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# Early Lessons From Accountable Care Models In The Private Sector: Partnerships Between Health Plans And Providers

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**ABSTRACT** New health care delivery and payment models in the private sector are being shaped by active collaboration between health insurance plans and providers. We examine key characteristics of several of these private accountable care models, including their overall efforts to improve the quality, efficiency, and accountability of care; their criteria for selecting providers; the payment methods and performance measures they are using; and the technical assistance they are supplying to participating providers. Our findings show that not all providers are equally ready to enter into these arrangements with health plans and therefore flexibility in design of these arrangements is critical. These findings also hold lessons for the emerging public accountable care models, such as the Medicare Shared Savings Program—underscoring providers' need for comprehensive and timely data and analytic reports; payment tailored to providers' readiness for these contracts; and measurement of quality across multiple years and care settings.

Provisions of the Affordable Care Act of 2010, including the Medicare Shared Savings Program and programs that will be implemented by the Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation, have the potential to bring public payment to bear on health system transformation. In recent years the private sector also has begun to develop a variety of models to transform payment and care. Among prominent examples are the Brookings-Dartmouth accountable care organization pilots,<sup>1</sup> as well as collaboratives among insurers and providers, such as an accountable care organization pilot program under development in Vermont.<sup>2-4</sup>

Because these models are new, much of the existing literature on the shared-savings or accountable care models either is theoretical<sup>5,6</sup> or focuses on a single health plan's program.<sup>7,8</sup> Other studies have focused on the provider per-

spective.<sup>9</sup> To add to the evolving knowledge base, we report here on findings from a study of accountable care models that have been implemented by a number of health plans.

The purpose of this study was to examine the key elements of this model that are emerging among private payers; to characterize these elements, including similarities and differences; and to identify specific considerations for policy makers and other interested parties. Based on our findings, we identify specific issues that need to be considered in future iterations of these models.

We believe that our analysis will be useful for other providers and health plans that are exploring accountable care arrangements. We also believe that it may help policy makers as they refine accountable care experiments in the public sector—for example, in development of the Final Rule for the Medicare Shared Savings Program and other programs.

## Study Data And Methods

**STUDY SAMPLE** Using publicly available data and preliminary interviews with health plans that are members of America's Health Insurance Plans, we identified twenty-two health plans with approximately thirty accountable care arrangements that were in place or in development. From these we selected eight health plans for further study.

Specifically, we focused on a mix of national and large regional organizations across diverse geographic areas; on a range of benefit designs to which the arrangements were applied (that is, fully insured versus self-insured); and on arrangements that had the ability to participate and provide information to the study team within the project's schedule. Although some of the health plans in our study also participate in the Brookings-Dartmouth pilots, we focused on other accountable care arrangements that these plans had forged outside the pilots.

Accountable care models developed by Aetna, Anthem/WellPoint, Blue Shield of California, Blue Cross Blue Shield of Illinois, Blue Cross Blue Shield of Minnesota, CIGNA, HealthPartners, and Horizon Blue Cross Blue Shield were the subject of our study. Together these plans represented two-thirds of the thirty identified accountable care model arrangements.

**SURVEY METHODS** We used structured telephone interviews with health plan medical directors and program operations staff and an interview guide to address accountable care model program goals, criteria for provider selection, performance metrics, payment methods, technical assistance, and any lessons or challenges.

**STUDY LIMITATIONS** Our study provides insights into the characteristics of several leading accountable care model arrangements. However, our results might not be generalizable across the health plan industry because our focus was only on eight plans that were members of America's Health Insurance Plans. Because the scope of this study was limited to health plans, our findings also do not reflect the views and experiences of providers participating in the accountable care model arrangements.

Our findings relate to characteristics of accountable care models during a defined period of time. The attributes of the models we describe are likely to change, because these models are constantly evolving to meet the needs of providers and patients.

## Study Findings

**SCOPE OF PROGRAMS** The scope of the accountable care models varied among the health plans interviewed. Some plans were implementing

these arrangements with specific employer accounts (with fewer than 100,000 members), while others were working with their providers in multiple geographic areas that included most of their commercial populations.

Participating provider organizations included large health systems or large multispecialty groups and were located in the West, Midwest, and Northeast US regions. These organizations varied in size (as measured by number of physicians) from 100 (in a physician practice) to 10,000 physicians (in a large health system). In most of the models we examined, the participating providers that contracted with the health plans represented legal entities. In one health plan, participants in the accountable care model arrangements came together "virtually" and established a governing board. Specifically, the organizations involved established a board that is responsible for program oversight, strategy, contracting, and funding decisions—all without any one organization "owning" the accountable care organization.

**FACTORS INFLUENCING DESIGN** Across all of the health plans interviewed, the key focus of new accountable care models was the three-part aim identified in the National Quality Strategy: better care, healthy people and communities, and affordable care.<sup>10</sup> Plans emphasized the need to improve quality and patient safety and to reduce unnecessary practice variation and costs. Instead of focusing contract negotiations solely on setting payment rates, health plans and providers are turning to the use of incentives and structured longer-term arrangements to improve quality and reduce costs.

Such arrangements were viewed as going beyond existing initiatives such as patient-centered medical homes. Although patient-centered medical homes are designed to provide coordinated care with a focus on primary care and chronic disease, analysts have raised questions about their ability to achieve patient-centered, coordinated care for primary and specialty care across all care settings.<sup>11</sup>

**PROVIDER SELECTION** Providers' ability to be successful in these new accountable care arrangements will depend on their capacity to organize their delivery of care to achieve performance and accountability requirements. Health plan representatives interviewed in this study agreed that an assessment of this capacity is needed to ensure that providers are ready to enter into these arrangements. Also, providers must be able to implement the types of changes within their organizations required to ensure sustainable care delivery in the long term.

The health plans that we studied used specific criteria, either formally through an application

process or informally, to evaluate a provider's readiness to enter into accountable care arrangements. The use of specific criteria is similar to the approach used by other collaboratives such as the Premier Accountable Care Implementation Collaborative.<sup>2,6</sup>

Although there is some overlap in the criteria—for example, leadership and investments in health information technology—our study provides additional insights into what payers look for in assessing provider readiness.<sup>12</sup> Exhibit 1 summarizes the key set of criteria that health plans use to assess the eligibility of the provider organizations for accountable care model arrangements.

One of the areas emphasized in existing provider-focused studies is shifting incentives within an organization to align individual providers' behavior with the overall goals of the organization.<sup>12</sup> Typically, health plans do not assess compensation structures for individual physicians in the participating provider organizations. However, one health plan looked for commitments from provider organizations that individual physicians within those organizations would be rewarded in a manner consistent with the compensation arrangement between the health plan and the provider organizations. That is, the provider organization would agree that over time, the payments and reimbursements to its individual physicians would reflect the payment and incentive structure for the organization as a whole.

**ROLE OF PATIENTS** Although much of the

debate on accountable care arrangements has focused on the role of providers in helping achieve the three-part aim, there is also growing recognition of the patient's role in attaining better health and reducing cost. Coupled with this recognition, there has been increased discussion of the types of incentives that might be used to buttress patients' roles.<sup>13</sup>

To gain a better understanding of patient incentives offered within the context of such arrangements, we asked health plans to list characteristics of the member population covered, as well as any specific incentives or changes to benefit design that were instituted as part of these models.

The patient populations "covered" under these accountable care arrangements are primarily commercial members in either fully insured or self-funded accounts. In six of the eight health plans, patients were enrolled in plans with open-access benefit designs such as preferred provider organizations. For the other two health plans in the study, the "covered" population were members associated with specific employer accounts, because implementation of these arrangements was based on employers' specific requests.

In general, the choice of which health plan benefit designs these arrangements would "cover" was determined by several factors: the need to improve quality and reduce costs in open-access benefit designs where patients have wide choice of providers; extending the quality and cost gains in health maintenance organization models to preferred provider organizations;

## EXHIBIT 1

### Provider Selection Criteria For Private-Sector Initiatives In Care Delivery And Payment Model Design

Criteria	Assessment of criteria
Clinical integration/ network adequacy	Strong focus on primary care with added capacity to provide full spectrum of clinical services, including primary and specialty care either from within the organization or through affiliations/partnerships with community physicians and facilities
Leadership	Presence of a strong, forward-thinking leadership and culture of commitment to accountable care
Long-term relationship	Willingness of provider groups to accept long-term arrangements of three years or more
Ability to initiate and implement change	Demonstrated either through a history of delivery system change and track record of population management such as successful management of HMO population, or a clearly articulated plan to implement organizational changes needed to promote value
Health IT infrastructure	Existence of strong health IT infrastructure either through adoption of electronic health records/patient registries or through alternative IT architecture that allows timely health data exchange with other providers involved in patient's care and the health plan
Patient panel size	Panel sizes that are sufficiently large to ensure reliable measurement of quality and cost; minimum patient panel size requirements typically exceeded ACA minimum requirements of 5,000 patients for the Medicare Shared Savings Program
Acceptance of new payment arrangements	Willingness to participate in performance-based reimbursement models and ability to accept financial risk for a specified portion of costs associated with a defined patient population

**SOURCE** Authors' analysis of data collected from eight health plans participating in the study. **NOTES** HMO is health maintenance organization. IT is information technology. ACA is Affordable Care Act.

# The attribution of patients to providers is an important issue, especially when patients can freely choose providers.

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and ascertaining which benefit designs constituted the majority of a health plan's membership. Most of the health plans in the study reported that they did not change their benefit designs or offer patient incentives specific to accountable care model arrangements.

Because these arrangements were mostly being implemented in preferred provider organizations, plans voiced concern about the challenge of coordinating care for patients who receive care from providers who are not part of the accountable care arrangement. However, a few plans had incorporated benefit designs or incentives tailored to these arrangements to help address this issue.

We identified three distinct patient-focused incentives or benefit design approaches under the accountable care arrangements, each implemented by different health plans.

► **REDUCED PREMIUMS:** One type of patient incentive involved a reduction in health insurance premiums (derived from reductions in the cost of care) for members who receive care from providers taking part in these arrangements. Such an approach allows the health plan to translate cost savings into reduced premiums while simultaneously providing access to high-quality care.

► **STAND-ALONE PRODUCT:** Another approach involved the implementation of a stand-alone "accountable care product" offered as an option together with a health plan's traditional benefit design offerings. The key features of such a product are lower premiums, because care under this product is coordinated and better managed; a narrower network of providers; and typically richer member benefits, such as lower copayments or coinsurance. Such a product offering was viewed as a way to distinguish a health plan from its competitors and help attract new members.

► **TIERED NETWORKS:** An alternative to these two approaches was building tiered networks

with differential member copayments around providers in accountable care arrangements that perform better than the market average on quality and cost. Such an approach allows more widespread application of accountable care arrangements to open-access benefit designs while simultaneously promoting patients' choice of high-quality providers. The approach was also viewed as helping address issues of patients' going to providers outside these arrangements, who may be far less likely to be focused on the objectives of the three-part aim.

► **OTHER APPROACHES:** Health plans that had not incorporated changes to benefit design or incentives specific to their accountable care models instead relied on existing programs that are offered to all members. These included differential cost sharing for using high-quality, efficient providers, and value-based benefit design, which reduces cost sharing for services that have strong evidence of clinical benefit. The plans offered varying reasons for not changing their benefit designs, such as the need to focus first on changing provider payment incentives to allow arrangements to be implemented in a time-sensitive manner and to ensure that patients continued to have choice of providers and did not feel "locked in."

In addition, health plans reported the need to focus efforts on reengineering care delivery in a manner that would ultimately result in improved patient outcomes and experience. Even in the absence of specific incentives, plans reported that patients who received care from providers under these arrangements would benefit from extended office hours; improved care management services, especially for chronic conditions; improved transitions among settings of care; and a patient-centered medical home component.

**PATIENT ATTRIBUTION** One of the key elements of accountable care model arrangements involves determining for which specific groups of patients a participating provider will be held accountable. The assignment of responsibility for patients' quality, cost, and experience of care to specific providers is called attribution. This assignment of responsibility is an important issue, especially when patients can freely choose providers, as is the case with preferred provider organization benefit designs.

In developing rules for attribution, a number of criteria need to be considered. These have been discussed elsewhere in the context of provider performance measurement and reporting.<sup>14</sup> Given that providers under these models are accountable for a defined population, additional criteria play a role in attribution. These include the need for ongoing reconciliation of



the attributed patient lists to account for movement of patients among providers.

Methods used to attribute patients to providers varied depending on the type of accountable care model arrangement. In an arrangement that involves an accountable care product, patients are assigned to providers based on enrollment in the product. Given that most patients were enrolled in preferred provider organizations, health plans used rules and data to attribute patients to providers.

► **SITE OF MOST FREQUENT VISITS:** Attribution to an accountable care organization was typically based on where the patients receive most of their primary care, for example, as determined by counts of visits to specific providers for services. Once the patient is attributed to a provider organization, the patient retains the ability to receive care from providers outside the accountable care arrangements, and the provider to whom the patient is attributed is still accountable for the quality and total cost of that patient's care.

► **TIMING:** A key element in attribution specific to accountable care arrangements is the timing of attribution and when providers are made aware of the patients for whom they are accountable. This timing determines whether the attribution is prospective or retrospective.

Prospective attribution uses historical claims data prior to the performance period and attributes patients to providers at the beginning of a performance period. In this approach, the providers have prospective knowledge of the patients for whom they are accountable.

Conversely, under retrospective attribution, claims data from the performance period are used to assign patients to providers at the end of the performance period. A critical aspect of retrospective attribution is sharing the methodology and formula for attribution with providers in advance.

The use of prospective versus retrospective attribution varied among the health plans interviewed. Health plans that used the prospective approach cited the importance of providers' knowing in advance the patients they are accountable for, because such information could help providers better address quality and cost issues and the continuum of needed care. To account for movement of patients as a result of geographic relocation, death, or disenrollment from a health plan, the list of patients attributed to a participating provider organization was reconciled regularly, such as every six to twelve months.

In addition, one health plan using the prospective attribution approach also tracked performance for all of its patients (attributed and non-

attributed) who received care at the participating provider organization, to ensure that the non-attributed patients received the same level of care that the attributed patients received.

For those health plans using a retrospective attribution methodology, providers were not aware of their attributed patient population until the end of the performance period. Health plans that used this methodology claimed that retrospective attribution allowed providers to focus on fundamental changes to their care delivery processes so that all patients received the same level of care.

#### **PERFORMANCE MEASUREMENT AND TARGETS**

Performance measurement in the context of accountable care models includes two components. The first is the selection and implementation of measures, and the second relates to the establishment of quality and cost targets for the participating providers. Variations in the use of measures across accountable care arrangements or regions were driven by the specific needs of the relevant patient population, variations in quality benchmarks, and alignment with existing initiatives either within the health plan or at the community level.

► **SELECTION OF MEASURES:** Measure selection was typically driven by commonly used criteria, such as the existence of a robust evidence base for the measure; whether or not the measure had been endorsed by the National Quality Forum or by specialty societies; use of the measure in other ongoing incentive programs; or whether use of the measure would help ensure a focus on the needs of the specific patient populations, such as management of patients with advanced illnesses. Exhibit 2 provides a sample list of measures that are currently in use.

Measures that are in use span what some analysts have classified as "beginning, intermediate, and advanced accountability."<sup>15</sup> Health plans strived to achieve some consistency in measurement through the use of a core set of measures. However, we also observed variation in the use of specific measures across accountable care arrangements or across geographic regions.

Plans used different approaches to achieving consistency in measurement. For example, two plans used quality measures that are being publicly reported by their respective regional collaborative based on data from multiple payers. These measures focused on high-priority conditions such as diabetes, cardiovascular care, and depression. They include both clinical process as well as measures of intermediate outcomes such as hemoglobin A1c control. Such an approach can help advance consistency in measurement and reinforce incentives across payers. Another approach to achieving such consistency was

**EXHIBIT 2****Types Of Performance Measures Implemented By Eight Health Plans Studied**

Measurement domain	Measure
<b>BETTER CARE</b>	
Diabetes	Hemoglobin A1c screening and control LDL cholesterol screening and control Nephropathy monitoring
Cardiovascular disease	Cholesterol screening and control Blood pressure management
Cardiac surgery	Deep sternal wound infection Surgical re-exploration Operative mortality for CABG
Patient safety	Central line-associated bloodstream infections Ventilator-associated pneumonia Catheter-associated urinary tract infections Avoidable ED visits All-cause readmissions
<b>HEALTHY PEOPLE/HEALTHY COMMUNITIES</b>	
Prevention	Annual well-child visits
Patient experience of care	CAHPS survey
<b>AFFORDABLE CARE</b>	
Cost of care	Risk-adjusted per member per month costs that typically includes costs for all services—professional, inpatient, specialty, ancillary, pharmaceutical, imaging, and laboratory cost—in calculation of total cost of care

**SOURCE** Authors' analysis of data collected from eight health plans participating in the study. **NOTES** LDL is low-density lipoprotein. CABG is coronary artery bypass graft. ED is emergency department. CAHPS is Consumer Assessment of Healthcare Providers and Systems.

working to align existing measures with those set forth in proposed regulations for the Medicare Shared Savings Program.

Additional areas for measurement beyond the core set of measures were identified through discussions with provider groups or based on analysis of data. Examples include a focus on quality of care for advanced illness and reductions in avoidable hospitalizations and emergency department visits.

► **QUALITY AND COST TARGETS:** The health plans reported working collaboratively with their providers to establish quality and cost targets for the performance period. Both quality and cost targets were based on the historical experience of a provider group over a specified period of time and were trended forward. Baseline costs were adjusted using general inflation or comparisons of a participating provider group's cost to the average of the provider network, or to trends in the local market. The use of peer groups for comparison has been well established as an approach to ensure providers' buy-in and reduce unwarranted variation.<sup>16</sup> It is also important in establishing targets. The use of local-market trends to adjust for costs was also seen as a way to correct for factors that were potentially outside providers' control.

The arrangements are flexible regarding tar-

gets and include rewards for both attainment of specific performance thresholds and improvement from past performance. Plans observed that using improvement alone to reward providers might not encourage participation by provider groups that are already top performers, and therefore many agreed that it was important to provide incentives for attainment of high standards of performance.

► **PAYMENT METHODS** All of the models we studied involved changes to payment methods and represented a movement away from fee-for-service in varying degrees. Health plans recognized that traditional pay-for-performance incentives had been shown to be insufficient<sup>17</sup> and that transformation of the delivery system required changes to payment.

► **BUILD ON EXISTING MODEL:** Although such movement away from fee-for-service was a core component of changes to payment, methods such as global payment were not immediately implemented. Rather, health plans sought to build on their existing reimbursement model, which was either fee-for-service or a combination of fee-for-service for hospitals and capitation for physicians.

Such an approach was born of the recognition that before global payment is instituted, providers need to gain greater experience with being

accountable for a population and must be more able and willing to assume financial risk for the total cost of care. Some health plans also mentioned that their initial priority was a focus on care redesign without the complexity of making major payment changes at the same time. Exhibit 3 shows the specific payment elements that were incorporated into the various payment models adopted by health plans.

Plans combined these different elements and also reported using different gradations of these various elements in their arrangements based on providers' readiness. For example, one payment model incorporated fee-for-service, traditional pay-for-performance incentives, plus a care management fee. The actual payment levels for each of these elements vary according to the negotiations with the provider organizations. In this approach, the care management fee could be reduced if performance targets were not met.

► **COMBINE APPROACHES:** Another approach involved combining the traditional concepts of fee-for-service and pay-for-performance incentives in a novel way. In this approach, each of these elements was considered to be separate and independent—a practice common in the pay-for-performance movement. Differential weights were assigned to the fee-for-service base rate, incentives for quality, and incentives for cost. Over the duration of the arrangement, the increments to the fee-for-service payment were to become smaller. Higher reimbursement would then be tied increasingly to achievement of quality and cost targets.

Another key feature of this model was that although providers could earn incentives for achieving cost targets, the structure of payment was such that earning only the cost-based incentive would not lead to sustainable reimbursement over time. This approach allowed the evolution of payment from guaranteed dollars to

earned dollars based on performance and accountability in later years of the contract.

► **INCORPORATE SHARED-RISK ELEMENTS:** We also observed variations in how shared-risk elements were incorporated into payment. In one approach, providers were at risk for expenditures that exceeded the agreed-upon target. The second approach was akin to a profit-and-loss model, in which the health plan, physicians, and hospitals were at risk for every expenditure category and the level of risk was calibrated to the level of control. This type of arrangement was viewed as being particularly effective at promoting collaboration, aligning incentives, and promoting joint accountability.

Health plans that did not incorporate shared-risk elements cited similar barriers to adoption, including lack of provider readiness and requirements in certain states for providers to have a license before they could accept risk. However, they all planned to incorporate shared risk in the near future.

**TECHNICAL ASSISTANCE** Technical assistance to providers has been identified as one of the key requirements to their success in accountable care arrangements.<sup>15</sup> Different types of assistance may be needed at different stages of implementation. Initially, provider organizations may require assistance to identify and develop capabilities needed to enter into accountable care arrangements. Organizations that are already participating in such arrangements, on the other hand, may require assistance with effectively managing the care of their patients to achieve performance targets.

Implementation assistance is being provided through existing learning networks such as the Brookings-Dartmouth or Premier learning collaboratives. However, providers need ongoing help with transforming their care delivery and effectively managing the health of their patient

### EXHIBIT 3

#### Key Payment Elements In Accountable Care Models

Payment element	Description and use
Incentives	Three of eight plans reported using incentives tied to quality and cost targets within their accountable care arrangements; in one instance, incentive was in the form of a withhold if cost targets were not met
Care management fee	Two of eight plans incorporated per member per month care management fee; fee was dependent on providers' achieving specific quality and cost targets
Shared savings/risk	A majority of plans incorporated shared-savings elements into their payment models; providers received a share of savings if actual expenditures for the attributed population were lower than the cost targets, contingent upon quality targets' being met; about half of plans incorporated a shared-risk element where providers share in the losses if actual total care expenditures for the attributed population exceeded agreed-upon cost target

**SOURCE** Authors' analysis of data collected from eight health plans participating in the study.



## Key Technical Assistance Provided To Participating Providers By Health Plans

Function	Types of assistance
Population health management	Providing multiple data and report formats, including: Detailed claims data—historical detailed claims history on attributed population; monthly claims extracts; daily hospital and ED census Analytic reports—combining provider-supplied and health plan data to identify gaps in care; site of service opportunities; predictive modeling reports that stratify patient by risk, out-of-network provider use by patients; comparisons to benchmarks; and progress toward targets and resource use
Disease and case management/tools for care improvement and decision making	Connecting providers with health plans' disease and case management services by: Embedding nurse case managers in provider practices to help with care delivery Providing clinical decision-support tools including condition-specific care guidelines and access to key data at point of care Hosting monthly clinical sessions and promoting collaboration between health plan care management teams and providers
Exchanging health information	Providing access to health information exchange systems that allow for two-way flow of information to facilitate case management and clinical decision support
Managing financial risk	Predictive modeling to help assess and manage risk; provision of stop-loss coverage or reinsurance

**SOURCE** Authors' analysis of data collected from eight health plans participating in the study. **NOTE** ED is emergency department.

populations. Such management requires access to timely, detailed data that can be acted upon; case or disease management services; and tools for care improvement.

Exhibit 4 summarizes the types of assistance provided by the health plans, mapped to the core functions of the providers. It provides an overview of the range of services that provider organizations required, even, in some cases, when they were large health systems. These types of services will be even more critical as smaller provider groups participate in such arrangements.

Participating provider organizations receive varying levels of technical assistance based on their specific needs and capabilities. For example, some of the participating provider groups have historically performed medical management of their patients and therefore may require only data and analytic reports from health plans. Even with provision of data and reports, specific considerations that need to be taken into account include ensuring that reports can be acted upon and do not consist merely of “dumping data”; determining the frequency of reporting, which may vary based on type of report; balancing provision of timely and comprehensive information with pitfalls of information overload; and helping provider groups understand and interpret the data and identify opportunities for improvement.

## Discussion

As noted, several provisions of the Affordable Care Act seek to promote accountable care. More recently, CMS released the Proposed Rule for the Medicare Shared Savings Program and announced additional accountable care initiatives through the Center for Medicare and Medicaid Innovation. Our study identified several important lessons that can inform how the rule is developed. In this section we discuss suggested changes to the Medicare Shared Savings Program and other important issues based on findings from our study.

**MEDICARE SHARED SAVINGS PROGRAM** A comparison of the common elements from the private-sector programs with the Medicare Shared Savings Program Proposed Rule shows some similarities but also notable differences. These include the extent of data sharing and availability, the level of technical assistance needed, performance standards, exclusivity of primary care providers, and the opportunity for beneficiaries to “opt out” of having their health data shared within the accountable care organization for population health activities. In finalizing the rule for the Medicare Shared Savings Program, CMS should consider the following changes.

**SHARING DATA AND REPORTS** Although the Proposed Rule specified certain data elements, these appear inadequate for effective population management, based on the breadth and depth of

data sharing and reporting in the private sector. CMS needs to provide different types of data and analytic reports to participating providers. The types of data and reports should be similar to what we described above. Health plans cited use of data in identifying opportunities for improved care management and instituting changes to delivery, including improved care coordination and transitions, discharge planning, and case and disease management.

**PROVIDING FLEXIBILITY IN ARRANGEMENTS** In contrast to the Shared Savings Program, which specifies levels of shared savings or losses for accountable care organizations, health plans tailored levels of risk and reward to match the their providers' capabilities and readiness. Other analysts have emphasized this type of flexibility.<sup>18</sup> It can increase participation in Medicare's program. Flexibility could be incorporated through provision of higher rewards to providers in risk arrangements as well as elimination of minimum savings rates for high performers.

Another key aspect of flexibility pertains to the level of technical assistance needed. The ability to calibrate such assistance based on providers' readiness will be important to maximize participation and to scale these arrangements.

**NEED FOR COHESIVE STRATEGY** Our analysis of the Medicare Shared Savings Program in the context of other federal incentive and value-based purchasing programs revealed several discrepancies. For example, there are key differences between the shared-savings plan and Medicare's Hospital Value-Based Purchasing program. We argue that establishing a cohesive strategy across all federal incentive programs, with aligned requirements for excellence, will be essential to achieving the three-part aim.

Discrepancies that should be rectified are as follows: differences in minimum attainment levels (thirtieth percentile for shared savings versus the median for value-based purchasing); rewards for both measure attainment and improvement under value-based purchasing, compared with measure attainment only in the Shared Savings Program; different measurement domains and weighting of these domains; and higher standards of performance under value-based purchasing than under shared savings.

**ROLE OF THE PATIENT** Given the broad choice of providers available to beneficiaries, mechanisms need to be built into the Medicare Shared Savings Program to ensure beneficiaries' accountability. One of the concerns expressed during our interviews, the issue of patients' seeking care outside the participating provider organizations, has been recognized and discussed elsewhere.

Health plans are addressing this issue at a

## CMS needs to consider incentives through which beneficiaries can be engaged in saving money and improving care.

minimum through differential copays and incentives for selecting high-value providers, development of new accountable care products, and value-based benefit design. In designing its program, CMS needs to consider incentives or other mechanisms through which beneficiaries can be engaged in the process of saving money and improving care.

**LONGITUDINAL MEASUREMENT** As the health care system transitions to models of care that are predicated on accountability over longer time frames, the focus of measurement also needs to evolve from assessing discrete short-term clinical processes of care to an emphasis on patient-centered longitudinal outcomes across time and care settings.

For example, quality measurement in diabetes usually tends to focus on process-of-care measures such as hemoglobin A1c testing and, in some instances, on intermediate outcomes such as hemoglobin A1c control. As providers become accountable for patients' health status over longer time horizons, quality performance in diabetes should be measured using intermediate and longer-term outcomes that include not only hemoglobin A1c control but also on avoidable complications.

Approaches to assessing multidimensional patient outcomes in a hospital setting have been proposed elsewhere. These approaches could be adapted to models currently under discussion.<sup>19</sup>

### Conclusion

The eight health plans and their models described in this article represent a subset of the efforts under way in the private sector. Preliminary data collected by the study team shows important levels of private-sector activity in testing alternative care delivery and payment model designs.

The ability to scale up these models and enable diffusion of best practices requires strong evi-

dence of the models' effectiveness. Some of the health plans in this study reported approximately 10 percent improvements in quality, a 15 percent decrease in readmissions and total patient days in a hospital, as well as annual savings of \$336 per patient. Formal evaluation stud-

ies will, however, be needed to ascertain the effectiveness of these models and, more important, to identify causal relationships between specific model elements and improvements in quality and efficiency. ■

## NOTES

- 1 Accountable Care Organization Learning Network [home page on the Internet]. Washington (DC): Brookings Institution; c2011 [last updated 2011; cited 2011 Aug 12]. Available from: <http://www.acolearningnetwork.org/>
- 2 Premier Inc. Accountable care collaboratives [Internet]. Charlotte (NC): Premier Inc.; [cited 2011 Aug 11]. Available from: <http://www.premierinc.com/quality-safety/tools-services/ACO/index.jsp>
- 3 American Medical Group Association. Accountable care organizations [Internet]. Alexandria (VA): AMGA; [cited 2011 Aug 12]. Available from: [http://www.amga.org/research/research/ACO/index\\_aco.asp](http://www.amga.org/research/research/ACO/index_aco.asp)
- 4 Hester J, Lewis J, McKethan A. The Vermont accountable care organization pilot: a community health system to control total medical costs and improve population health [Internet]. New York (NY): Commonwealth Fund; 2010 May [cited 2011 Aug 12]. Available from: [http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/May/1403\\_Hester\\_Vermont\\_accountable\\_care\\_org\\_pilot.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/May/1403_Hester_Vermont_accountable_care_org_pilot.pdf)
- 5 Goldsmith J. Accountable care organizations: the case for flexible partnerships between health plans and providers. *Health Aff (Millwood)*. 2011;30(1):32-40.
- 6 Devore S, Champion RW. Driving population health through accountable care organizations. *Health Aff (Millwood)*. 2011;30(1):41-50.
- 7 Chernew ME, Mechanic RE, Landon BE, Safran DG. Private-payer innovation in Massachusetts: the alternative quality contract. *Health Aff (Millwood)*. 2011;30(1):51-61.
- 8 Steele GD, Haynes JA, Davis DE, Tomcavage J, Stewart WF, Graf TR, et al. How Geisinger's advanced medical home model argues the case for rapid-cycle innovation. *Health Aff (Millwood)*. 2010;29(11):2047-53.
- 9 Shields MC, Patel PH, Manning M, Sacks L. A model for integrating independent physicians into accountable care organizations. *Health Aff (Millwood)*. 2011;30(1):161-72.
- 10 Department of Health and Human Services. Report to Congress: national strategy for quality improvement in health care [Internet]. Washington (DC): HHS; 2011 Mar [cited 2011 Aug 12]. Available from: <http://www.healthcare.gov/center/reports/quality03212011a.html>
- 11 Fisher ES. Building a medical neighborhood for the medical home. *N Engl J Med*. 2008;359(12):1202-5.
- 12 Moore KD, Coddington DC. From volume to value: the transition to accountable care organizations. Greenwood Village (CO): McManis Consulting; 2011.
- 13 Sinaiko AD, Rosenthal MB. Patients' role in accountable care organizations. *N Engl J Med*. 2010;363(27):2583-5.
- 14 Higgins AR, Zeddies T, Pearson SD. Measuring the performance of individual physicians by collecting data from multiple health plans: the results of a two-state test. *Health Aff (Millwood)*. 2011;30(4):673-81.
- 15 McClellan M, McKethan A, Lewis J, Roski J, Fisher E. A national strategy to put accountable care into practice. *Health Aff (Millwood)*. 2010;29(5):982-90.
- 16 Greene R. Beyond the efficiency index: finding a better way to reduce overuse and increase efficiency in physician care. *Health Aff (Millwood)*. 2008;27(4):250-9.
- 17 Pearson SD, Schneider EC, Kleinman KP, Coltin KL, Singer JA. The impact of pay-for-performance on health care quality in Massachusetts, 2001-2003. *Health Aff (Millwood)*. 2008;27(4):1167-76.
- 18 Liberman S, Bertko JM. Building regulatory and operational flexibility into accountable care organizations and shared savings. *Health Aff (Millwood)*. 2011;30(1):23-31.
- 19 Tompkins CP, Higgins AR, Ritter GA. Measuring outcomes and efficiency in Medicare value-based purchasing. *Health Aff (Millwood)*. 2009;28(2):251-61.