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How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations

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ABSTRACT The Patient Protection and Affordable Care Act establishes a national voluntary program for accountable care organizations (ACOs) by January 2012 under the auspices of the Centers for Medicare and Medicaid Services (CMS). The act also creates a Center for Medicare and Medicaid Innovation in the CMS. We propose that the CMS allow flexibility and tiers in ACOs based on their specific circumstances, such as the degree to which they are or are not fully integrated systems. Further, we propose that the CMS assume responsibility for ACO provisions and develop an ordered system for learning how to create and sustain ACOs. Key steps would include setting specific performance goals, developing skills and tools that facilitate change, establishing measurement and accountability mechanisms, and supporting leadership development.

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

Combined with payment reform, ACOs are seen as one way to reduce the rate of increase in health care costs over time, while also improving the coordination and quality of care for patients.¹⁻³ Bending the cost curve will be necessary if the expansion of health insurance coverage to an estimated thirty-two million Americans is to be affordable over time.

Provisions In The Reform Law

The health reform act instructs the CMS on the capabilities that ACOs must display to participate in the federal program. These

include a sufficient number of primary care professionals to provide services to at least 5,000 beneficiaries and the ability to report data on cost, quality, and overall patient care experience for Medicare fee-for-service beneficiaries. Participating groups must also agree to enroll in the CMS program for at least three years and exhibit a legal structure that permits them to receive payments for shared savings from the CMS and distribute a portion of the payments. The shared savings would be generated when the group provides care to beneficiaries for less than a Medicare benchmark cost while meeting criteria for patient service and quality of care.

We recommend that the CMS's new Center for Medicare and Medicaid Innovation be charged with stimulating and overseeing the development of ACOs. The Innovation Center should communicate the potential advantages of ACOs to all parties, carefully align new payment incentives with the capabilities outlined in the provisions of the health reform law, and develop a learning system to support the formation and sustainability of the organizations.

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Why Pursue ACOs?

Accountable care organizations have potential advantages for patients, physicians and other clinicians, hospitals, and payers—particularly in regard to providing more cost-effective care to a growing number of chronically ill Americans. Many people with chronic illnesses have multiple conditions and see as many as seven or eight physicians, in different locations. The multiple physicians and visits result in uncoordinated care that is reflected in preventable hospital admissions and readmissions, poor adherence to medication regimens, and inadequate follow-up care.

FINANCIAL INCENTIVES ACOs can address these issues by creating and responding to financial incentives that provide rewards for keeping people well. They can also bring clinicians together into teams that take responsibility for all of patients' care across the spectrum of medical conditions and facilities. They provide a foundation for implementing electronic health records and electronic visits—for instance, through e-mail and telephone appointments—to improve care management processes and encourage patients to be involved in their own care. The organizations also use performance measures that provide external accountability to payers and the public, and internal metrics to facilitate improved care.

PHYSICIAN SHORTAGES Although ACOs are not themselves a complete solution to the acute shortage of primary care clinicians across the country, they may help alleviate the shortage by allowing primary care practices to care for larger numbers of patients more efficiently through team-based practice. In addition, the combination of a more positive work environment and payment incentives may help attract more medical and nursing school graduates into primary care.

BUNDLED PAYMENT The typical hospital business model today is based on generating net income from the inpatient margin—in other words, total payments for inpatient care minus the costs of inpatient treatment. However, as the CMS moves toward bundled payment—a single payment to hospitals and physicians jointly for a given condition or procedure—as well as toward capitation—a set payment per member per month—the business model will necessarily change. It will be based on the total margin generated by providing overall care to the patient across the care continuum, not just when he or she is an inpatient.

Thus, incentives will be created for hospitals to work closely with physicians to achieve shared savings, subject to meeting quality and service criteria.⁴ Currently, 70 percent of hospital lead-

ers believe that their institution could be a part of an accountable care organization within the next five years.⁵

LESS FRAGMENTATION Many insurers contract with networks of small physician practices, which results in fragmented relationships among primary care physicians, specialist physicians, other clinicians, and hospitals. The result is costly and often ineffective care that puts upward pressure on premiums to the insurer and on costs to employers. If ACOs can reduce some of the fragmentation and provide a platform for the delivery of more-integrated care, insurers and employers should benefit directly.

Given these potential advantages, the key policy issue for the CMS becomes how to structure and implement the ACO concept so as to maximize its advantages. This will require the CMS to encourage the development of flexible models and payment approaches for ACOs that can be adapted to fit local communities and market conditions. It will also require the creation of a system in which all parties can learn from others' experiences.

Accountable Care Models

Accountable care organizations will be largely based on physician practices that, in turn, may be organized as patient-centered medical homes.⁶ Many ACOs will also include hospitals, home health agencies, nursing homes, and perhaps other delivery organizations. There are at least five different types of practice arrangements that could serve as ACOs. These are the integrated or organized delivery system, multi-specialty group practices, physician-hospital organizations, independent practice associations, and “virtual” physician organizations, all described below.⁴

INTEGRATED DELIVERY SYSTEMS Integrated delivery systems involve a common ownership of hospitals, physician practices, and—in some cases—an insurance plan. Some examples are Kaiser Permanente, Group Health Cooperative of Puget Sound, and Geisinger Health System.⁷ These systems typically have aligned financial incentives, electronic health records, team-based care, and resources to support cost-effective care.

MULTISPECIALTY GROUP PRACTICES Multispecialty group practices usually own or have a strong affiliation with a hospital. Examples of this type of arrangement include Mayo Clinic and Cleveland Clinic.⁸ They usually do not own a health plan but, rather, have contracts with multiple health plans in their areas. Most have a long history of physician leadership and highly developed mechanisms for providing

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coordinated clinical care.

PHYSICIAN-HOSPITAL ORGANIZATIONS These organizations are a subset of the hospital's medical staff. One example is Advocate Health in Chicago.⁹ Most were formed in the 1990s in response to managed care pressures to negotiate with health plans. Some function like multispecialty group practices, focusing on reorganizing the delivery of care to achieve more cost-effective coordination. Although they may be less well suited than integrated delivery systems or multispecialty practices to qualify as ACOs, many could structure themselves to meet the criteria for that type of organization.

INDEPENDENT PRACTICE ASSOCIATIONS Independent practice associations consist of individual physician practices that came together largely for purposes of contracting with health plans. Over time, however, many of these have evolved into more-organized networks of practices that are actively engaged in practice redesign, quality improvement initiatives, and implementation of electronic health records. One example is Hill Physicians Group, in Northern California.¹⁰ Such organizations could qualify as ACOs, and that might encourage other independent practice associations to evolve similarly, given sufficiently strong financial incentives and technical assistance.

VIRTUAL PHYSICIAN ORGANIZATIONS Finally, a number of small, independent physician practices, many located in rural areas, can organize to become "virtual" physician organizations, such as Community Care of North Carolina.¹¹ This process can be led by individual physicians in rural areas or by a local medical foundation, state Medicaid agency, or similar organization that can provide the leadership, infrastructure, and resources to help small practices develop disease registries; implement electronic health records; share information; and provide better-coordinated, cost-effective care. These virtual networks could qualify as ACOs and serve as models for other groups of small practices.

Qualification Tiers

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

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

Thus, rather than requiring that all practices interested in becoming accountable care organizations meet all of the requirements contained in the health reform law to the same degree, we recommend that the CMS consider creating three tiers of qualification criteria, as outlined below.^{12,13} Potential ACOs could submit a three-year plan to the CMS for qualifying for ACO status at any one of the three tiers.

The tiering approach is attractive from both a policy and a practice perspective. It would allow physician practices to start at a low level, with fewer capabilities. Practices could advance to higher levels (offering greater rewards) over time as they become able to meet stricter criteria.

TIER 1 The accountable care organization at this tier might bear little financial risk but would be eligible to receive shared savings and bonuses if it meets quality benchmarks and reduces per beneficiary spending below an agreed-upon target. It could receive most of its payments on a fee-for-service basis.

Tier 1 requirements might include establishing a legal practice entity with a designated governance and management structure. The organization could be required to indicate the specific nature of the ownership or contractual relationships among physicians, hospitals, and its other units. Organizations in this tier might also be required to have a sufficient number of primary care physicians to care for a defined population of patients of sufficient size to reliably report performance results.

The CMS could also require the capability to report a basic set of performance measures based on at least administrative data. Initially, virtual physician organizations and loosely organized independent practice associations would find Tier 1 criteria the most appropriate and

achievable.

TIER 2 Organizations at this tier might be eligible to receive a greater proportion of savings if they achieve spending rates below a specified target, but they would also be at risk for spending above the target. They could be paid more through partial capitation and selected bundled payments. These ACOs would be required to meet the same governance and contractual criteria as organizations in Tier 1.

Groups in Tier 2 would also be required to report more comprehensive data on performance measures that include patient experience and clinical performance for a variety of conditions, such as asthma, diabetes, and congestive heart failure. They would also have to meet specific standards for financial reporting, including revenue and expense projections and the maintenance of minimum cash reserves. Groups interested in the physician-hospital organization model might find Tier 2 eligibility criteria attractive.

TIER 3 Accountable care organizations at this level would be reimbursed through full capitation or extensive partial capitation and bundled payments. They would be eligible for the highest level of reward but also exposed to the greatest amount of risk. In addition to the criteria for the other tiers, qualifying criteria for Tier 3 might include public reporting of comprehensive data on performance measures drawn from electronic health records, including patient reports of health-related outcomes and quality of life.

Tier 3 organizations might also be required to meet additional, more stringent, standards for financial reporting and cash reserves. Integrated delivery systems and multispecialty group practices would be most likely to qualify as Tier 3 groups.

Implementing A Learning System

Given the need to adapt different models of accountable care organizations to local market circumstances, and to match the risks and rewards to the different models, policy makers need to create a system of learning from experiments with ACOs. This system would help promote more rapid diffusion of successful models and achievements across the country.

Previous research and experience suggest four cornerstones for the learning system: a focus on goals and objectives that motivate efforts to change; skills and tools that facilitate change, including the implementation of electronic health records, care management processes, methods of continuous quality improvement, and the effective use of teams; measurement of and accountability for performance; and strong

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leadership. The CMS's new Center for Medicare and Medicaid Innovation, working with the CMS Quality Improvement Organizations and private-sector organizations such as the Institute for Healthcare Improvement and the National Center for Healthcare Leadership, is the best vehicle for developing such a learning system.

STRATEGIC-FOCUSED GOALS AND OBJECTIVES

To facilitate delivery system transformation and focus attention on desired health outcomes, payment systems need to change. Payment based on outcomes achieved, rather than on volume of services provided, will be the motivation for providers to focus their attention on improving the underlying systems of care. The change will motivate them to ask such questions as, Why do I have so many diabetic patients whose blood sugar levels are over 9 percent? Why do I have to spend so much unproductive time with some patients and not have enough time for others? What are my patients doing between visits? Why are my patient experience scores in the lowest quartile of my group?

SKILLS AND TOOLS In addition to having a motivation to learn, providers need the skills and tools to address the questions raised. These include, in particular, the use of evidence-based care management processes, the adoption of continuous quality improvement techniques, the ability to develop effective teams, and the implementation of electronic health records and registries. Much has been written about each of these skills and tools, but they need to be considered as an integrated set of competencies required to effectively respond to the new payment incentives for providing better-coordinated, cost-effective care.

For example, recent research on the use of health information technology (IT) extension centers to help physicians adopt electronic health records suggests that the adoption by itself has only a limited impact. Instead, it is important to link the centers' assistance to an overall approach to practice redesign, and to developing team-based and evidence-based use

of care management processes.¹⁴ Particular attention should be given to implementing electronic health records that can transfer relevant information to different kinds of providers within accountable care organizations and to external organizations as needed.

MEASUREMENT AND ACCOUNTABILITY Key to learning is receiving accurate feedback on one's performance in a timely fashion. Thus, electronic health records must facilitate not only patient diagnosis and treatment but also the ability to aggregate data across patients. These data can form the basis of feedback reports for both individual clinicians and a practice at large, enabling providers to assess deviations from desired performance goals and to take corrective action.

The recommendations of the Institute of Medicine Performance Measurement Report and the work of the National Quality Forum and the Agency for Healthcare Research and Quality (AHRQ) constitute a portfolio of measures available for use.¹⁵⁻¹⁷ As performance measures improve over time, they can be grouped into three categories. The first is measures with known reliability, validity, and feasibility that are now ready for "prime time." The second is performance measures that are almost ready but that require further testing, particularly to determine which kinds of practice settings can provide the needed data. The third is measures that are promising but whose reliability, validity, and feasibility still need verification.

LEADERSHIP Clinical and managerial leadership will be needed to implement accountable care organizations. Integrated delivery systems, multispecialty group practices, physician-hospital organizations, and independent practice associations have benefited greatly from the leadership of key people over the years. Leaders are needed to motivate and set an example for others to follow in creating ACOs. Leaders have an important part to play in developing the skills and tools to respond to the new payment incentives and the necessary systems to measure performance and accountability. Validated competencies of effective leadership can be used.¹⁸ The CMS should set aside specific funds for the development of leadership competencies within new ACOs.

Discussion

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

ACOs.

A PORTFOLIO APPROACH We recommend that a variety of organizations offer technical assistance. The CMS Quality Improvement Organizations are one source. Most of them have considerable experience and expertise in quality improvement and process redesign, the implementation of electronic health records, and the promotion of care management processes. Private-sector organizations such as the Institute for Healthcare Improvement can also play key roles.

Local and statewide foundations and regional collaboratives can also be important sources of assistance. These include the Pittsburgh Regional Health Initiative,¹⁹ the Twin Cities Integrated Clinical Services Institute (ICSI), and California's Integrated Healthcare Association.

An additional approach would be to develop a network of more-mature health care delivery organizations around the country. These organizations could serve as mentors to less-mature delivery organizations, to provide assistance in developing the learning system. One such mentor might be the Council of Accountable Physician Practices, which is a subsidiary of the American Group Practice Association and comprises some of the country's leading multispecialty group practices.

The CMS might give these mentoring organizations a bonus payment for providing technical assistance to selected organizations across the country for a defined period of time. The mentors would teach best practices in care management processes, practice redesign, development of effective teams, implementation of electronic health records, and other related skills.

The payment to the mentoring organization might be structured so that 50 percent of its bonus payment would be paid up front, with the remainder paid only if the recipient organization successfully implemented these best practices, meeting predetermined criteria for success. Examples could include implementing a patient reminder follow-up system for medication adherence for diabetic patients, a transitional care program from hospitals to primary care sites, and a patient self-management program.

SYSTEMATIC EVALUATION AND FEEDBACK To accelerate learning from and improvement of the ACO model and to help all ACOs learn from each other's experiences, their implementation should be systematically and comprehensively evaluated. The use of standard measures of cost and quality performance would provide one important source of data. But additional data will be needed on how electronic health records, care

management processes, quality improvement initiatives, and leadership training programs are implemented.

Data will also be needed about the local context within which each ACO operates, including the size of the market, the concentration of payers, and related factors. Only through such a comprehensive assessment will we be able to learn rapidly from the successes and failures and maximize the probability that the program as a whole will succeed.

CONCLUSION The CMS should emphasize innovations in both payment and practice models,

which must evolve within the context of the learning system. There are many challenges to the development and implementation of accountable care organizations beyond those discussed, such as legal and regulatory barriers.²⁰ But the CMS's actions can dramatically increase the chances of success for these organizations. As discussed, actions by the CMS should include recognizing the need for different models of ACOs adapted to local circumstances, having different levels of qualification appropriately matched with different payment models, and developing an associated system for learning. ■

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NOTES

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