needs to be responsive first to the needs of individuals and the public as a whole, the governance of the organizations will need to be inclusive and participatory and develop strategies that benefit both the population served and the participating stakeholders. These organizations will need not only a structural skeleton but the equivalent of a nervous system that enables each part of the organization to receive and share information in such a way that meets the needs of all participants. The organization will need to provide or arrange to provide other systems with capable technical support for diverse activities such as well-coordinated, patient-centered care (e.g., care coordinators), comprehensive preventive services (e.g., community and patient outreach), and enhancement of operational efficiency (e.g., Lean methods).

The ACO model shows significant promise in helping to transform the U.S. health system to achieve these aims. But much work needs to be done to establish ACOs, make sure they are able to achieve the goals of the program, and spread the model so that all Americans are able to access this type of care. It will require development of trust among all the parties, and willingness to test multiple approaches, measure results, and adapt rapidly to improve performance. Government leadership and flexibility are essential, as are activated and engaged clinicians and patients who embrace accountability for better care and health outcomes. If all this occurs, accountable care organizations can play an instrumental role in achieving a high performance U.S. health system over the coming decade.

## NOTES

<sup>1</sup> Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), enacted March 23, 2010, <http://docs.house.gov/energycommerce/ppacacon.pdf>.

<sup>2</sup> See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, Proposed Rule, [http://www.ofr.gov/OFRUpload/OFRData/2011-07880\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2011-07880_PI.pdf).

<sup>3</sup> A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008); and K. Grumbach, T. Bodenheimer, and P. Grundy, *The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies* (Washington, D.C.: Patient-Centered Primary Care Collaborative, Aug. 2009), <http://familymedicine.medschool.ucsf.edu/cepc/pdf/outcomes%20of%20pcmh%20for%20White%20House%20Aug%202009.pdf>.

<sup>4</sup> Ibid.

<sup>5</sup> D. M. Berwick, T. W. Nolan, and J. Whittington, “The Triple Aim: Care, Health, and Cost,” *Health Affairs*, May 2008 27(3):759–69.

<sup>6</sup> Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

<sup>7</sup> K. Davis, S. Guterman, S. R. Collins, K. Stremikis, S. Rustgi, and R. Nuzum, *Starting on the Path to a High Performance Health System: Analysis of Health System Reform Provisions of Reform Bills in the House of Representatives and Senate* (New York: The Commonwealth Fund, Sept. 2010).

<sup>8</sup> For a more detailed discussion of a framework for moving from fee-for-service to increasingly bundled payments, see S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih, “Using Medicare Payment Policy to Transform the Health System: A Framework for Improving Performance,” *Health Affairs* Web Exclusive, Jan. 27, 2009, w238–w250.

<sup>9</sup> Shih, Davis, Schoenbaum et al., *Organizing the U.S. Health Care Delivery System*, 2008.

<sup>10</sup> Commission on a High Performance Health System, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007); and Commission, *Path to a High Performance U.S. Health System*, 2009.

<sup>11</sup> Congressional Budget Office, Letter to the Honorable Harry Reid, Dec. 19, 2009, [http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid\\_Letter\\_Managers\\_Correction\\_Noted.pdf](http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers_Correction_Noted.pdf).

<sup>12</sup> For more information on alternative models for ACOs, see B. D. Steiner, A. C. Denham, E. Ashkin et al., “Community Care of North Carolina: Improving Care Through Community Health Networks,” *Annals of Family Medicine*, Sept.–Oct. 2008 6(4):361–67; D. R. Rittenhouse and S. M. Shortell, “The Patient-Centered Medical Home: Will It Stand the Test of Health Reform?” *Journal of the American Medical Association*, June 2009 301(19):2038–40; G. D. Steele, “Reforming the Health Care Delivery System,” Testimony, Committee on Finance, U.S. Senate, April 21, 2009, <http://www.geisinger.org/about/healthier/62520-1%20SenateFinance%20Tstmnl->

[ReaderSprds.pdf](#); and K. Davis, “Coherent and Transparent Health Care Payment: Sending the Right Signals in the Marketplace,” The Commonwealth Fund Blog, Aug. 2, 2010.

<sup>13</sup> R. J. Reid, K. Coleman, E. A. Johnson et al., “The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers,” *Health Affairs*, May 2010 29(5):835–43.

<sup>14</sup> Evaluating Blue Cross Blue Shield of Michigan’s Physician Group Incentive Program, The Commonwealth Fund Grant to the University of Michigan, Principal Investigator Christy Lemak, Ph.D., May 1, 2010–Oct. 31, 2012, <http://www.commonwealthfund.org/Content/Grants/2010/April/Evaluating-Blue-Cross-Blue-Shield-of-Michigans-Physician-Group-Incentive-Program.aspx>.

<sup>15</sup> Mercer, *Executive Summary of Community Care of North Carolina Evaluation* (New York: Mercer, 2008), <http://www.communitycarenc.com/PDFDocs/Mercer%20ABD%20Report%20SFY08.pdf>.

<sup>16</sup> S. Wilhide and T. Henderson, *Community Care of North Carolina: A Provider-Led Strategy for Delivering Cost-Effective Primary Care to Medicaid Beneficiaries* (Washington, D.C.: American Academy of Family Physicians, June 2006), [http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/policy/state/medicaid/ncfull.Par.0001.File.tmp/ncfullreport.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/state/medicaid/ncfull.Par.0001.File.tmp/ncfullreport.pdf).

<sup>17</sup> Community Care of North Carolina (CCNC) has created 14 modules to help states adopt or adapt the CCNC model or its components. The modules are forthcoming and will be available on the CCNC Web site, <http://www.communitycarenc.com/>.

<sup>18</sup> W. Holt, *The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care* (New York: The Commonwealth Fund, March 2010).

<sup>19</sup> A. S. O’Malley, A. Tynan, G. R. Cohen et al., *Coordination of Care by Primary Care Practices: Strategies, Lessons and Implications* (Washington, D.C.: Center for Studying Health System Change, April 2009), <http://www.hschange.org/CONTENT/1058/>.

<sup>20</sup> K. Grumbach, T. Bodenheimer, and P. Grundy, *The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies* (Washington, D.C.: Patient-Centered Primary Care Collaborative, Aug. 2009).

<sup>21</sup> R. J. Gilfillan, J. Tomcavage, M. B. Rosenthal et al., “Value and the Medical Home: Effects of Transformed Primary Care,” *American Journal of Managed Care*, Aug. 2010 16(8):607–14.

<sup>22</sup> D. A. Dorr, A. B. Wilcox, C. P. Brunner et al. “The Effect of Technology-Supported, Multidisease Care Management on the Mortality and Hospitalization of Seniors,” *Journal of the American Geriatrics Society*, Dec. 2009 56(12):2195–202; and D. A. Dorr, “Advanced Models of Primary Care: Care Management Plus Pilot and Dissemination,” Presentation at the White House Roundtable on Advanced Medical Home Models of Primary Care, Aug. 10, 2009, [http://caremanagementplus.org/documents/2009/8.WHRT\\_2009\\_AdvancedModelsPC.pdf](http://caremanagementplus.org/documents/2009/8.WHRT_2009_AdvancedModelsPC.pdf).

<sup>23</sup> Bundled payment also has been proposed for high-cost medical conditions or chronic conditions; in those applications, the bundle of services and corresponding payment amount would be somewhat more complicated to specify, and it would be more difficult to develop methods applicable to patients with multiple conditions.

<sup>24</sup> D. McCarthy, K. Mueller, and I. Tillmann, *HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda* (New York: The Commonwealth Fund, June 2009).

<sup>25</sup> Evaluating the Global Payment Model Developed by Blue Cross Blue Shield of Massachusetts, The Commonwealth Fund Grant to Harvard University, Principal Investigator Michael Chernew, Ph.D., Aug. 1, 2009–July 31, 2011, <http://www.commonwealthfund.org/Content/Grants/2009/Aug/Evaluating-the-Global-Payment-Model-Developed-by-Blue-Cross-Blue-Shield-of-MA.aspx>.

<sup>26</sup> F. de Brantes and A. Rastogi, *Evidence-Informed Case Rates: Paying for Safer, More Reliable Care* (New York: The Commonwealth Fund, June 2008).

<sup>27</sup> One important feature of the PGP demonstration was that a large portion of the distribution of shared savings (50 percent in the third, fourth, and fifth years) to each participating practice was determined by the extent to which it met a set of quality improvement metrics.

<sup>28</sup> S. Klein, “Building Accountable Care Organizations That Improve Quality and Lower Costs—A View from the Field,” *Quality Matters* (New York: The Commonwealth Fund, June 2010); and Centers for Medicare and Medicaid Services, “Medicare Physician Group Practice Demonstration: Physician Groups Continue to Improve Quality and Generate Savings Under Medicare Physician Pay-for-Performance Demonstration,” Dec. 2010, [http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP\\_Fact\\_Sheet.pdf](http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf).

<sup>29</sup> D. McCarthy and K. Mueller, *Organizing for Higher Performance: Case Studies of Organized Delivery Systems—Series Overview, Findings, and Methods* (New York: The Commonwealth Fund, July 2009).

<sup>30</sup> For example, Premier, Inc., a private membership group of health care facilities, has launched two collaboratives. One is designed help hospitals get ready for developing ACOs. The other is designed to help hospitals that are ready to implement ACOs. See <http://www.premierinc.com/about/news/10-may/aco052010.jsp>.

<sup>31</sup> Centers for Medicare and Medicaid Services Office of Legislation, *Medicare “Accountable Care Organizations” Shared Savings Program—New Section 1899 of Title XVIII, Preliminary Questions & Answers*, <http://www4.cms.gov/officeoflegislation/downloads/accountablecareorganization.pdf>.

<sup>32</sup> B. Starfield, L. Shi, and J. Macinko, “Contribution of Primary Care to Health Systems and Health,” *Milbank Quarterly*, 2005 83(3):457–502; and J. Macinko, B. Starfield, and L. Shi, “Quantifying the Health Benefits of Primary Care, in the United States,” *International Journal of Health Services*, 2007 37(1):111–26.

<sup>33</sup> C. Schoen, R. Osborn, M. M. Doty, M. Bishop, J. Peugh, and N. Murukutla, “Toward Higher-Performance Health Systems: Adults’ Health Care Experiences in Seven Countries, 2007,” *Health Affairs* Web Exclusive, Oct. 31, 2007, w717–w734.

<sup>34</sup> C. R. Jaén, R. L. Ferrer, W. L. Miller et al., “Patient Outcomes at 26 Months in the Patient-Centered Medical Home National Demonstration Project,” *Annals of Family Medicine*, 2010 8(Suppl. 1):S57–S67.

<sup>35</sup> D. R. Rittenhouse, S. M. Shortell, and E. S. Fisher, “Primary Care and Accountable Care—Two Essential Elements of Delivery-System Reform,” *New England Journal of Medicine*, Dec. 10, 2009 361(24):2301–3.

<sup>36</sup> Ibid.

<sup>37</sup> See A. Robinow, *The Potential of Global Payment: Insights from the Field* (New York: The Commonwealth Fund, Feb. 2010).

<sup>38</sup> R. E. Gliklich and N. A. Dreyer (eds.), *Registries for Evaluating Patient Outcomes: A User's Guide*, 2nd ed. (prepared by Outcome DEcIDE Center [Outcome Sciences, Inc. d/b/a Outcome] under Contract No. HHSA290200500351 TO3). AHRQ Publication No.10-EHC049 (Rockville, Md.: Agency for Healthcare Research and Quality, Sept. 2010).

<sup>39</sup> K. Davis, S. C. Schoenbaum, and M. M. Doty, "Factors Affecting Adherence to Physician Advice," unpublished manuscript based on analysis of The Commonwealth Fund's 2001 Health Care Quality Survey.

<sup>40</sup> This review could be in accordance with the draft principles developed by the National Alliance for Physician Competence and included in *Good Medical Practice—USA*, version 1.1, March 9, 2009, <http://gmpusa.org/Docs/GoodMedicalPractice-USA-V1-1.pdf>.

<sup>41</sup> E. S. Fisher, M. B. McClellan, and J. Bertko, "Fostering Accountable Health Care: Moving Forward In Medicare," *Health Affairs*, March/April 2009 28(2): w219–31.

<sup>42</sup> Medicare Payment Advisory Commission, *Report to the Congress: Improving Incentives in the Medicare Program* (Washington, D.C.: MedPAC, June 2009).

<sup>43</sup> M. B. McClellan and E. S. Fisher (eds.), *Accountable Care Learning Network Toolkit* (Washington, D.C.: Brookings Institution, Jan. 2011), <https://xteam.brookings.edu/bdacoln/Documents/ACO Toolkit January 2011.pdf>.

<sup>44</sup> Medicare Payment Advisory Commission, "Accountable Care Organizations" in *Report to the Congress: Improving Incentives in the Medicare Program* (Washington, D.C.: MedPAC, June 2009).

<sup>45</sup> S. Guterman, K. Davis, K. Stremikis, and H. Drake, "Innovation in Medicare and Medicaid Will Be Central to Health Reform's Success," *Health Affairs*, June 2010 29(6):1188–93.

<sup>46</sup> S. M. Shortell, L. P. Casalino, and E. S. Fisher, *Implementing Accountable Care Organizations* (Berkeley, Calif.: Berkeley Center on Health, Economic, and Family Security, 2010); and S. M. Shortell, L. P. Casalino, and E. S. Fisher, "How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations," *Health Affairs*, July 2010 29(7):1293–98.

<sup>47</sup> M. B. McClellan, A. N. McKethan, J. L. Lewis et al., "A National Strategy to Put Accountable Care into Practice," *Health Affairs*, May 2010 29(5):982–90; and M. B. McClellan and E. S. Fisher (eds.), *Accountable Care Learning Network Toolkit* (Washington, D.C.: Brookings Institution, Jan. 2011), <https://xteam.brookings.edu/bdacoln/Documents/ACO Toolkit January 2011.pdf>.

<sup>48</sup> Robinow, *Potential of Global Payment*, 2010.