



Accountable Care Organizations: Can They Rein In Health Care Spending for States?

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In a traditional fee-for-service (FFS) health care system, health insurance carriers compensate physicians and hospitals for the volume of care provided rather than the quality of care provided. At the center of the current health care reform debate is the conundrum of how to lower health care costs while enhancing the quality of, and improving access to, care. One potential solution is the Accountable Care Organization (ACOs) model.

Unlike other systems of care—such as the Patient-Centered Medical Home (PCMH)—a list of specific elements cannot qualify a health care delivery system as a certified ACO. Because the number of established ACOs is limited and the details leading to successful ACOs vary, accountable care is based on the general concept of requiring the health system to reward quality of care over quantity of care. Provided in this work are conflicting theories and definitions of the ideal ACO, as well as details of existing accountable care programs and government and private efforts to establish new ACOs. Policymakers and health care officials currently are working to establish ACO pilot projects in a variety of geographic locations to determine which variables best contribute to a decrease in costs and improvements in quality within a sustainable payment structure.

Definitions / Background on ACOs

An ACO is a local entity and a related set of providers, which can include primary care physicians, specialists, and hospitals, that are held accountable for the cost and quality of care delivered to a defined subset of traditional Medicare program beneficiaries or other defined populations, such as commercial health plan subscribers.¹

Related Terms

This work explicitly uses the term “ACO;” however, other terminology denote similar concepts: ⁱⁱ

- “Accountable Care Systems” can consist of several ACOs. ⁱⁱⁱ
- An “Accountable Care Network” is a stage for small hospitals and physician practices transitioning to become an ACO. ^{iv}
- A “Bonus-Eligible Organization” (BEO) is a concept “similar to the accountable care organization models,” defined by the Congressional Budget Office (CBO) as “a group of providers...that work together to manage and coordinate care for patients. BEOs could consist of physicians practicing in groups, networks of discrete physician practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, integrated delivery systems, or community based coalitions of providers.” ^v
- An “Organized System of Care,” a concept of the Blue Cross Blue Shield of Michigan’s Physician Group Incentive Program, is a provider-led, population-based, coordinated care process that achieves benchmark performance for quality, cost and patient experience with care. ^{vi}
- “Accountable Care Entity” is an ACO-equivalent term used by the Centers for Medicare and Medicaid Services (CMS). ^{vii}
- “Accountable Health Community” is a term used by the Oregon Health Fund Board, expanding the ACO concept to foster shared accountability for quality and cost among all providers serving a defined population across the continuum of care. Focusing on the community includes broader measures of community and public health. ^{viii} Minnesota is currently considering the implementation of a similar concept, referred to as “Accountable Care Communities.” ^{ix}

Variations in ACO Makeup

Due to the limited amount of analysis completed concerning the makeup of existing ACOs, researchers disagree over the framework needed for an ACO to be successful. Prominent theories include:

- In their [2007 report](#) for the Robert Wood Johnson Foundation^x and [2008 article](#) in the *Journal of the American Medical Association*,^{xi} Stephen M. Shortell, PhD, MPH and Lawrence P. Casalino, MD, PhD propose five different ACO models: a Multi-specialty Group Practice, a Hospital Medical Staff Organization, a Physician-Hospital Organization, an Interdependent Practice Organization, and a Health Plan-Provider Organization or Network.
- In a [2006 article](#)^{xii} and [2009 article](#)^{xiii} in *Health Affairs*, Elliot S. Fisher, MD, MPH and his colleagues suggest that an ACO can consist of all physicians in a geographic area who admit patients to a particular hospital.
- The Medicare Payment Advisory Commission (MedPAC)—an independent congressional agency established in 1997 to advise the U.S. Congress on issues affecting the Medicare

program—claims that an ACO should consist of primary care physicians, specialists, and at least one hospital, or can develop from an integrated delivery system, a physician-hospital organization or an academic medical center. For further details on MedPAC’s interpretation of the ideal ACO model, refer to its [2009 report](#)^{xiv} to Congress on improving incentives within Medicare.

- In 2008, the CBO released [Budget Options, Volume I: Health Care](#),^{xv} which explains that “physicians practicing in groups, networks of discrete physician practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, integrated delivery systems, or community-based coalitions of providers” can make up a BEO (the equivalent of an ACO).
- According to Harold D. Miller’s [2009 report](#)^{xvi} for the Center for Healthcare Quality and Payment Reform, “there is very little evidence to prove that any particular type of provider or organizational structure cannot successfully manage total costs and quality for a defined population.” Miller contends that an ACO “is not a structure, or even a process, but an outcome – reducing or controlling the costs of health care for a population of individuals while maintaining, or preferably improving, the quality of that care.”

For Miller, primary care is the core of an ACO, and in order to provide comprehensive, efficient care, primary care providers must have good working relationships with specialists and hospitals, but these providers do not necessarily have to be part of the ACO. Including hospitals in an organization is advantageous as their extensive administrative resources can add to the available tools used in measuring quality. However, because most primary care providers work with or are affiliated with a local hospital, inclusion in the ACO is not essential. Similarly, specialists can enhance primary care by helping to avoid gaps in care and providing expertise needed to care for patients, particularly those with multiple chronic conditions, but primary care providers within an ACO could continue to coordinate care with specialists outside the organization.

Who Is Accountable?

In theory, everyone involved within an ACO should be accountable for some role in delivery of care. In order to remain competitive, insurers should be accountable for controlling overall costs and quality. State governments or regional public-private authorities could also play a role—being accountable for establishing budgets, overseeing payments, and monitoring performance across all providers.^{xvii} An ACO also encourages individuals to become more accountable by providing incentives to choose the providers with the “highest value added;” for example, no co-insurance or deductibles for selecting providers in the top tier of cost and quality performance.^{xviii} Physicians ought to be accountable for providing quality care and minimizing costs, but this does not mean that providers assume insurance risk. ACO costs should be risk/severity adjusted, which is explained in further detail below.^{xix} The organization also is accountable, providing financial rewards for good performance based on comprehensive quality and spending measurement and monitoring.^{xx}

Emphasis on Primary Care

Most researchers agree that an ACO needs a strong foundation of primary care providers to be sustainable. To lower costs and improve quality of care, the providers within an ACO must establish a particular culture that emphasizes a complementary rather than competitive delivery of care, requiring clear communication and effective coordination. This culture must include inclusiveness of care with a focus on the health of the community, not just the individuals that make it up. Risk adjustments compensate for disproportional distributions of individuals with chronic conditions to avoid “cherry-picking” only healthy patients; ACOs can also provide financial disincentives for dropping difficult patients.

Because ACOs require physician accountability for the overall health of a patient, considering both short-term and long-term needs, healthy patient-doctor relationships are also vital. To prevent defensive medical care, providers receive financial incentives to reduce unnecessary tests and hospital admissions.^{xxi} If primary care capacity continues to decline, some worry this could ultimately limit the successful development of ACOs, although the rise in medical homes potentially could lead to increased consideration of adopting an accountable care model.^{xxii}

Measuring Cost and Quality

Because ACOs base financial incentives on a provider’s ability to improve cost and quality of care, measuring these factors is essential. Actual savings, not random fluctuations in spending or a lack of high-cost patients, should account for lowered costs. To track progress and reward accordingly, analysis of a provider’s performance must be timely. Benchmarks measure performances, comparing results from previous years to determine if ACOs are cutting costs and enhancing quality of care. Most research considers a two percent reduction in overall costs from the previous benchmark period to be a reasonable goal.^{xxiii} Implementing health information technology (HIT) can assist providers in easily facilitating the production of reliable data.^{xxiv}

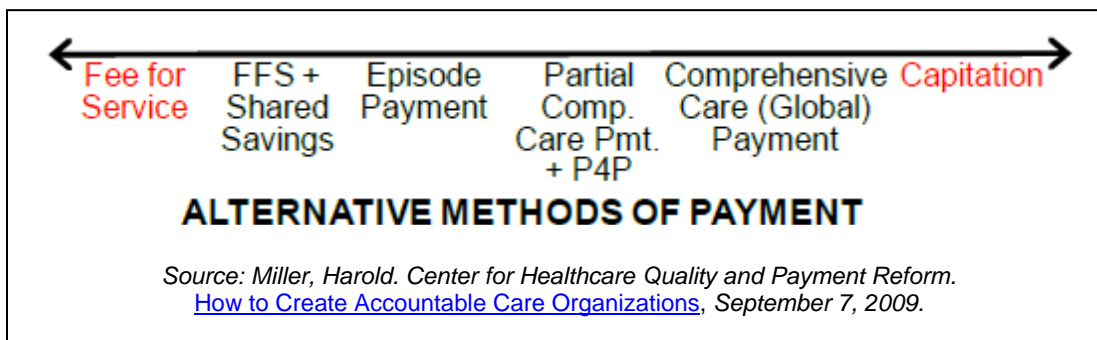
Some researchers contend that an ACO must have at least 5,000 enrollees in order to be sustainable and that small practices would have difficulty forming an ACO without joining with other physician groups. However, others claim that another option is establishing a “virtual ACO,” which would allow physicians working in close proximity and serving the same patients to become an ACO without merging practices.^{xxv}

Payment System Possibilities^{xxvi}

Because FFS payment systems require little accountability concerning the costs and quality of care provided, some degree of payment reform must accompany the creation of an ACO.

- FFS with bonuses or shared savings would most likely entice providers to form an ACO with minimal burden of transitioning. Although FFS alone pays more for more care, which is the opposite of what ACOs try to accomplish, adding bonuses for providing efficient and quality care requires providers to be accountable for the type of care provided and would remove incentives from providing unnecessary care. Penalties for spending over established targets based on predicted costs could fund bonuses.^{xxvii}

- Episode-based payment or bundling refers to paying a single amount to cover all of the services provided to an individual patient during a single episode of care, rather than making either a single payment for all care during a year or separate payments for each individual service. This gives providers an incentive to coordinate activities, eliminate unnecessary services and avoid complications.
- Partial comprehensive payment allows an ACO to receive a single payment to cover all of the costs associated with ambulatory care services but not for inpatient services. ACOs have a significant withhold/bonus payment based on the costs of inpatient care services associated with those patients similar to shared savings payment systems, but partial comprehension provides more flexibility to ACOs about how to deliver care.
- Global payment pays a single price for all of the health care services needed by the people cared for by the ACO for a fixed period of time, with the amount of the payment adjusted based on the types and severity of the conditions those patients have and on the quality of care delivered. “Comprehensive Care Payment,” “Condition-Adjusted Capitation,” and “Risk-Adjusted Global Fees” also refer to this form of payment.
- Capitation transfers all risk to providers and penalizes those who take on sicker patients. Under this non-risk-adjusted payment system, payers give health care providers a fixed amount of money for every patient, regardless of how healthy or sick each patient is.



Voluntary or Mandatory? ^{xxviii}

Within the Medicare program, there are pros and cons for both voluntary and mandatory participation, which are summarized in the chart below. According to a 2009 MedPAC [report](#), in a voluntary, bonus-only ACO model, ACOs receive bonuses for meeting cost and quality targets. With constrained FFS rates, Medicare could fund bonuses at a sufficient level to change provider behavior without increasing overall spending due to random variation. Under a mandatory, bonus-and-withhold model, shared savings and penalizing providers who fail to meet cost and quality targets could fund bonuses.

A comparison of two types of accountable care organizations

	Voluntary	Mandatory
Organization characteristics	Physicians and hospitals choose to form ACO and be held jointly responsible for the quality of care and the level of spending on their Medicare patients.	All physicians and hospitals are assigned to virtual ACOs and held jointly responsible for the quality of care and the level of spending on their Medicare patients.
	Model is dependent on physicians and hospitals agreeing to form PHOs.	Physicians and hospitals are assigned to virtual ACOs.
	Model requires waiting for PHOs to form.	Implementation could encourage PHOs to form.
	Physicians and hospitals agree on how to share revenues, or the government mandates a bonus structure.	Medicare administers a system of withholds and bonuses.
	ACOs have capability to make joint decisions. Unorganized providers would remain outside the system.	Some ACOs have structures that allow joint decision making. Unorganized providers face financial incentives to develop structures for joint decision making.
Incentives	Only those that expect to gain from bonuses would be likely to join.	Everyone is subject to withholds and bonuses.
	Bonuses are given to top performers, while poor performers face no penalties (or they will not join).	Bonuses are given to top performers and penalties are applied to performers with low quality and high costs.
	Difficult patients could be dropped or transferred to non-ACO providers.	ACOs could drop patients, but another ACO would continue to be responsible for cost and quality.
Implications	Providers face no risk.	Providers face some risk.
	Medicare continues to depend on restraining FFS payment rates to make the system sustainable.	ACO incentives provide Medicare a strong lever—possibly instead of restraining FFS rates—to induce sustainability.
	ACO bonuses would be funded with shared savings and by restraining FFS rates. This would result in relatively lower FFS rates than under a mandatory system given any set level of Medicare spending.	ACO bonuses would be funded by shared savings and penalties for providers with poor quality and high costs.
	There could be an increase in the ACOs' market power engendering antitrust issues.	There could be an increase in the ACOs' market power engendering antitrust issues.

Note: ACO (accountable care organization), PHO (physician-hospital organization), FFS (fee-for-service).

Source: Medicare Payment Advisory Commission. [Report to the Congress: Improving Incentives in the Medicare Program](#), June 15, 2009.

In its Medicare reform principles, the American Medical Association suggests that ACOs should be strictly voluntary for physicians.^{xxix}

Differentiating Between ACOs and Other Systems of Care

Patient-Centered Medical Home

ACOs and medical homes are based on different qualifications but should not be seen as mutually exclusive. For instance, the WellMed Medical Group in Texas is both a PCMH and an ACO (further details provided below). Both delivery systems emphasize the importance of primary care providers

leading the coordination of care, providing whole-person oriented care, and working to improve the quality of care provided. However, most medical homes do not necessarily require that the primary care practice accept accountability for the total costs of care for patients or for the population-level quality outcomes.^{xxx} Some contend that medical homes should be thought of as a critical component of a successful ACOs.

Managed Care

In the 1990s, many policymakers promoted managed care as a means to controlling health care costs. This model of care received criticism from consumers and providers because many health insurance plans held providers accountable for all risk, including “insurance risk” (e.g., whether an individual gets ill) rather than just the “performance risk” (e.g., the ability to successfully treat the illness in a cost-effective way).^{xxxii} Such restrictions lead to providers avoiding treating patients with multiple or expensive-to-treat conditions. Within accountable care, providers are only required to be accountable for the quality of care provided—not the level of care needed. An ACO can choose—but should never be required—to accept insurance risk.

Examples of Existing ACOs

[Medicare Physician Group Practice Demonstration](#) (10 participating locations across 10 states)^{xxxii}

BACKGROUND

- Initiated by CMS in April 2005 as result of the Medicare, Medicaid, and State Children’s Health Insurance Program Benefits Improvement and Protection Act of 2000
- 10 large Physician Group Practices (PGPs) participating (ranging from 232 to 1,291 affiliated physicians, each serving at least 5,000 patients)
- Participants include two freestanding physician group practices; two faculty group practices within academic medical centers; five belong to an integrated delivery system (that includes at least one hospital); and one physician network sponsored by a hospital and comprised of 60 small and individual physician practices
- No enrollment; beneficiaries retroactively assigned to the PGP site used most often over one year
- Enhanced quality through a variety of care management programs and information technology including electronic health records (EHR), patient disease registries, and patient monitoring systems
- Locations: Billings Clinic, MT; Dartmouth-Hitchcock Clinic, NH; The Everett Clinic, WA; Geisinger Health System, PA; Middlesex Health System, CT; Marshfield Clinic, WI; Forsyth Medical Group, NC; Park Nicollet Health Services, MN; St. John’s Health System, MO; and University of Michigan Faculty Group Practice, MI

PAYMENT STRUCTURE

- Medicare FFS system, traditional service coverage, co-pay and deductible structures, freedom of provider choice maintained
- Up to 80 percent of the savings generated is shared with the PGPs; Medicare Trust Funds retain at least 20 percent

MEASUREMENT OF COST & QUALITY

- Base year (BY), 2004, used as benchmark to measure quality improvements in performance year one (PY1)
- Target expenditures based on Comparison Groups (CGs), drawn from each PGP's geographic service area
- Quality improvements measurements in PY1 based on 10 factors, PY2 based on 27, and PY3 based on 32

RESULTS

- Despite differences in organizational structures, the PGPs attained similar levels of quality performance measures; between BY and PY2, the PGPs increased quality scores an average of 9 percentage points on the diabetes mellitus measure, 11 percentage points on heart failure measures, and 5 percentage points on coronary artery disease measures
- PGPs improved claims-based quality process indicators more than their CGs
- Combined PY1 and PY2 savings totaled nearly \$27 million; performance payments for four PGPs surpassed \$21 million; 2 PGPs lost a total of \$3.5 million, leaving total savings for the Medicare Trust funds as "minimal"
- The 6 PGPs not earning performance payments in PY2 had higher than the local average expenditures prior to the demonstration; their performance improved during the demonstration but not sufficiently to share in savings
- Analyses could not determine the extent to which savings were influenced by pre-existing expenditure trends or resulted from Demonstration's financial incentives
- Although not an expected outcome, the Demonstration improved patients' access to care

[The Mayo Clinic](#) (Arizona, Florida, Minnesota)^{xxxiii}

- World's first and largest integrated multi-specialty group medical practice
- Salaried staff access shared system resources, reducing competition among departments
- Staff of almost 55,000 serves 520,000 annually in four owned hospitals and outpatient facilities
- Emphasizes teamwork to coordinate care in a timely manner and to build quality patient-provider relationships
- Valued professional allied health staff build long-term careers at the Mayo Clinic
- Physician-led committees promote broad participation and development of workforce
- Improves access by allowing same-day or next day appointments at several primary care clinics and scheduling system uses algorithms to assign new patients to physicians and orchestrate patients' visits
- Expanded chronic care management by using telephonic outreach to patients not making regular visits, requiring pre-visit planning to identify patient needs and schedule laboratory testing, and providing patient education and follow-up to promote treatment adherence between visits
- Integration of HIT includes:
 - EHR terminals in every office, work room and exam room inform primary care physicians of visits with specialists and emergency care visits
 - Electronic charts share information with patients at point of care and used in virtual consultations with physicians

- Free web services available onsite to patients to help them communicate with family and friends
- Medicare spending per person is similar to national average but patients have fewer hospital days and physician visits

[Geisinger Health System](#) (Pennsylvania)^{xxxiv}

- Participates in the Medicare Physician Group Practice Demonstration
- Serves population of 2.6 million, primarily treating older patients, many of whom have multiple chronic diseases
- Employs 800 physicians at more than 50 clinical practice sites, 38 of which are primary care sites in local communities
- Provides bundle payments for acute care procedures, enhanced support for primary care physicians and their care teams and improved chronic disease management and transitions of care
- Utilizes EHR as key to improving quality, including:
 - Via an online portal, patients can access portions of the EHR, view lab results, schedule appointments, correspond with their physician, and renew medications
 - Operational registries provide reminders to physicians, including referrals, lab tests, and patient emails
 - Registries focused on ensuring chronic disease return visits, tracking pneumococcal vaccinations, and managing diabetes
- Admission rates decreased by 25 percent; readmission rates reduced 50 percent

[Kaiser Permanente](#) (California, Colorado, Georgia, Hawaii, Mid-Atlantic, Ohio & Northwest)^{xxxv}

- Largest nonprofit integrated health care delivery system in the U.S.
- Organizes, finances and delivers medical care in a “closed” group-model care system (members generally obtain care from only Permanente physicians)
- Owns and operates 35 medical centers—hospitals with multi-specialty outpatient and ancillary services—and 431 medical office buildings
- Nearly 167,000 employees and 14,600 physicians
- Multi-specialty groups of physicians accept a fixed payment (capitation) to provide clinical care, quality improvement, and resource management
- Emphasizes strong primary care as an efficient way to providing most care and integrates behavioral health and primary care
- Integration of HIT includes:
 - EHRs, which provide laboratory, medication and imaging data
 - Electronic prescribing and test ordering
 - Population and patient-panel management tools, including disease registries
 - Decision support tools such as medication-safety alerts, preventive-care reminders and online clinical guidelines
 - Electronic referrals that directly schedule appointments with specialists
 - Performance monitoring and reporting capabilities
 - Patient registration and billing functions

- Results include decline in smoking prevalence, improvement in blood pressure, blood glucose, and cholesterol control, and decrease in hospitalization rates

[Cleveland Clinic](#) (Ohio, Florida, Toronto, Canada)^{xxxvi}

- Nonprofit, multi-specialty academic medical center that integrates clinical and hospital care with research and education
- On staff are 2,000 salaried physicians and scientists, representing 120 specialties and subspecialties
- In 2008, 4.2 million visits and more than 165,000 hospital admissions
- Use physician “institutes,” or integrated practice units that combine specialties around a specific organ or disease system to provide collaborative, patient-centered care
- Utilizes internet-based medicine, including online second opinions, patient-accessible EHR, prescription renewal, and appointment requests and cancellations
- Treating chronically ill patients over the last two years of life, Medicare reimbursements average \$34,437 per decedent, nearly half the amount paid for similar patients at UCLA

[Denver Health](#) (Colorado)^{xxxvii}

- Largest health care safety-net provider in Colorado and state’s major Medicaid provider
- Comprehensive and integrated health care system serving approximately 25 percent of Denver residents
- Medicaid providers receive capitated payments
- Multi-professional team cares for critically ill patients
- Medical decisions are data-driven and feedback loops allow for continuous quality improvement
- Focused on building infrastructure for high performance:
 - HIT
 - Centralized data warehouse that integrates both clinical and financial data, allowing for standardized reporting
 - Single imaged electronic-recorded format so providers can retrieve patient information in real time
 - Provides patient alerts, such as reminders for needed preventative services and immunizations
 - Providers have online access to medical literature
 - Workforce
 - Four-part strategy hiring practices to recruit and retain the “right people”
 - Utilizes a talent bank, an interview tool that measures “talent intensities,” training for key leaders regarding selection, and an employee-engagement survey
 - Strong commitment to training health professions on-site
- Emphasizes high-quality, patient-centered care to uninsured and low-income populations; accomplished “open access” scheduling system, reducing no-show rates by half
- Addresses access barriers to low-income individuals, such as a 24-hour call line available in Spanish and locating clinics near bus lines and next to the Department of Human Services to improve interrelated social services

- Average inpatient charge per stay for Medicaid patients is one-third lower than at other metro Denver hospitals

Group Health Cooperative (Washington, Northern Idaho)^{xxxviii}

- One of the two consumer-governed health plans in the U.S.
- About 600,000 members across Washington State and northern Idaho
- Two-thirds receive care through an integrated network of facilities owned and operated by the co-op, includes 26 primary care centers, six specialty care units, and one hospital
- Salaried doctors have incentive to provide the most appropriate treatment for patients and to keep them well
- Utilizing HIT by:
 - Converting to EHR in 2000; allowing patients to view their own records via an online portal
 - Using email to account for 25 percent of physician-patient interactions
 - Adopting full digital medical records, including diagnostic images, electrocardiograms, call logs, and notes from multiple practitioners
- Premium rates are comparable to those of competitors
- Patient-centered medical home pilot has 29 percent fewer emergency room visits than patients in other clinics and 11 percent fewer preventable hospitalizations

Intermountain Health Care (Utah, Southeastern Idaho)

- Not-for-profit, integrated delivery system employing 28,000 staff, including 700 physicians in a multi-specialty group practice
- Operates 21 hospitals, 140 clinics and physician offices, 42 pharmacies, and a 500,000-member health plan
- Early adoption of EHR and development of evidence-based clinical process models
- Focus on reducing inappropriate use of services, particularly among pregnant women by implementing evidence-based clinical guidelines along with performance monitoring, peer review and patient education
- Quality improvement involves activities that:
 - Focus primarily on the performance of local patient-care delivery, rather than the generation of new scientific knowledge
 - Attempt to consistently implement established best practices based on existing evidence
 - Use “open-loop systems” in which clinicians are instructed to modify implementation protocols based on patient need^{xxxix}
- Measuring ethical conduct standards also contributes to quality improvement
- Improvement in working relationships between clinician and patient; e.g., Patient Safety Initiative created guidelines to protect patients from falls and reduce the incidence of pressure sores
- Premature births and elective inductions reduced nearly 30 percent from 1999 to 2005^{xi}

Grand Junction (Colorado) ^{xli}

- Not a formally integrated system; most of its health care payers and providers are unaffiliated with one another
- Implementing a state-of-the-art HIT network, enhancing care coordination and limiting duplication
- Has a high-functioning safety net system that works well with local doctors and hospitals and employs the latest innovations in primary, preventive, and palliative care
- Providers take collective responsibility for better serving the needs of patients
- In 2006, average Medicare spending per capita was \$5,900, about thirty percent lower than the national average of \$8,300
- Rates high on measures of medical quality, having extremely low readmission rates to hospitals and among lowest number of average days spent in the hospital by people at the end of their lives

WellMed Medical Group (Texas, Florida) ^{xlii}

- Currently has 24 clinics surrounding San Antonio, three in Austin and eight in Florida, 1200 employees, more than 90 providers
- Serves over 90,000 patients
- Medical management company specializing in managing medical services for seniors
- Full-risk capitation contracts with CMS and Medicare Advantage plans
- Upside only risk pool sharing and quality incentive programs
- Focuses on primary-care physician coordinating teams to better provide care
- Rewards providers for eliminating waste, improving quality and closing gaps in care
- In 2008, average length of stay is 3.30 days; national average is 4.78
- Claims for congestive heart failure patients fell from \$873 to \$542

Blue Cross Blue Shield of Michigan's Physician Group Incentive Program (Michigan) ^{xliii}

- Incentive program that connects physician organizations across Michigan to encourage information sharing about various aspects of health care
- FFS payment with incentives to redirect a meaningful proportion of professional payment and considerable physician effort toward practice transformation and population-level performance
- As of January 2010, 38 physician organizations participate, including 8,148 primary care physicians and select specialists; the size of Physician Organizations (POs) range from 30 to 1,200 physicians
- Promotes natural communities of caregivers to form physician organizations, rather than using pre-established criteria
- Performance is measured at the population level by PO
- Explicit expectation that POs will develop and use shared information systems and shared processes of care and collectively share responsibility for quality and efficiency of care
- POs participate in "Initiatives," focused on specific areas of care with opportunities for improvement (e.g., Emergency Departments use, imaging rates), each with potential incentive dollars for quality and efficiency
- Improved the quality of care for patients with chronic conditions (compared to the performance of physician organizations on 18 national standard measures)

- Increased generic dispensing 3.8 percentage points in the first year resulting in \$8.9 million in savings, while a 5.3 percentage point increase in the second year reaped \$19.9 million in savings

State Efforts to Test and Promote ACOs

Colorado

The [Accountable Care Collaborative](#) is part of the Colorado Department of Health Care Policy and Financing's Medicaid reform effort. It is designed to create a regional model of accountability for improving health, functioning and self-sufficiency of all Medicaid clients, as well as controlling costs, reducing unexplained variation in care, improving timely access to care, enhancing client and provider satisfaction and coordinating care across provider settings and social services. The goal of the Accountable Care Collaborative is to improve health outcomes for Medicaid clients through a coordinated, client-centered, outcomes-focused system while supporting providers and protecting safety-net providers.

Key items under consideration by the Department are:

- A Statewide Data and Analytics Organization that would
 - Create a Web-based health information system;
 - Provide care management software support;
 - Extract state information to identify data-driven opportunities to improve care and outcomes; and
 - Offer provider IT support.
- Regional Care Coordination Organizations that would provide:
 - Care coordination with other programs such as behavioral health, long-term care, social services, government benefits and programs, food/nutrition; and
 - Incentives to providers/networks that meet certain guidelines and measurements of care.

The Collaborative posted a Request for Information in July 2009 to gather information from stakeholders to further develop the accountability model and a Request for Proposals will be announced in early 2010. The Department plans to implement the program in late 2010 starting with 60,000 clients and will expand the program if it demonstrates success.

Maryland

During the state's 2010 legislative session, the General Assembly enacted [HB 1093](#) / [SB 723](#) authorizing insurers to enter into contracts with "clinically integrated organizations" to pay for the coordination of covered services and incentives to promote the efficient, medically appropriate delivery of medical services. Taking effect July 1, 2010, the bills define a "clinically integrated organization" as a joint venture between a hospital and physicians that:

- 1) has received an advisory opinion from the Federal Trade Commission and has been established to evaluate and improve the practice patterns of the health care providers and create a high degree of cooperation, collaboration, and mutual interdependence among the

- health care providers who participate in the joint venture to promote the efficient, medically appropriate delivery of covered medical services; or
- 2) is accountable for total spending and quality and the Insurance Commissioner determines meets the criteria established by the federal Department of Health and Human Services for an accountable care organization.

Massachusetts^{xiv}

In 2008, the Massachusetts legislature enacted [legislation](#) establishing the Special Commission on the Health Care Payment System and charging it with investigating system reform and restructuring to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care. As required by the legislation, in June 2009, the Special Commission reported [recommendations](#) to the General Court—the state’s legislature—and the governor. After meeting on nine occasions, the Special Commission concluded that global payments with adjustments to reward provisions of accessible and high quality care will “promote safe, timely, efficient, effective, equitable, patient-centered care, and thereby reduce growth and levels of per capital health care spending.”

In order to implement global payments fully in Massachusetts, the Special Commission endorses developing ACOs to accept responsibility for all or most of the care that enrollees need. ACOs will be composed of hospitals, physicians and/or other clinician and non-clinician providers working as a team to manage both the provision and coordination of care for the full range of services that patients are expected to need. ACOs could be real (incorporated) or virtual (contractually networked) organizations—potentially including, for example, a large physician organization that would contract with one or more hospitals and ancillary providers. Providers may decide to use established relationships to create an ACO, or they may enter into new relationships that they view as beneficial to their patients.

The Special Commission anticipates that a broad array of ACO models might emerge, and it encourages the development of a large number of ACOs. ACOs might have various central organizational forms—for example, physician-hospital organizations, consolidated medical groups, independent practice associations, or integrated delivery systems. In addition, they might form different legal relationships among the parties associated with the central organization—for example by contract or various forms of ownership. Finally, they might differ in the extent of exclusivity among different components of the organization. Differences in these aspects of organizations can correspond to differences in organizational culture and mission, differences in how financial risks and benefits are shared among different components of the organizations, and varying degrees of clinical integration. These recommendations will likely be incorporated into legislation during the state’s 2010 legislative session.

Minnesota^{xiv}

The Institute for Clinical Systems Improvement (ICSI) was established in 1993 by HealthPartners, Mayo Clinic, and Park Nicollet Health Services to improve patient care in Minnesota through innovations in evidence-based medicine. As an independent, nonprofit organization, ICSI develops evidence-based health care guidelines and helps members implement best clinical practices for their

patients. Most Minnesota physicians (85 percent) participate in ICSI through 57 group practices, all of the health plans are involved, and business representatives also are involved in the decision-making process. ICSI is currently focused on redesigning outpatient care and exploring new methods for improving the patient-centeredness and value of care.

MN Community Measurement (MNCM) was created by Minnesota's health plans in 2004 to report statewide health care quality measures across medical groups. Using ICSI guidelines and data supplied by the health plans, MNCM measures, compares, and reports "HealthScores" for over 700 provider groups and clinics across the state. Medical groups and clinics use MNCM HealthScores to improve patient care, employers and patients access these scores for information about the cost and quality of health care services, and health plans base their pay-for-performance programs off the HealthScores. As a result of [2008 health reforms](#), MNCM is working with the Minnesota Department of Health to accelerate and expand existing quality measures and to establish a state system of pay-for-performance.

Minnesota was an early leader in using payment reform to achieve better health outcomes. In 1997, for example, the state implemented Minnesota Senior Health Options (MSHO), a special managed care program that blends funds from the Medicare and Medicaid programs to improve the delivery and coordination of all Medicare and Medicaid services received by seniors who are eligible for coverage under both programs. MSHO simplified and increased access to a broad range of services for dually eligible seniors, resulting in significantly fewer hospital days and preventable hospitalizations compared with the traditional Medicare and Medicaid programs.

According to a [2009 Commonwealth Fund report](#), the current federal discussion concerning ACOs is in part inspired by Minnesota's well-organized group medical practices. In 2008, the state considered moving from the current fee-for-service system to one in which providers were held accountable for the total cost of care; however, ultimately, this approach was not approved and the legislation took a more modest approach to payment reform. The 2008 reforms included establishing a single comprehensive set of provider quality metrics, requiring a statewide system of quality-based incentive payments to be used by public and private health care purchasers, creating payments for care coordination to support "health care homes," and setting up a process to define "baskets of care" to bundle services together in a way that creates incentives for health care providers to cooperate and innovate to improve health care quality and reduce cost. The legislation also established a process to group providers based on their total cost of care and quality of care to develop a value index for providers that will be transparent to the public and health care purchasers.

Minnesota was the first state in the nation to require all health care providers and group purchasers to exchange common health care business transactions electronically, a process that began in 2009. State health officials expect that the requirement will reduce health care administrative costs by more than \$60 million per year. In addition to requiring all health care providers and payers to use an electronic prescribing system by 2011, the 2008 health reform requires all providers to have interoperable electronic health records by 2015. The Governor also announced a goal that all Minnesota residents have the option of an online personal health portfolio by 2011.

The state adopted a policy to not pay for certain medical mistakes and follow pay-for-performance standards for diabetes, hospital stays, preventive care, and cardiac care. In 2008, the U.S.

Department of Health and Human Services designated Minnesota a Chartered Value Exchange, a special federal distinction for strong commitment to improving quality and value in health care. Minnesota is currently exploring the concept of “Accountable Care Communities,” which would ask an entire community to take accountability for the health of its population by encouraging exercise, facilitating access to healthy foods, etc. in addition to delivering efficient, effective health care services and public health programs.^{xlvi}

Following the passage of the state’s health reform legislation in 2008, the state organized health reform work groups around specific aspects of the reform package, each tasked with developing strategy and helping to implement the new law. A [May 18, 2010](#) meeting focused on Accountable Care Organizations in Minnesota and included discussion of how the 2008 law can be utilized to transition from a fee-for-service to an accountable care model.

Because Governor Tim Pawlenty (R) cut funding in 2009 for the state’s General Assistance Medical Care program, which provides state-subsidized health care to low-income adults, Minnesota legislators considered introducing [legislation](#) that would extend the programs using remaining funds and delivering care through ACOs. State legislators eventually reached a consensus with the Governor, passing [HF 1](#) of the first special session of 2010, authorizing the state health commissioner to: (1) develop a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population; and (2) apply for grants or demonstrations under the federal Patient Protection and Affordable Care Act to establish ACOs. The bill also allows ACOs to provide outpatient prescription drug coverage.

New Jersey

In October 2009, the [New Jersey Department of Human Services](#) inquired regarding obtaining a Section 1115 Medicaid waiver to establish a health care home using a care coordination model. In order to better provide care to those residents in need of state-subsidized care, an Accountable Care Management Entity would manage pilot projects developed by local communities with established performance targets.^{xlvii}

The Robert Wood Johnson Medical School in New Brunswick, NJ also is working to promote accountable care in the state. The school is creating an academic health center-related ACO to link the disparate elements of health care delivery across a large swath. The school will oversee the test ACO, which will operate in the central part of the state. Expected to launch in early 2010, the program will be primary care-based, consist of 100 to 150 primary care practices and some subspecialty practices, and be linked to five or six area hospitals. The program will require providers to focus on local accountability, shared savings, and performance measurements.^{xlviii}

Oregon^{xlix}

In June 2007, the Oregon Legislative Assembly passed the [Healthy Oregon Act](#), which established the Oregon Health Fund Board and required it to develop the Oregon Health Fund program comprehensive plan. In November 2008, the Board issued a [final report](#), recommending the legislature create an Oregon Health Authority to coordinate the state’s existing patchwork system of purchasing and regulating health care, community services and workforce training. Over time, the

Authority will develop strategic policy plans and legislative proposals for implementing the Oregon Health Fund Board's comprehensive plan. One of the plan's main goals is to create a locus of accountability for quality and cost across the continuum of care by creating a tool to measure performance at the community level. By creating accountable care communities, the Board hopes to expand the ACO model to encompass a full range of care systems and also include broader measures of community and public health. In its final report, the Board recommends that the state begin to develop accountable care communities by July 2010.

The state legislature incorporated these recommendations into a recent health reform bill, [HB 2009](#), which was signed by the Governor in June 2009. The bill also established the [Oregon Health Policy Board](#), requiring it to guide and support community-centered health initiatives to address critical risk factors, especially those that contribute to chronic disease. The Board also must develop a plan, due to the state legislature by December 2010, to cover all Oregon residents by 2015. Monthly meetings will be held throughout 2010 in order to reach this deadline. The December 2009 meeting included an educational presentation and conversation concerning ACOs.

Vermont

The Vermont General Assembly passed a [2008 bill](#) requiring the state's Commission on Health Care Reform to conduct a study determining the feasibility of a pilot in community-based payment reform and integration of care, including the ACO model. In August 2008, upon completing the feasibility study, the Commission published [findings](#) outlining the elements needed for a successful pilot, possible risks, and potential scope of services. An enacted [2009 bill](#) requires the Commission to convene a workgroup to support the development of an application by at least one Vermont network of community health care providers for participation in a national ACO state learning collaborative sponsored by the Dartmouth Institute for Health Policy and Clinical Practice and the Brookings Institution.

In April 2009, the [Dartmouth Institute for Health Policy and Clinical Practice](#) received funding from the Centers for Disease Control and Prevention (CDC) to improve population health in Vermont and New Hampshire. The Dartmouth Population Health Research Center will bring together a broad coalition of partners to focus on reducing cardiovascular disease—the leading cause of death in the two states. Initial efforts will center on the communities of Manchester and Keene, NH, and St. Johnsbury, VT.¹ Further pilot projects for St. Johnsbury and other areas of Vermont and New Hampshire are in development. Dr. Elliott S. Fisher, a leading researcher and author on ACOs, will lead the Center. The United Health Alliance/Southwestern Vermont Medical Center is also participating in the Brookings-Dartmouth ACO Learning Network (more details below). Further details of the Vermont ACO pilot, including key recommendations, can be found in a May 2010 [Commonwealth Fund report](#).^{li}

Washington

During the 2010 legislative session, the Washington Legislature passed [SB 6522](#), establishing at least two ACO pilot projects in the state by January 2012. The bill requires the state health care authority and Department of Social and Health Services to convene a work group by January 1, 2011 to support the development of an application by at least one integrated health care delivery system

and one network of nonintegrated community health care providers for participating in the ACO learning and payment collaborative. The work group shall research other opportunities to establish the pilot projects that become available through Medicaid, Medicare, or other federal programs. Coordination with the state's established primary care medical home reimbursement pilot projects is also required of the work group. The bill provides exemption from state antitrust laws, and immunity from federal antitrust laws, for activities undertaken pursuant to pilots designed and implemented.

The legislation defines an ACO as an entity that enables networks consisting of health care providers or a health care delivery system to become accountable for the overall costs and quality of care for the population they jointly serve and to share in the savings created by improving quality and slowing spending growth while relying on the following principles:

(a) Local accountability:

- (i) ACOs will be composed of local delivery systems; and
- (ii) ACOs spending benchmarks will make the local system accountable for cost, quality, and capacity;

(b) Appropriate payment models:

- (i) ACOs with expenditures below benchmarks are recognized and rewarded with appropriate financial incentives.
- (ii) Payment models have financial incentives that allow stakeholders to make investments that improve care and slow cost growth such as health information technology;

(c) Performance measurement:

- (i) Measurement will be essential to ensure that appropriate care is being delivered and that cost savings are not the result of limiting necessary care.
- (ii) ACOs will report patient experience data in addition to clinical process and outcome measures.

Other ACO Initiatives

Federal Legislation

The enacted health reform bill, [H.R. 3591](#) *the Patient Protection and Affordable Care Act*, allows providers organized as ACOs to share in the cost savings achieved for the Medicare program. The bill requires organizations, as of January 1, 2012, seeking to qualify as an ACO to agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care. The legislation allows pediatric medical providers participating in an ACO to also share in cost-savings. Refer to the [ADDENDUM](#) for the legislative text concerning ACOs.

According to a CMS report on [Medicare 'Accountable Care Organizations'](#),^{lii} the following forms of organizations may become an ACO under the Medicare shared savings program:

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

Initially introduced as [H.R. 2959](#), the Accountable Care Promotion Act of 2009, provisions establishing ACO pilot programs were incorporated into the House health care reform bill, [H.R. 3962](#), which was not enacted. The Medicare and Medicaid pilot programs would have tested different payment incentive models designed to reduce the growth of expenditures and improve health outcomes. The models specified in the legislation included a performance target model and a partial capitation model, as well as additional models to be developed by the Secretary of Health and Human Services.

[American Academy of Family Physicians](#)

In late 2009, AAFP adopted 16 [ACO principles](#) to guide the structure and payment provided in an ACO.

Structure

1. The core of an Accountable Care Organization is to provide accessible, effective, team-based primary care for the defined population it serves, which includes efforts to deliver care in a culturally competent and responsive manner.
2. Should include strong physician leadership, be clinically integrated and operated in a true partnership among physicians and all other participants.
3. Physician and patient participation in an Accountable Care Organization should be voluntary. However, if patients are assigned to an Accountable Care Organization they should be encouraged to select a primary care physician.
4. Nationally-accepted, validated clinical measures focused on ambulatory and inpatient care should be used to measure performance and augment efficiency and patient experience measures.
5. Clinically integrated information systems should provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions of care.
6. Accountable Care Organization participants will support continuous innovation to identify best practices that provide value to patients.
7. Organizational relationships, spending and quality benchmarks, and payment distribution mechanisms need to be clearly defined and agreed to by participants.
8. Accountable Care Organization structure and payment systems should be implemented in an incremental manner and monitored to prevent "unintended consequences," such as poor access to physicians or denial of needed care.
9. A sufficient number of patients in an Accountable Care Organization is necessary to statistically determine if the care provided and not mere chance resulted in the reported outcomes.
10. Primary care physicians and sub-specialists should have the option to participate in multiple Accountable Care Organizations.
11. Accountable Care Organizations should purposefully involve and provide incentives for patient engagement in their health and wellness.
12. Changes to antitrust regulations and to Stark self-referral regulations need to be explored to allow physicians to fully participate in Accountable Care Organizations especially for physicians in small- and medium-sized practices.

Payment

13. Payment models and incentives must align mutual accountability at all levels, fostered by transparency and focus on disease prevention, care management, and coordination.
14. Recognition as an Accountable Care Organization and rewards for its performance should be based on a combination of absolute standards, relative performance, and improvement.
15. Payment changes should evolve over time in ways that support the transitional changes in care processes and information systems.
16. Primary care practices designated as PCMH and participating in an Accountable Care Organization should be eligible for payments in both models of care (i.e. fee-for-service, episode/bundled payment, global payment, care management fee, bonuses, shared savings, blended payment, etc.)

In late 2010, AAFP joined a number of other primary care organizations—the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association—in releasing the following [Joint Principles for Accountable Care Organizations](#).

Structure

1. The core purpose of an Accountable Care Organization is to provide accessible, effective, team-based integrated care based on the Joint Principles of the Patient Centered Medical Home for the defined population it serves, which includes assurances that care is delivered in a culturally competent and patient and/or family-centered manner.
2. The Accountable Care Organization should demonstrate strong leadership from among physicians and other healthcare professionals, including significant and equitable representation from primary care and specialty physicians, in its administrative structure, policy development, and decision-making processes; clinical integration in the provision of care; and processes to facilitate operation as a true partnership among physicians and all other participants.
3. Organizational relationships and all relevant clinical, legal, and administrative processes within the Accountable Care Organization should be clearly defined and transparent to physicians, other related healthcare professionals, and the public. This includes methods of payment including the application of any risk adjustment strategies for both pediatric and adult patients, quality management processes, and processes to promote efficiency and value in delivery system performance.
4. Accountable Care Organizations should include processes for patient and/or family panel input in relevant policy development and decision-making.
5. Accountable Care Organizations should include a commitment to improving the health of the population served through programs and services that address needs identified by the community including, for example, interfacing with state Title V programs, early intervention programs, Head Start offices, and public education entities.
6. Accountable Care Organizations should provide incentives for patient and/or family engagement in their health and wellness.
7. Participation by physicians, other healthcare professionals, and patients/families in an ACO should be voluntary. However, if patients are assigned to an ACO, they should be encouraged to select a primary care physician.
8. Nationally-accepted, reliable and validated clinical measures focused on ambulatory and inpatient care should be used by Accountable Care Organizations to measure performance and efficiency and evaluate patient experience. These measurement processes should be transparent, and informed by input from primary and specialty care physicians and other healthcare professionals participating in the Accountable Care Organization. .
9. Accountable Care Organizations should implement clinically integrated information systems to provide relevant information at the point of care and assist in care coordination among multiple clinicians and across transitions and sites of care.
10. The structure and related payment systems of the Accountable Care Organization should be implemented and monitored to prevent "adverse unintended consequences," such as poor access to physicians, denial of needed care, or discrimination against the treatment of the more medically complex or difficult-to-treat patients.
11. Primary care physicians, specialty physicians, and other healthcare professionals should have the option to participate in multiple Accountable Care Organizations.
12. Barriers to small practice participation within the Accountable Care Organization should be addressed and eliminated. These barriers include the small size of their patient panels and their current limited and future access to capital, health information technology infrastructure needs, and care coordination and management resources.
13. Accountable Care Organizations should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.
14. Accountable Care Organizations should promote processes to reduce administrative complexities and related unnecessary burdens that affect participating practices and the patients/families to whom they provide service.

Payment

15. Payment models and incentives implemented by Accountable Care Organizations must align mutual accountability at all levels, fostered by transparency and focused on health promotion and healthy development, disease prevention, care management, and care coordination.
16. Payment models and incentives implemented by Accountable Care Organizations should adequately reflect the relative contributions of participating physicians and other healthcare professionals to increased quality and efficiency and demonstrate value in the delivery of care.
17. Payment models should recognize effort required to involve family, community/educational resources and other pertinent entities and activities related to care management/care coordination of patients with complex conditions.
18. Recognition as an Accountable Care Organization and rewards for its performance should be based on processes that combine achievement relative to set target levels of performance, achievement relative to other participants, and improvement that have been developed with significant input from primary and specialty care physicians and other healthcare professionals. .

19. Practices participating within the Accountable Care Organization that achieve recognition as medical homes by NCQA, other nationally accepted certification entities, and/or related processes (e.g. state government recognition) should be provided with additional financial incentives.

20. The structure of the Accountable Care Organization should adequately protect ACO physicians and other healthcare professional participants from “insurance risk,” unless clearly agreed as a requirement for participation.

21. Accountable Care Organizations can employ a variety of payment approaches to align the incentives for improving quality and enhancing efficiency while reducing overall costs including but not limited to blended fee-for-service /prospective payment, shared savings, episode/case rates and partial capitation.

[American Medical Group Association](#)

On May 28, 2010, AMGA also released a set of [ACO principles](#) to help guide the regulatory activity following the passage of federal health reform.

Principle I (Guiding Principle): Multispecialty Medical Groups and Other Organized Systems of Care Make the Strongest Foundation for ACOs

AMGA believes multispecialty medical groups and other organized systems of care should be the foundation of any ACO. Multispecialty medical groups are more likely to invest in health information technology, form teams of providers, collect and analyze data, and provide direct physician feedback on clinical care. Studies suggest that multispecialty medical groups are more likely to use care management processes and may use fewer resources than other modes of health care delivery. Evidence shows there is greater collaboration among physician specialties and allied health professionals in large, multispecialty medical groups. The key components of care coordination, team-based care, and accountability for the patient care provided form the foundation for successful ACOs and are the backbone of multispecialty medical groups and other organized systems of care.

Principle II: ACOs Must be Physician-Led

Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. As such, they are the core component of medical care delivery. The strongest underpinning of a true ACO is the physician-directed, multispecialty medical group or other organized system of care. Physician-led multispecialty medical groups, integrated delivery systems, and physician-led organized systems of care already function as ACOs. These ACOs have demonstrated their ability to be the most effective and efficient vehicle for providing the highest quality of medical services to Americans.

Principle III: Accountability for Health Care Services

AMGA defines an ACO as a physician-led, patient-centric entity that has invested in the necessary infrastructure to measure, assess, and advance the effectiveness and efficiency of patient care. The ACO should provide integrated, team-based, coordinated health care services across provider specialties and settings. It is willing to be held accountable for clinical results and cost efficiencies in the communities served. ACOs may be integrated actually or “virtually” with other providers to offer the scope of needed services for patients.

Principle IV: ACO Incentives Must Be Aligned to Foster Voluntary Participation

In order to create real delivery system change, ACO rewards (opportunities for shared savings or partial capitation) must be aligned with the participation risks (start-up costs, systems investments, “culture” changes, and financial uncertainty). ACOs agree to be accountable to their patients on both the quality and efficiency spectrum. Developing this capacity is costly, labor intensive, disruptive, and uncertain. Payment methodologies commensurate to these factors must be made available to encourage ACO development.

Principle V: ACOs Must Have a Primary Care Core

To function as a comprehensive source of patient care, foster true care coordination, provide the framework for patient-centered care, and achieve optimal results, an ACO should be anchored by a core of primary care physicians and services appropriate and adequate to meet the needs of the community population it serves.

Principle VI: ACOs Should Be “Learning Organizations”

Inherent in the ACO concept is the idea that internally produced data and feedback should be used to standardize care processes and continually improve performance. Standardized care processes reduce unwanted variation in

the practice of medicine, making it easier for physicians and other members of the health care team to do “the right thing” on a consistent basis in meeting the needs of their patients. “Learning organizations” are health care organizations that gather and use data to improve the efficiency and safety of patient care. As the lessons learned in one ACO may be scalable and transferable, that information should be communicated, on a voluntary basis, with others interested in improving quality and efficiency of health care delivery.

Principle VII: ACO Core Values and Attributes

An ACO is an organization that provides a coordinated continuum of health care services and is willing to be held accountable for the quality and efficiency of the health care provided to the ACO’s community. An ACO subscribes to the core values and demonstrates attributes enumerated:

CORE VALUES

- *Quality*: Continuous striving to improve patient care through measuring and reporting on clinical and service components of care and applying these findings to improve these measures through tools such as benchmarking, best practices, and peer review.
- *Patient-centered care*: Timely information sharing between patients and physicians. This allows patients to become active participants in their own care and to receive services depending on their individual needs and preferences.
- *Care coordination*: Through the use of an electronic medical record; dedicated care managers to monitor and provide timely interventions; use of evidence-based guidelines; systematic monitoring of patient quality and efficiency; and coordination among provider specialties and settings. Ensuring that patients receive the care they need, when they need it.
- *Accountability*: Physician and system responsibility and accountability for the quality and the cost of patient care.
- *Innovation*: Openness to adoption and adaptation of evolving health care delivery models. This includes a modern infrastructure (electronic medical records, patient registries, electronic prescribing, secure electronic communication with patients, electronic claims submission, etc.) and striving for continued improvement in patient care.
- *Physician self-governance*: Support of professionalism, physician participation in group governance, and physician direction of clinical decision-making.
- *Leadership development*: Creating a practice environment supportive of and seeking to enhance skills, knowledge, and experience of physicians’ management and executive abilities.

ATTRIBUTES

- The organization is a physician-led, multispecialty group medical practice or other physician-led organized system of care
- The organization has a stable governance structure
- The organization has a centralized administration
- The organization has an infrastructure necessary to be accountable
- The organization is quality driven

[Brookings-Dartmouth ACO Learning Network](#) ^{liii}

The Accountable Care Organization Learning Network, a joint initiative of the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice, focuses on practical steps toward implementing more accountable health care and building greater value into the care delivery process by using ACOs. The Network offers practical guidance and a forum for interested and engaged parties to learn from one another throughout the process of planning and implementation. More than 50 medical centers and health organizations from across the U.S. are currently members of the Network. Two physician-governed medical groups in southern California, HealthCare Partners and Monarch HealthCare, [announced](#) participation along with Anthem Blue Cross in the ACO pilot project.

[Medicare Payment Advisory Commission](#)

In June 2009, MedPAC released a [report](#) to Congress on improving incentives in Medicare. Discussed in the report are paths to promote delivery system reform, which included developing ACOs. For ACOs to improve quality successfully while constraining cost growth, the report finds:

- Spending targets for an ACO should be set in advance. Targets could be based on the ACO's past experience plus a single national allowance for spending growth per capita. Alternatively, the allowance could be set as a function of prior utilization trends, with low-service-use areas receiving a higher allowance, and high-use areas receiving a lower allowance (which would provide a greater incentive to control utilization).
- ACOs need to be fairly large (at least 5,000 patients) to distinguish actual improvement from random variation.
- ACOs need a formal organization and structure that allows for joint decisions because savings would primarily result from the joint incentive to change overall practice patterns and eventually constrain capacity.
- Private insurers may have to provide ACO-type incentives because a large share of the patients in a practice would need to be in an ACO to overcome FFS incentives to expand capacity and volume.

[New Hampshire Citizens' Health Initiative](#)

The Initiative currently has a medical home pilot project, and in his [2010 State of the State address](#), Governor John Lynch (D) announced that a multi-stakeholder, multi-carrier ACO pilot project is also in the works. The Initiative partnered with the Dartmouth Institute for Health Policy and Clinical Practice for the five-year project with the goal to improve population health in both New Hampshire and Vermont. A [Call for Proposal](#) was published welcoming responses from small and large hospitals, independent physician organizations, and integrated delivery systems due June 1, 2010.

[Pittsburgh Regional Health Initiative's Accountable Care Network Project](#) ^{liv}

CMS recently selected Southwestern Pennsylvania to participate in its [EHR Demonstration](#). The Pittsburgh Regional Health Initiative (PRHI), a nonprofit operating arm of the Jewish Healthcare Foundation—a group that promotes quality medical care initiatives—recruited 278 small practices clustered around several community hospitals to take part in the Demonstration. PRHI currently is working with these practices to develop a series of Accountable Care Network (ACN) pilots.

The ACN pilots will focus on transitions of care and coordinated disease management for specific patient populations with one or two chronic illnesses. Rather than embarking on the formation of a new legal structure, internal governance, and negotiating bundled payments that is necessary for ACOs, these pilots will concentrate on collaborating to evaluate and improve care in a targeted area, either developing internal data and quality measurement capability or arranging to receive such information from payers.

[Premier Healthcare Alliance](#)

Premier and 19 members launched two ACO Collaboratives serving more than 1.2 million patients. The ACO Implementation Collaborative is designed for health systems currently able to pursue becoming an ACO, while the ACO Readiness Collaborative is for health systems that first must develop the organization, skills, team and operational capabilities necessary to become ACOs and ultimately join the Implementation Collaborative. Participating health system members are located in 15 states, covering urban, rural and suburban populations that range in size from 4,000 to 7.5 million residents.

[State Quality Improvement Institute](#)

In 2008, AcademyHealth and the Commonwealth Fund launched the State Quality Improvement Institute (SQII), a technical assistance project for states that have made or are ready to make substantial commitments to health care quality improvement. The nine states competitively selected to participate are Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington. The SQII facilitates ongoing collaboration between and among high-level state executive, legislative, municipal and private-sector team members, and provides opportunities for contact with expert faculty to support care improvement in three priority areas: 1) delivery and financing systems reform, 2) care coordination/chronic care management, and 3) data integration/transparency. Several states have used their work with the program to advance accountable care initiatives.

Comparison of Payment Reform Models

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/ patients
Strengthens primary care directly or indirectly	Yes - Provides incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes - Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No - Only for bundled payments that result in greater support for primary-care physicians	Yes - Assuming that primary care services are included in the partial capitation model allows for infrastructure, process improvement, and a new model for care delivery	Yes - Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes - Significant incentive to coordinate among participating providers	No - Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes (for those within the bundle) - Depending on how the payment is structured, can improve care coordination	Yes- Strong incentive to coordinate and take other steps to reduce overall costs	Yes- Strong incentive to coordinate and take other steps to reduce overall costs
Removes payment incentives to increase volume	Yes - Adds an incentive based on value, not volume	No - There is no incentive in the medical home to decrease volume	No, outside the bundle - There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No - Strong efficiency incentive for services that fall within the partial capitation model	Yes - Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes - In the form of shared savings based on total per-capita costs	No - Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No - Strong efficiency incentive for services that fall within partial capitation	Yes - Very strong accountability for per-capita cost
Requires providers to bear risk for excess costs	No - While there might be risk-sharing in some models, the model does not have to include provider risk	No - No risk for providers continuing to increase volume and intensity	Yes, within episode - Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes - Only for services inside the partial capitation model	Yes - Providers are responsible for costs that are greater than the payment
Requires "lock-in" of patients to specific providers	No - Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes - To give providers a PMPM payment, patients must be assigned	No - Bundled payments are for a specific duration or procedure and do not require patient "lock-in" outside of the episode	Yes (for some) - Depending on the model, patients might need to be assigned to a primary-care physician	Yes - To calculate appropriate payments, patients must be assigned

Source: Brookings-Dartmouth ACO Learning Network. [Issue Brief: Accountable Care Organizations](#), March 2009.

ADDENDUM

Provisions concerning Accountable Care Organizations in the [Patient Protection and Affordable Care Act](#)

Pages 538-540

SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION.—

(1) *IN GENERAL.*—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(2) *DURATION.*—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) *APPLICATION.*—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) *PERFORMANCE GUIDELINES.*—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) *SAVINGS REQUIREMENT.*—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) *MINIMUM PARTICIPATION PERIOD.*—A provider desiring to be recognized as an accountable care organization under the demonstration project shall enter into an agreement with the State to participate in the project for not less than a 3-year period.

(d) *INCENTIVE PAYMENT.*—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

(e) *AUTHORIZATION OF APPROPRIATIONS.*—There are authorized to be appropriated such sums as are necessary to carry out this section.

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SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM. Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

“SHARED SAVINGS PROGRAM “SEC. 1899.

(a) ESTABLISHMENT.—

‘(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ‘program’) that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

“(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an ‘ACO’); and

“(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

“(b) ELIGIBLE ACOS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

“(A) 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.

“(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

“(2) REQUIREMENTS.—An ACO shall meet the following requirements:

“(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

“(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the ‘agreement period’).

“(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

“(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection(c) in order to be eligible to participate in the ACO program.

“(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

“(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

“(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

“(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

“(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

“(i) clinical processes and outcomes;

“(ii) patient and, where practicable, caregiver experience of care; and

“(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

“(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to

evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post-hospital discharge follow-up by ACO professionals, as the Secretary determines appropriate.

“(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

“(D) OTHER REPORTING REQUIREMENTS.— The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration when calculating any payments otherwise made under subsection (d).

(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

“(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

“(B) The independence at home medical practice pilot program under section 1866E.

“(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

“(d) PAYMENTS AND TREATMENT OF SAVINGS.—

“(1) PAYMENTS.—

“(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

“(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

“(ii) the ACO meets the requirement under subparagraph (B)(i).

“(B) SAVINGS REQUIREMENT AND BENCHMARK.—

“(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

“(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

“(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the

requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

“(3) **MONITORING AVOIDANCE OF AT-RISK PATIENTS.**—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

“(4) **TERMINATION.**—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

“(e) **ADMINISTRATION.**—Chapter 35 of title 44, United States Code, shall not apply to the program.

“(f) **WAIVER AUTHORITY.**—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

“(g) **LIMITATIONS ON REVIEW.**—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(1) the specification of criteria under subsection (a)(1)(B);

“(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

“(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

“(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

“(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

“(6) the termination of an ACO under subsection (d)(4).

“(h) **DEFINITIONS.**—In this section:

“(1) **ACO PROFESSIONAL.**—The term ‘ACO professional’ means—

“(A) a physician (as defined in section 1861(r)(1)); and “(B) a practitioner described in section 1842(b)(18)(C)(i).

“(2) **HOSPITAL.**—The term ‘hospital’ means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

“(3) **MEDICARE FEE-FOR-SERVICE BENEFICIARY.**—The term ‘Medicare fee-for-service beneficiary’ means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.”

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