

Discussion Paper

Sustainable Success in Accountable Care

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April 21, 2016



NATIONAL ACADEMY OF MEDICINE

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ACKNOWLEDGMENTS

The authors are particularly grateful for the writing and editing contributions offered by Mina Bakhtiar and Katherine Burns.

The authors were assisted in their efforts by the following individuals:

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Accountable care organizations

The fragmented nature of the delivery and financing of health care in the United States, coupled with misdirected incentives dominating the payment structure, has driven national expenditures to be the highest in the world for health outcomes that are, at best, on par with the rest of the developed world. The Affordable Care Act of 2010 envisions a sustainable future by promoting health care delivery models that foster more efficient and effective health care services for both individuals and communities. As innovative models with the potential to contribute directly to lowering costs and improving outcomes, accountable care organizations (ACOs) present encouraging potential for leading the charge to redesign our health system. ACOs have become the programmatic and conceptual framework that is the centerpiece of moving our health care system from volume to value. Yet, with significant organizational, economic, legal, political, cultural, and conceptual challenges facing the formation and sustainable success of ACOs, the task remains formidable.

Projections suggest an increase in health care spending of, on average, 5.8 percent per year each year through 2024 without a comparable level of quality improvement. However, the impressive growth of the accountable care movement in the past few years presents potential for progress. The number of participating organizations nearly doubled in 2013 alone, and, as of March 2015, 744 participants have been identified, providing coverage to over 23 million Americans. ACOs have been established through a diversity of arrangements, with 54 percent under government contracts, 29 percent under commercial contracts, and 14 percent under a combination of government and commercial contracts (Tu et al. 2015).

In 2013 participation was dominated by larger practices, with 43 percent of ACOs formed by physician groups, 39 percent by hospital systems, 9 percent by insurance providers, and 9 percent by other health care delivery organizations (Muhlestein 2014). In early 2015, 89 providers became ACOs under the Medicare Shared Savings Program (MSSP) (Muhlestein 2015).

Reports from the first two years of spending for both public and private ACOs support the potential for the ACO model to achieve the Triple Aim of better quality care, improved patient centered outcomes, and lower costs. Assessments of the third performance year of the Pioneer ACO model report total model savings of \$120 million—and \$82 million in shared savings, along with improved quality in 28 of 33 benchmarks reported (CMS August 2015). The Pioneer year-two quality performance results showed a 19 percent increase in performance on mean

quality scores—with improved results on 28 of 33 quality measures within the past year alone. The second year financial performance results found that collectively, the Pioneer and Medicare Shared Savings models saved \$372 million in programmatic spending and qualified for \$445 million in shared savings payments. Additionally, many of the commercial, payer-led ACOs are reporting success in their first phases of implementation. In January 2016, the Center for Medicare and Medicaid Services (CMS) announced 21 ACOs to participate in the Next Generation Model. Among these ACOs are former MSSP and Pioneer participants, as well as several organizations that have not previously participated in Medicare ACO programs (ACLC 2016).

These early reports are positive, yet significant uncertainty and variability remains surrounding the specific programmatic characteristics, methods of implementation, and measurement and metrics for success of the model. The positive news is encouraging, but sufficient evidence is still to be developed demonstrating the long-term potential and sustainability of the accountable care model. The largely uneven development of ACOs thus far provides evidence for this concern. While ACOs now collectively provide coverage to approximately 23.5 million Americans, most have developed in high-cost, affluent areas with stable, high-quality care, allowing for a smooth transition to the ACO model (Peterson et al. 2014). Largely, urban health systems are better positioned to launch these new models of care delivery due in part to the high amount of capital and sophisticated infrastructure and technology required to start and sustain an ACO.

Furthermore, identifying best practices has been difficult thus far given the mixed results reported by ACOs on an individual level. Thirteen of the ACOs participating in the CMS Pioneer ACO Model program did not demonstrate statistically significant savings in total Medicare spending for the first year in comparison to their local fee-for-service (FFS) markets. In the second performance year, 21 of the participant ACOs did not demonstrate significant savings (Green et al. 2015).

In addition, 13 of the participating ACOs have withdrawn from the Pioneer program. Eleven of the withdrawing Pioneer ACOs were providers who have reported not having benefitted from the partnership as anticipated, particularly considering their strong position and promise when entering the program (Beck 2014). Eight Pioneer ACOs achieved an estimated \$155.4 million in savings for total Medicare spending within the first year. Yet, these ACOs were diverse and incomparable in terms of geographic location, size, organizational structure, and average Medicare spending in their local markets. As these examples illustrate, diversity complicates the ability to determine a readiness assessment and strategy for transitioning to a value-based model of care. However, they also show the potential for the ACO model to work in various settings across the nation.

The MSSP, the other ACO program run by CMS, reports similar performance results. In 2014, 27 percent of participating ACOs met the standard to qualify for shared savings necessary to earn bonuses (CMS August 2015). Yet, enrollment in the program continues to grow, with 405 ACOs participating in the Shared Savings Program as of December 2014, and CMS has committed to continuous evaluation and modification of the program to ensure its sustainability (Cavanaugh 2014).

While private ACOs show promise for improved outcomes at lower cost, best practices and assessments of outcomes likewise remain scarce. The diverse spectrum of accountable care and value-based payment models that currently exist makes it difficult for those looking to redesign their system to find a clear roadmap to follow. Assessing the reported results and identifying best practices from payer-led ACOs will be even more difficult given the lack of standardization and transparency of results within the private sector.

Despite the uneven productivity of ACOs to achieve their goals in the early years of implementation, the long-term vision is compelling. The proposed redesign of the CMS Shared Savings Program echoes this point. Performance results from the first two years and feedback from participants suggest that the program's sustainability will require CMS to reassess the risk requirement and high standard of savings imposed on ACOs within the first few years of operation (Cavanaugh 2014). The mission of ACOs is to generate sustained long-term savings, rather than high short-term savings. Given the significant investment that will be required to make this transformation in care delivery, careful assessment of the financial, quality, and patient experience performance measures for both public and private ACOs is required. The importance and magnitude of the investment needed to achieve a continuously learning health system must be fully understood, and more conversation is needed on the sufficiency of the financial support and incentives in the current policy and economic environment in achieving full maturation of population-based payment models.

The Affordable Care Act provides a high-level outline of payment reform and capitation model for ACOs, yet what remains unspecified and largely unknown are the investments and the timeline required for implementing the necessary cultural, structural, and financial changes to successfully transition to value-based payment. Ongoing investment is needed to successfully and sustainably convert the health financing system to the ACO model. However, without a clear roadmap of how, when, and at what scale these investments should be made, organizations risk exhausting their capital before completing the transformation. There is material risk that operational cash flow and savings may not be sufficient to sustain these models once they are fully functioning. A longer-term strategy is required to ensure the sustainable success of ACOs to lead the way to a continuously learning health system.

Given the magnitude of uncertainty and the severity of its implications for the future of our health care system, we have come together to offer insights gleaned from our work in launching accountable care organizations both to highlight the most pressing issues that need to be addressed and to provide a framework for navigating the transformation to pay-for-performance and value-based care. Using the experiences at our own organizations, we have identified the core elements required to successfully and sustainably transition to the ACO model: governance, leadership, medical management infrastructure (especially if scaled on an HMO/full-risk foundation), technology, administrative infrastructure/execution-oriented design, patient engagement, core operating principles, and a financial structure and incentives framework. While substantial work has been done to outline the guiding principles for programmatic and cultural transformation to the ACO model, little is understood or discussed surrounding the business case and financial investment needed for a complete transition (Fuchs and Schaeffer 2012; Shortell et al. 2013). This Discussion Paper seeks to complement and build on these conversations by

providing a roadmap for the business model transition and ongoing investments necessary to sustain better care and health outcomes at lower cost.

Orientation to sustainability from the outset

The complexity of the ACO arrangement with either a public or private payer cannot be understated. Despite the acknowledgment that these partnerships require substantial investment, currently no uniform, agreed-upon framework exists to outline the initial entry into this new model of care delivery. The impulse for many organizations entering into this new arrangement is to approach the initial efforts with a project orientation. Such an approach is problematic because of the significant differences that exist between a project-oriented mentality and a baseline understanding of the business and investment strategies required for long-term success and sustainability.

Often, when designing the implementation strategy from a project-oriented mindset, the timeline and resources are aligned to match the initial ACO measurements and incentives structure. Yet, if accountable care organizations are to succeed long term, their infrastructure, financial model, and benchmark metrics must also be set with a long-term perspective. Business models must be structured from the very beginning to be adaptive and adjustable. In order to ensure this, a dramatically different mindset must be applied to the forming of these arrangements. One of the most fundamental issues for delivery systems will be the proper sequencing and management around the assumption of financial risk. With the boom in the accountable care movement, hospitals and some physicians are taking on the roles of insurers and insurers are taking on roles as care deliverers. As roles and responsibilities continue to shift, what must be made clear is the need for well-developed tools and capabilities to understand and manage the financial risk associated with these new payment structures.

When specifying the financial partnership, stakeholders must have the long view for success, rather than driving near-term savings. Stakeholders need to recognize that accountable care organizations are meant to transform not only care delivery models but also management models, and changing culture and operational protocols within an ACO model takes profound effort over time. Rather than focusing on initial incentives and targets, we argue that a more practical and sustainable strategy is needed, using the core elements of governance, leadership, technology, administrative infrastructure, core operating principles, financial structure, and incentives framework to frame the arrangement.

Governance

Health care organizations must adapt existing governance arrangements for the new care delivery environment. Historically, hospitals and health systems use the “organized medical staff” as a governance arrangement. This structure has typically focused on quality of care and facility access rather than on the imperatives needed to simultaneously improve quality, control costs, and enhance the patient experience. As health systems take on new accountabilities and associated risks to achieve the Triple Aim, governance arrangements will need to be integrated on a systems level, which requires moving away from the current structure of using councils and committees.

The ultimate goal of the ACO movement is to facilitate the re-creation of the health care delivery system, beginning with the clinical perspective, and, as such, the composition of the governing body must include a large contingent of committed providers, supplemented by seasoned health care administrative and financial leaders. These leaders must adopt a stance of ownership. The enterprise will succeed or fail to the degree that they reflect strong alignment on the changes necessary and use their formal and informal power to achieve a transformed organization. Leader development also requires commitment to ongoing education, with the goals of enlarging personal leadership capacity, learning the core elements of governance, and understanding the intricacies of leading a managed care enterprise. Performance should be centered in the core values, mission, and strategic objectives of the organization and measured by key performance targets embraced by all involved.

Leadership

For many of the same reasons, leadership roles, scope, and function will need to evolve for sustainable ACO success. It cannot be underscored enough that transformation to the accountable care model is a transformation in health care's management system. Leaders will need to be adaptive and action oriented in order to successfully guide the development of their ACO. A conceptual framework for adaptive leadership worth considering is that leaders cannot supply all the answers and mandate providers and their staff into compliance. Rather, the role of leadership is to create a safe "holding environment" in which competing cultural paradigms, old and new, can be carefully examined and new behavioral expectations can be explored (Heifetz 1998). What is needed is a core group of senior-level leaders with a shared commitment to the goals of the Triple Aim and the skills needed to engage providers in these adaptive conversations. The ensuing dialogue should provide insight into both the individual and the collective change capacity within the organization as well as the likely "velocity" of that change.

This emphasis on the need for ACO leaders to drive action at a pace consistent with the performance measurement timeframe particularly requires strong physician leadership. While the concept of physician leadership is widely acknowledged, less discussed is the need for flexibility in that leadership role. One example of this principle is seen in many health systems' search for senior physician leaders to advance their population health strategy. Descriptions of these positions often lack a clearly defined scope in terms of both the role and its relation to legacy business and clinical leaders. The transformation requires a combination of soft skills, such as influence, trustworthiness, and change management, and hard skills, such as financial acumen, organization redesign, and clinical program development and management.

Technology

Substantial investment in the development and continuous refinement of the underlying technology is required for sustainable ACO success. Basic analytic and reporting capability—table stakes for ACO formation—will need to evolve. ACOs require technology to turn data into knowledge and knowledge into action for both individuals and populations. Existing electronic health record (EHR) systems are largely designed for data capture and reporting in a volume-driven, fee-for-service environment. Current incentives drive EHR vendors to focus on

highlighting their return on investment from enhanced revenue generation rather than developing functionality for real-time, meaningful data collection that would help foster a continuously learning health system. ACOs will need to build their data infrastructure around predictive analytics that will allow them to identify, analyze, and reduce system “leakage” of accountable members; normalize and present actionable information to clinicians, care managers, and other health professionals working on population health; and perform data mining for unexpected variation and changes in trends for quality measurement and reporting. Such data can and should be used to identify promising opportunities for improvement within the ACOs’ specific populations, initially and through their maturation, making the ability to capture and analyze these data fundamental to the sustainable success of ACOs.

Administrative infrastructure

In a volume-driven world, the billable visit has been the coin of the realm. Many administrative processes are organized around both visit volume and revenue optimization. Although this need continues, it will have to be balanced by the competing need for new infrastructure that adapts to a population-driven care model. Certain systems have led the way, deploying secure messaging, group visits, patient portals, and three-way videoconferencing between the primary care physician, specialist, and patient. Yet infrastructure development is still significantly lacking in its ability to capture patient experience and patient-reported outcomes. For ACOs to be successful, their administrations will need to learn how to shift their systems so that they are able to better understand and improve the experience of their patients and populations.

Core operating principles

The basic core operating principles of the health care enterprise will have to evolve and become aligned with sustainable improvement in both individual and population health. While nearly every care delivery system has a mission of improving the health of the patient population and the surrounding community, the structure of accountable care organizations places a different significance and responsibility on this mission. ACOs must move away from specialty services and procedures toward a more effective primary care and preventive care model that improves health outside of a hospital setting. Given that fee for service will continue to be a prominent payment mechanism for some time, ACOs must manage a degree of organizational chaos, operating in two financial reimbursement worlds. To help navigate this chaos, ACO leadership must ensure the culture and core operating principles emphasize rewarding appropriate use and reducing overuse. The new paradigm is one in which revenue optimization and waste reduction will represent a transitional state on the way to full systems of value-based payment. This is as important as any challenge to the ACO model and leadership that can communicate how to navigate this challenge is a key to sustainability.

Financial structure and incentives

Aligning key performance indicators that measure and assess sustainability with the financial structure and incentive framework is vital. Determining whether to directly invest in ACOs as a lead actor or as a part of a joint venture is a key issue faced by many current systems. In order to determine the structure of capitalization and revenue flows for their ACOs, stakeholders must

ensure legacy incentive frameworks evolve to appropriately balance and manage productivity, quality, cost, and patient experience. Looking at leading organizations' actual experience in this regard is instructive.

Business and investment models

Given that the journey to accountable care within a population health context remains relatively early in the process, it is not surprising that, even within the framing context of these core operational and cultural elements, significant variation exists. Yet, even in this period of experimentation, we acknowledge that the core financial and business model is primarily driven by the entity or entities responsible for the risk. Using our collective experience leading ACOs operating in a variety of contexts, we have identified certain fundamental design elements, business models, and investment best practices. We use the following sections of this paper to showcase several approaches to specifying the financial model strategies and structural requirements for implementation of a sustainable ACO.

The models

To discuss the elements critical to forming a sustainable business and investment model for an ACO, highlighted below are the key elements and experiences of three of the longest operating ACOs in the nation: California Public Employees Retirement System (CalPERS), Essence Health Medical Advantage (MA), and Premier Partnership for Care Transformation (PACT) collaboratives. In particular, we focus on the financial model assumptions, strategies, and tools that were implemented in the initial years of operation and the lessons learned as the ACOs matured. While these three ACOs developed out of a variety of circumstances, with different resources available, and out of different environments, the best practices and lessons learned highlighted below have been identified for their applicability and feasibility broadly.

Negotiations to form the CalPERS ACO began between Blue Shield of California (BSC), Hill Physicians Medical Group, and Dignity Health in 2008 before the term ACO was popular. BSC and the two providers came together to address the growing concern over the projected premium trends for the CalPERS population in the Sacramento region of California. After two years of negotiating the fundamental financial and cross-organizational structure, the ACO opened on January 1, 2010. CalPERS operates as one of the longest running and largest commercial ACOs in the nation, with an approximate membership of 42,000 people as reported in 2014 (Melnick and Green, 2014).

In the St. Louis, Missouri area, the Essence Healthcare (EH) plan was formed over ten years ago by local physicians. The physicians came together to create a health coverage plan to ensure Medicare patients in their area could receive high-quality care. Essence Healthcare has a current membership of approximately 50,000 Medicare patients in Missouri and southern Illinois (Anderson 2015). Essence Healthcare reports reducing fee-for-service Medicare costs by 30 percent (Leventhal 2014).

A group of thirty health care systems has successfully implemented ACO delivery models in a variety of market settings through the Premier's Partnership for Care

Transformation (PACT Population Health Collaboratives). The first step for each health system has been to create a legal entity from which to align the continuum of care, such as a clinically integrated network (CIN) model, always with the fundamental strategy of achieving the Triple Aim.

Partners invested for the long term

Long-term commitment is a key attribute for the success of ACOs, if they are meant to be the cornerstone of a new care delivery system. The mission of this new model is to provide a long-term solution to achieving better quality health at lower cost for all Americans. The changes required must be disruptive yet sustainable. Especially given the resistance of some players in the health care sector, all organizations and actors who are beginning the transition to an ACO model must recognize that this shift requires embracing the initial and ongoing commitment and investment. This commitment requires more than a simple declaration. It develops from a shared purpose among the partners, clinically related and financially in partnership, and often it is born out of a desire both to provide better care and to fight external competition.

For the CalPERS ACO, in addition to facing an unsustainable cost trend, the three organizations individually faced strong competition from a fully integrated competitor, Kaiser Permanente. The stakeholders recognized that only collectively would they be able to compete with Kaiser and that, even with their partnership, the process of strengthening their share of the market would take years given Kaiser's long-term investment in building its market strength. Thus, the organizations devised a contract that involved a joint multiyear commitment to a global budget designed to keep the medical cost trend for the ACO population flat for the first year and to mitigate it by at least 50 percent long term. Along with the "sweat equity" that each organization brought to the table, they agreed to a collective contribution of approximately \$1 million dollars each year to cover additional resources, largely clinical, that were essential in meeting the ACO's aggressive goals. While most of the resources were allocated to Hill Physicians, the three ACO partners shared in these expenses equally.

In the case of the Essence Healthcare MA plan, the core group of founding primary care physicians were motivated to implement their vision of collaborative payment for value-based care (Leventhal 2014). The physicians sought to have a strong leadership role in patient-focused care coordination in the context of population management, and they were driven by the significant salary gap between themselves and other physicians treating the Medicare patient population in their area. However, the independent primary care physicians who formed Essence Healthcare did not have the capital required to build a collaborative MA health plan, considering the significant capital reserve requirements and operational cost structure needed. Instead, they turned to investors to start a plan that met all of CMS' enterprise requirements.

To harness a long-term commitment, members of the Premier PACT Population Health Collaborative have contracted with multiple payers and market segments for shared savings-type models. In order to support long-term sustainability, it was believed that multiple payers and partners would be required when moving to a new delivery and

payment model. Thus, to assist with this transformation, PACT Collaborative members have coalesced around the implementation of a common accountable care model that includes the following key components: health home, high-value network of non-primary care providers (PCPs), people-centered foundation, population health data management, sophisticated general management and leadership, and a close payer partnership. (As an example, AtlantiCare, an integrated delivery system in southern New Jersey, has entered into an ACO model with the UNITE HERE Local 54 Casino workers union.)

Determining the capital support structure

Due to the costs associated with creating the infrastructures necessary for the delivery of coordinated care, a sustainable financial model must provide adequate financial incentives to fund the buildout of key infrastructure such as the medical home, the information technology (IT) assets required for interoperability between systems, care management systems, and much more. Often, this requires an up-front payment to encourage investment in the necessary management changes as well as shared savings to incentivize providers to continue in the model long term. Payment policies need to reflect this reality.

For both the CalPERS ACO and the Essence Healthcare MA plan, the development and implementation of the new governance, leadership, core operating principles, and financial and incentive framework were primarily funded through initial financial contributions by payers and providers to drive the necessary initial and ongoing work of being an ACO. (In the case of EH, outside investment supplemented funding.)

For the Premier PACT Collaborative members, in addition to FFS payments, CINs often contract directly with payers or employers for services that include fees for care management in patient-centered medical homes, transformational funding to support care management and information technology, pay-for-performance incentives in order to meet targets for quality and performance, and shared savings, which are gained from reducing the cost trend distributed to physicians. Experience shows that the CIN should involve PCPs, specialty care physicians, and the hospital. Other services, such as home care, skilled nursing, and rehabilitation, can be included through cooperative partnerships or contractual arrangements. The ability to develop single-signature contractual arrangements with government and private health plans is a distinct advantage of a CIN.

Quality and financial goals that drive continuous improvement

Despite the different types of structural organizations, and motivations for their creation, ACOs must share a common partner rationale that provides significant alignment, focus, and, ultimately, results. Frequently, and in the case for the CalPERS and Essence Healthcare ACOs, their arrangements form global budgets with shared upside and downside risk. Given the early stages of development for this new model of care, best practices for accepting and assigning risk remain a work in progress. However, what is clear is the need for specific well-understood quality and financial goals that naturally drive continuous improvement within all partner organizations from the outset. This continuous improvement can be seen in a variety of forms: through people- and technology-enabled process streamlining; program-driven case

management; incentive maximization and penalty minimization through MA-enhanced encounters and readmissions; and value-based care decisions through shared decision making. ACO partners need to understand the strategic need to welcome new options of how care delivery is structured and implemented. They must take proactive, measured steps toward addressing institutional core structures.

Members of the PACT Collaborative fully understand the need to continuously drive improvements within their ACOs in terms of quality, patient experience, and costs. To facilitate this improvement cycle, members of the Collaborative have begun utilizing an advanced data analytics program. This analytics program allows the Collaborative to compare performance on a large common set of measures, and to use the data to identify, share, and implement best practices, and then to use a data-driven approach to track progress to improvement. By optimizing patients' experiences as they move across the continuum of care, the ACOs intend to be a continuously learning system that constantly improves outcomes.

Active communication and transparency

Within an accountable care global budget with shared upside and downside risk, the most fundamental element is contractual responsibility for financial transparency. Transparency of data is a necessary condition for ACOs to be successful in managing their population. Total flows and buckets of expenses must be clearly defined and any clinical and payment data generated related to patient care services must be made available as soon as possible to ACO partners. This information transparency allows for downstream care decisions to be made as effectively and efficiently as possible. Such a process will allow for preservation or increase in the collectively shared savings pool and will foster an accountable care ecosystem that directly impacts the success and sustainability of the financial model.

As previously discussed, ACOs require strong governance capability. Transparent, frequent communication can build that support. Beyond specific operational, patient care-related financial and clinical data communications, communicating specific quality and cost goals as well as the analytics that report progress toward those goals helps to identify and develop interventions for negative variance areas at physician, location, organization, and overall levels. This infrastructure capacity allows ACOs to react to results in real time and rapidly evolve their organization toward best practice management and outcomes.

Implementing the transition

As stated earlier, the move to value-based accountable care is a journey from the current landscape in which fee for service remains the dominant payment mechanism. In order to grow the ACO market footprint, a deliberate approach needs to be undertaken that allows for the interested entities to demonstrate their measured and value-based risk profile and readiness in terms of culture, process, and technology before beginning the transition. That said, the transition is none the less daunting.

Shifting from FFS to value-based payments

Until FFS gives way as the dominant payment mechanism, entities involved in accountable care will need to operate with both the FFS environment and the value-based environment. Requiring entities to have one foot in both worlds is incredibly frustrating and adds a significant challenge to determining how much and when to invest in their ACO. Because the national environment currently poses a significant counterweight, entities must fully understand how well positioned they are to make the transition. Once they understand what “low-hanging fruit” exists and where their weaknesses are, they then can better design a risk profile and financial incentives that will set them up for success both in the first few years as well as in the long term.

At Essence Healthcare, when a new independent provider entity—usually a PCP-dominated independent practice association (IPA) or hospital-owned PCP group—communicates an intention to join the accountable care MA plan, an advisory team works with them to complete a risk readiness assessment. This assessment allows for the creation of a customized plan to take advantage of any existing pay-for-performance programs while outlining a one- to two-year roadmap for incorporating shared upside/downside risk into their practice. The plan addresses the readiness gaps which could include items such as focused quality measure improvement, physician-level incentives driving compensation, and transition from a FFS physician care team to a population-based care team.

Though not in the CalPERS ACO, in other Blue Shield of California ACO collaboratives the hospitals use the ACO program as a “glide path” toward compensation models, including capitation, reflecting increasing degrees of financial risk.

Taking on too much risk prior to being prepared has been a concern for the PACT Collaborative members. Due to this, many have utilized upside-risk-only models to allow for the opportunity to develop infrastructure and to gain experience managing the health of a population and risk prior to moving to a two-sided model.

Identifying inefficiencies and waste

The push to move care outside of the hospital to the population and community level stems from the exceedingly high costs unnecessarily generated when the hospital setting serves as the focus of care delivery. Thus, when first looking to identify areas of waste and care improvement, most ACOs look to the institutional setting. Again, performing a readiness assessment before beginning the transition will help entities identify the easy wins before moving on to more challenging goals.

As these initial areas of waste are eliminated, the ACO will need to be able to shift its improvement efforts and initiatives to the more complex or difficult-to-address areas of waste. To aid in this process of continuous improvement, another common best practice has been to create baseline metrics and set realistic quality and cost goals. Once these goals are achieved, these high-performing ACOs then reset the goals with a potentially different mix of metrics, depending on an overall assessment of current performance as opposed to waiting for the annual—or longer—contracting cycle.

The CalPERS ACO focused first on eliminating waste within the hospital process before looking into the outpatient process of care delivery. They also began by using a nationally popular set of utilization management benchmarks, but transitioned to the more aggressive goal of achieving at least the risk-adjusted 88th percentile of the group being benchmarked.

In the case of Essence Healthcare, the PCPs targeted both hospital-associated waste and non-hospital-related waste. When their sickest patients do end up in the hospital, a number of physicians have returned to performing rounds themselves to ensure that the care provided in the hospital is both effective and efficient. Non-hospital-related waste reduction is accomplished by scrutinizing referral patterns from PCP to specialist and then redirecting patients to specialists who provide the same or better quality care at lower cost. Essence Healthcare providers use an analytics and point-of-care population management system to assess the quality and cost per patient of each of their referring specialists. The system aggregates claims, EHRs, lab, drug, and other data in a patient-centric manner to make this assessment.

Several Premier PACT Collaborative members have adopted criteria developed as a part of the Choosing Wisely campaign to eliminate waste. As an example, Rockford Health System has adopted the American College of Radiology guidance to reduce CT scans for children under the age of ten.

Engaging major cost drivers

Despite the variability of circumstances in which ACOs are created, there must always be an emphasis on profitability. As was the case with both CalPERS and Essence Healthcare, a meticulous analysis should be done for major cost drivers—such as hospital bed days and emergency department visits. Programs and policies to support improved value-based care are fundamental, with redesigned incentives forming the basis for provider choices which support effective and efficient use of resources. Organizations also must be aware that even with large accountable care populations—both CalPERS and Essence Healthcare serve over 40,000 members—a few high-cost cases can pose significant risk to the overall performance of the ACO. Particularly challenging are patients in the Neonatal Intensive Care Unit, patients with complex cancers, and patients with other conditions associated with end of life. In order to overcome the bearing of unpredictable adverse medical events or of complex patients, all parties involved in the ACO must be fully committed and engaged in the long-term mission and the continuous improvement efforts necessary to achieve it.

To mitigate the risk associated with high-cost, high-risk patients, Essence Healthcare and Blue Shield ensure that an important component of their contracts with providers is the existence and funding of stop-loss insurance. Equally important is the assurance that incentives and compensation at the physician level are not hurt by these complex cases. Defraying the costs of these cases results in a more secure financial structure.

Premier PACT Collaborative members have utilized care coordination of beneficiaries with multiple chronic conditions as a way to drive profitability. This care coordination

has worked to reduce both in-patient volume and post-acute care, particularly with skilled nursing facilities. As an example, Mosaic Life Care, a Collaborative member, identified post-acute care spending as a major driver of their ACO's costs. Mosaic worked with their post-acute care providers to establish a post-acute Advanced Practice Registered Nurse/Physician staffing model and protocols for discharge planning with care managers. This process has worked to reduce post-acute utilization by 30 percent.

Investing in the data infrastructure

The utility and necessity of having a strong data and technology infrastructure cannot be overemphasized. However, when bringing together several entities, all with their own data and IT systems, technology and interoperability can also be one of the initial barriers to smooth operations. The faster entities can develop and implement a common health information exchange, the sooner they will see improvements in the quality and efficiency of care. Having a common platform allows clinicians to access almost real-time information on their patients, which will facilitate the management of the ACO's population by allowing them to create action lists of patients needing clinical or care management interventions. Significant investment is needed to create such a platform but, even once created, implementation of a cross-organizational IT platform is often needlessly complicated by lack of standardization among health information technology (HIT) vendors. An integrated information system is crucial for long-term success (Robinson et al. 2014).

From the outset the CalPERS partners acknowledged the challenge of information sharing. Initially Blue Shield of California developed a series of financial and utilization dashboards from submitted claims and authorization data received from the other partners to give a picture of ACO performance. However, given the significant lag in data collection and analysis, it had limited operational use, forcing the partners to use a variety of piecemeal electronic and lower-technology strategies—including telephone and fax communications—to share real-time patient data. Combining hospital and medical group data from authorizations provided a timelier picture of utilization. Yet, given the persistence of issues and limitations in the ACO partners' ability to share information, Blue Shield of California announced in August of 2014 that it would invest \$35.6 million in the California Integrated Data Exchange (CalINDEX) to accelerate identical shared data among all participants to the health system. CalINDEX will facilitate the flow of clinical information between accountable care partners to support day-to-day coordination of care.

In the interim, the partners continue to improve the current data infrastructure. For Essence Healthcare, five years into the creation of the collaborative MA plan, the organization determined that they needed to develop technology to aggregate the necessary data to perform population management across disparate EHR systems and to integrate existing claims, labs, drugs, and other data. The PCPs knew that they needed analytics before and after the point of care as well as an aggregated, patient-centered view of their data that would best inform care decisions and improve quality and cost dimensions. Therefore, Essence Healthcare tapped into private investors who shared their vision for a transformed health and health care system. Over the last 10 years this has

amounted to well over \$100 million of investment toward more sophisticated data infrastructure.

PACT Collaborative members recognize that their ability to manage the health of their populations is tied very closely to the effectiveness of their data and IT infrastructure. This includes the utilization of a claims-based data analytics program, interoperable electronic health records, predictive modeling, and programs to assist with care management. Summa Health and Wellstar are two examples of organizations with robust IT systems utilized in qualifying for Medicare Shared Savings.

Sustainable model results to date

The CalPERS, Essence Healthcare, and Premier PACT ACOs best practices have been highlighted. Each has achieved savings and improved quality despite the challenges and uncertainties faced. In order to advocate for the core operating elements and financial model assumptions, strategies, and tools we have called out in this paper, we believe it is important to share the results of these two relatively mature accountable care models along key dimensions.

- **Longevity.** Both CalPERS and Essence Healthcare were envisioned and created before the term “accountable care” came into use, and both have been gaining strength and momentum over the five years of CalPERS’ existence and nine years of Essence Healthcare’s existence. Importantly, both entities have maintained essentially the same financial model since their inception. The PACT Collaborative has been used by its members to identify and quickly disperse best practices around cost and quality for several years. This collaborative methodology has allowed the member ACOs to learn from others and to incorporate a preferred operating model consistent with their specific environment. It must be expected, however, that any ACO will inevitably encounter challenging years (as the CalPERS ACO did in 2014). The ACO partners must be committed to the long term and must be prepared to aggressively and continually reevaluate which interventions are yielding results, which are not, and whether systemic deficiencies in infrastructure and/or resources are impeding performance.
- **Impact.** The impact of CalPERS and Essence Healthcare changed the way both partners and competitors plan and operate in their respective marketplaces. CalPERS is viewed as a model for other large private purchasers around the country to consider, and Essence Healthcare has become the number one MA plan in the St. Louis market in terms of size, quality, and patient and provider satisfaction. Premier’s large network of hospital relationships allows for a very broad dissemination of best practices nationally.
- **Cost improvement.** CalPERS ACO has reported gross savings over four years of \$105 million, with net savings to CalPERS of \$95 million—\$20 million distributed to the partners as shared savings incentives. This includes a case-adjusted reduction in inpatient days of 25 percent.
Essence Healthcare has seen a 30 percent cost reduction between its operating model and the unmanaged FFS Medicare control group, resulting in a medical loss ratio of 65

percent before shared savings distribution. These savings are in part driven by a 49 percent reduction in inpatient days and a 62 percent reduction in nursing facility days.

- **Quality improvement.** One of the core operating principles of each of the cases cited is to create any cost savings subject to achieving quality goals. Essence Healthcare, after maintaining a 4.5-star MA plan rating for the last three years, was able to recently score an elite 5-star rating (Anderson 2015). All of the ten independent provider groups under contract have improved their overall quality scores every year since joining. Hill Physicians Medical Group was already a top-performing medical group under California's commercial pay-for-performance program managed by the Integrated Healthcare Association and funded by a consortium of payers, including Blue Shield of California. Hill Physicians Medical Group has been able to maintain their high level of quality performance in the CalPERS ACO population and has been working with Blue Shield of California to develop programs that address quality concerns beyond the clinical process measures which comprise pay for performance. Palliative care and physician access are key areas of improvement.
- **Extensibility.** Blue Shield of California is using the learnings from the CalPERS initiative in its twenty-five other commercial ACOs. Essence Healthcare's population health and accountable management platform is now being offered by the affiliate entity Lumeris and is used across the country to cover millions of MA, MSSP, and commercial lives. Similarly, PACT has touched hundreds of its partners in their evaluation of how to move from volume to value.

Cultural and structural prerequisites

Specifying the financial model for success is essential to ACO sustainability. Yet, building on this foundation will require a different kind of care environment—one that can only be created by making significant changes to the culture and structure of our current delivery models.

Population- and systems-oriented providers

Before considering the structural requirements of successful ACO implementation and development, one must start by understanding the cultural shifts that we are asking providers to make. Successful physicians do not consider themselves “unaccountable.” Primary care providers take pride in practicing high-quality, cost-effective medicine in a customer-friendly manner. Similarly, most specialists would suggest excellent outcomes accompanied by a great patient experience. However, there is little definitive information to support these assertions in our current fee-for-service payment model.

The current system with its associated lack of system-wide financial alignment is partially to blame for the disconnect that has occurred. Another key contributor is the large cultural shift we are asking our providers to make, with very little guidance or support. Providers are now being required to seek out patients rather than to provide high-quality care to those who choose to seek care. Furthermore, local reputation is no longer sufficient proxy for quality care. By dispelling these anecdotal perspectives, the provider culture must shift from being individualistic to

embracing a larger, more articulated “community” of providers willing to hold each other accountable to improve the health and well-being of a defined population.

The burden and responsibility of this initial change in culture falls on ACO leaders to provide the appropriate opportunity for additional providers to engage in and experience the culture shift in a tangible way. Governance board-chartered committees can effectively serve as working venues to help providers to define what tools they will need to achieve improved metrics on quality and resource use. Driven in large part by physician leaders, these efforts will require willing collaboration toward defined goals.

The twenty members of the Rainier Washington ACO Quality of Care Committee engaged in a nominal group exercise to identify seventeen far-ranging clinical initiatives designed to capture the energy inherent in the group. These projects ranged from more traditional efforts around chronic care improvement and management of the MSSP quality metrics to an emerging partnership with several local fire districts to help identify high-risk seniors and the implementation of the Perioperative Surgical Home model within its partner hospitals. Simultaneously, its contracting committee is actively engaging local payers, and the finance committee is developing a sustainable ACO budget and financial incentive model to reward superior provider performance.

Care organizations employing systems strategies

Hospital ACO partners have their own challenges with their cultures. Hospital and health systems cultural bias often demands the delivery of greater volumes of quality service. Yet, they are now being asked to move away from operating as the centerpiece of a community’s care delivery system, driven by revenue generation and market share pursuits. Instead, hospitals must redefine their role as a highly valued high-tech ACO provider accessed only by the most critically ill or injured. This remodeling will demand intentional and disruptive reengineering as hospitals make the transformation to that of a cost center within the managed care construct of the ACO.

The cultural shift for physicians in the clinic is equally difficult. In this setting, the pressures of a production-oriented style of practice can quickly overwhelm attempts to reengineer care delivery processes. Smaller practices often struggle to adopt new technologies and workflow models because of the resource constraints. Staffing may be limited to only the essential personnel necessary for providing patient care services, or the clinic and its providers may have limited experience with systematic performance improvement models. Consequently, the rate of change that is currently required becomes overwhelming, and providers disengage from the initiative, considering it yet another unfunded mandate. ACO leaders must acknowledge these barriers and support their frontline providers by implementing strategies and incentives for fostering and facilitating practice engagement. Further, their example will send an implicit message regarding the continuity and depth of the new cultural expectations.

The Rainier ACO approach to practice engagement has focused on three key areas to encourage practice transformational activities, namely, (1) deployment of tools and technology, (2) leveraging performance reports, and (3) financial incentives. As a

provider organization, it operates from the philosophical perspective that providers cannot be asked to make changes without being provided the tools and support to successfully achieve those changes. Second, the focus on changes is structured to allow individual providers to be more successful in terms of both clinical care and administrative efficiency. For instance, the Rainier ACO has implemented a web-based care coordination and referral management platform designed to reduce the administrative burden involving clinical document management and insurance processing while also enhancing the clinical conversation among providers working together on behalf of common patients. It is approaching quality metrics management in a similar fashion by aligning workflow with an analytics system to effectively address patient gaps in care. Finally, it is working to develop supplemental reimbursement at the practice level to help defray the costs of ACO engagement. In the end, the goal is to experience the iterative nature of gaining insight and changing behavior.

Culture of health engagement

The impact of an emerging group of ACO leaders will be short lived unless a culture shift also occurs on a national level and payment mechanisms are rapidly realigned to achieve the stated goals of improving system performance to enhance the value of care. Our society has not invested nearly enough in community health and ambulatory delivery systems from which most people receive the majority of their care. The collective demand for acute care services supported by fee-for-service payments rather than the promotion of prevention, healthy lifestyles, and financial stewardship further exacerbates the situation. Reversing history and deeply ingrained behaviors will be nearly impossible until payment systems become fully aligned to reward the Triple Aim goals across all segments of the delivery system.

Involving patients and the public is crucial to the sustainability of these cultural and structural shifts. The pursuit of health and wellness needs to become the societal norm. High-deductible health plans are forcing patients to become more informed consumers of health care services. With efforts such as the Choosing Wisely campaign, providers, patients, community leaders, and policy makers alike have an opportunity to learn and experience new approaches to shared decision making and resource stewardship. We must together redefine what it means to seek the best care to include quality and cost performance, clinical efficacy, and impact on quality of life. The ACO model envisions designing all components from a people-centric perspective, which entails the utilization of activities that will ensure better engagement, activation, satisfaction, and increased self-accountability for health. ACO leaders must be ready to take the lead in fostering community conversations focused on these issues.

Summary

This Discussion Paper has drawn upon ACO case studies and our expertise to illustrate the challenges that must be met to achieve continuous improvement in ACO quality of care and cost. Early results coming from ACOs have demonstrated the ability of these care delivery models to deliver significant improvements in care while reducing the costs of delivering that care. Our

case studies show the potential for provider and payer entities to more effectively pursue the Triple Aim when assuming partial or full risk for the management of a specific population.

Analysis of financial and quality performance measures released by CMS underscores the need for greater clarity on performance and the requirements to obtain the next level of achievement and organizational stability. The case studies and opportunities discussed have also highlighted the remaining key challenges that threaten and complicate the path to a sustainable ACO business model, from which important lessons can be drawn to help further define the long-term maturation of ACOs.

First, the business model must account for the personal, technical, and financial investments necessary. It is not uncommon for organizations to underestimate the level of investment—both financial and otherwise—needed to make this transition. Thus, leadership is critical. Effective clinical leadership, in particular, is the *sine qua non* of a successful ACO and experienced, strong clinical leaders that understand what it takes to transform a provider culture are in short supply. Second, the goals of the ACO must be clearly defined from the outset in order to empower clinicians to be leaders in promoting this shared vision. Third, and finally, the matrix of effective governance must be clearly understood, which requires actionable analytics produced through technological integration, proper alignment of incentives to drive behavior, and the necessary investments to reorganize clinical practice. The challenge of doing all of this simultaneously is significant. The improvement in efficiency and patient-centered outcomes generates real optimism in creating a sustainably humane health care system.

Once organizational alignment and leadership are addressed, sustainability rests on resources available through an adequate funding model. There are several models operational today in the commercial ACO environment: (1) often self-funding by the partners, which means health plan and/or provider partners make a meaningful initial investment to jump-start the organization; (2) public-sector (e.g., Coordinated Care Organizations or Center for Medicare and Medicaid Innovation [CMMI]) sources; or (3) occasionally providers and plans looking to third-party private investors who are aligned with the strategy and leadership of the ACO.

None of these approaches is inherently more successful than the others. In order to be sustainable long term, the payment model employed must include the strategies and tools discussed in this paper, with significant emphasis placed on at least two important factors: the funding to build key infrastructure and a method for rewarding gains in quality, patient experience, and cost reduction. As previously highlighted, necessary infrastructure importantly includes meaningful IT investments in all areas of care delivery and administration.

There does seem to be justification to look to additional government engagement—primarily from CMS and its CMMI. CMS, in particular, has promoted the success of value-based payment as an essential step in transitioning from the FFS environment in which our care delivery system predominantly operates. The commercial ACO represents the most complete value payment construct yet initiated to move from volume to value. Given that, we suggest increasing the funding to Pioneer, MSSP, and Next Generation programs as well as to look into testing commercial applications—perhaps with large employers who believe that commercial ACOs are an important network innovation.

To genuinely move the needle in this transition, government and commercial population health management innovations are likely to require further resources—if not in the form of up-front capital, increased financial incentives for providers that are sufficient to run an ACO practice. The greater the risk apportioned to providers, the greater the financial reward for achieving quality, cost, and service metrics should be. In short, moving from the dominant FFS model to more rational and effective payment mechanisms that improve care requires meaningful financial and policy support from the public sector.

The dichotomy in care delivery caused by and arising from conflicting payment methodologies continues to be a key obstacle to ACO long-term success. Practicing care sometimes to maximize revenue and in others to enhance the overall value of care is untenable as a long-term strategy and frustrating in the short term. For providers to optimize care delivery, a tipping point must be reached to allow them to focus on value. Greater public and private investment focused on keeping people healthy can accelerate this process, as could policies that maximize and maintain the long-term health of the population. Financial or other incentives that encourage patients to remain in the ACO over time will reassure providers that their patients will stay in their network and that their investments in care management will have a human and financial return on investment. Continuity in a population further rationalizes investment in preventive services that support population health. This support and acceleration of reform will be crucial to ensuring fixed payment models become the dominant paradigm.

Finally, health policy also needs to reflect the increased demands that entities face to sustain ACOs. Given that coordinating care efficiently across the continuum is an information-intensive activity, consideration of policies promoting the exchange of information via an Application Programming Interface (API) needs to be given. One of the greatest hurdles to coordinated care among providers is the inability to exchange patient information contained in EHRs and other health information technologies. Each EHR vendor has proprietary software that organizes data into a format in a slightly different way, using somewhat different protocols. To date, the EHR and HIT vendors have employed a business model that restricts the flow of information by making it extremely difficult to extract patient information, as well as other valuable information. Recent surveys of ACO leaders suggest that they are increasingly concerned with the “lack of interoperability and workflow integration” of their systems (Premier, Inc. 2014). Moreover, 76 percent report no interface with Health Information Exchanges (HIEs). Nationwide, HIEs are under development, yet many barriers still exist that hamper their effective use. Meaningful use and the associated emerging fast Healthcare Interoperability Resources standards will make a real difference; however, the timeline for them to make their way through the health IT ecosystem is not conducive to fully optimized ACO development and outcomes.

One potential solution to this barrier is to implement policies that would require EHR vendors to provide an API to third-party developers. Much as the existence of a published API by smartphone vendors has allowed for the development of a myriad of applications, such an approach to the EHR would encourage innovation by independent developers and result in an avalanche of useful applications for providers.¹ Policies should foster this type of innovation and

¹ To be fair, major vendors are becoming more transparent in the delivery of their protocols.

focus on standardizing EHR and HIT vendor output rather than maintaining the status quo of inaccessible and proprietary EHR data. Only once vendors change their business models and culture to allow patient and administrative data to be shared across the spectrum of an ACO will we be able to fully integrate our systems to deliver high-value care. Unless this particular challenge is met with more urgency from both the public and private sectors, ACO sustainability is threatened.

Payers and providers have the capability to meet many of the challenges noted. Picking and growing the right leaders, reorganizing the delivery of care, setting up effective governance mechanisms, and thinking differently about patient engagement and financial risk are all within their scope. Indeed, our case studies show that this can be achieved and sustained. However, continuing to operate in the old world of FFS while funding these efforts works only temporarily. For sustainable success, stakeholders across the industry must align their leadership and resources to investment in a value-based payment system that supports the notion of a continuously learning health system. For those of us dedicated to a healthier America this is rewarding work. The real reward comes from seeing much-improved patient-centered outcomes that simultaneously demonstrate a human and efficient system of financing care.

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Suggested Citation

Bodaken, B., R. Bankowitz, T. Ferris, J. Hansen, J. Hirshleifer, S. Kronlund, D. Labby, R. MacCornack, M. McClellan, and L. Sandy. 2016. *Sustainable Success in Accountable Care*. Discussion Paper. Washington, DC: National Academy of Medicine. <http://nam.edu/wp-content/uploads/2016/04/Sustainable-Success-in-Accountable-Care.pdf>.

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