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JAMA. 2010;303(17):1747-1748 (doi:10.1001/jama.2010.575)

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Implementing Qualifications Criteria and Technical Assistance for Accountable Care Organizations

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HEALTH CARE REFORM HAS EXTENDED INSURANCE COVERAGE to 32 million Americans while eliminating denial of coverage for preexisting conditions. Although this increase in financial accessibility to care is a significant achievement, it begs the question “can the health care delivery system effectively respond to the increased demand?” Given past and current experience, the prognosis is not good. Health care costs continue to increase at a rate higher than overall inflation. At the current annual rate of spending, the Medicare Trust Fund will be bankrupt in 2017. Care for the increasing number of persons with chronic illness remains highly fragmented. There are far too many preventable deaths, medical errors, hospital-acquired infections, and preventable hospital readmissions, as well as an acute shortage of primary care clinicians. The recently passed Healthcare Reform Bill (HR 3590) contains provisions to begin addressing these deficiencies, including a provision for the development of accountable care organizations (ACOs) that may be based in large part on patient-centered medical homes.

ACOs are organizations that include physicians, hospitals, and other health care organizations with the legal structure to receive and distribute payments to participating physicians and hospitals to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high-quality and efficient services.¹ The ACO model is based on 3 design principles: accountability of the ACO for the entire continuum of care for a defined population of patients; payment reforms that reward quality improvement and slow spending increases while avoiding excessive financial risk for the ACOs; and reliable performance measurement to support improvement and provide public confidence that lower cost can be achieved with better care.² The probability of ACOs succeeding and the speed with which they might spread across the United States will depend on many factors; 2 of the most important involve determining the qualifications criteria and providing the required technical assistance to practices desiring to become ACOs.

Qualifications Criteria

Five types of health care delivery organizations could potentially qualify as ACOs: integrated delivery systems (IDSs) that include 1 or more hospitals and large numbers of physicians employed by the hospitals, multispecialty group practices (MSPGs), physician-hospital organizations (PHOs),

independent practice associations (IPAs), and loosely organized small physician practices.^{3,4} IDSs, MSPGs, and the small number of high-functioning PHOs and IPAs that now exist could move quickly toward attaining ACO status. Most PHOs and IPAs would have to substantially improve their operations to function well as ACOs. Loosely organized small practices would need to form “virtual” networks that, over time, could qualify as ACOs. A balance should be struck in developing criteria stringent enough to induce desired changes and yet not so stringent that a substantial proportion of organizations are omitted or demotivated to seek qualification. One suggestion is that a 3-tier system of qualification be created. Under this system, practices would submit a 3-year plan to the secretary of Health and Human Services or directly to the Centers for Medicare & Medicaid Services (CMS) for achieving qualification status at the various levels. Each level would have an associated risk-reward payment relationship that would increase from the base level I to the highest level III.

Level I ACOs would bear no financial risk but would be eligible to receive shared savings and bonuses if predefined quality targets were met and per-beneficiary spending reduced below a set target. Level I ACO, minimum requirements would be set: establish a legal practice entity with a designated governance and management leadership; demonstrate the capacity to report a basic set of performance measures based on administrative data; include within the ACO a sufficient number of primary care physicians to ensure the required minimum number of patients for performance measurement and provide a plan for handling transitions between inpatient and outpatient care.

Level II ACOs would be eligible to receive a greater proportion of savings below a predetermined target but also would be at risk for a proportion of spending above the target. They might also be paid through a higher percentage of revenue derived from bundled payments and other non-fee-for-service arrangements. These ACOs might be required to meet all of the above criteria plus the following: participate in more comprehensive performance measures that would include expanded patient experience measures and clinical performance for individuals with chronic disease such as asthma, diabetes, and congestive heart failure; and meet more stringent standards for financial reporting including financial projections and minimum cash reserves.

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Level III ACOs could be paid through full or partial capitation in which they would assume the greatest risk as well as rewards. Substantial bonuses for providing high-quality care and positive patient experience would be available. Level III ACOs would need to meet all of the previous criteria plus the following: public reporting of a comprehensive set of performance measures drawn from electronic health records (EHRs) and patient reports of health-related outcomes and quality of care for specific populations; and meeting additional, more stringent standards for financial reporting and being required to hold larger cash reserves.

These levels are only examples and should be adjusted based on current knowledge of provider organizations and data accumulated over time. The important idea is that practices can start at a lower level of developing the capabilities to provide cost-effective coordinated care and advance to higher levels as their expertise and experience increase. The risk-reward relationships would be adjusted accordingly.

Technical Assistance

Loosely organized small practices, most IPAs, and many PHOs would probably require considerable technical assistance for widespread implementation of ACOs to occur.^{5,6} This assistance will fall into 2 broad categories. The first is assistance in developing the organizational, legal, financial, and budgeting relationships with payers required to establish the various payment programs and support performance reporting requirements. Standardized templates should be developed that focus on the legal, financial, and organizational criteria.

Second, many organizations would need considerable assistance in practice redesign, process improvement and quality improvement capabilities, teamwork, EHR implementation, and leadership development. Practice redesign assistance would be needed to establish open access scheduling systems that facilitate same-day appointments, group visits for patients with similar conditions, use of e-mail and “e-visits” to help patients manage their care between visits, development of patient self-management support programs, and expanding the roles and responsibilities of nurses and other health professionals. Many organizations will also need assistance in learning the skills and tools associated with process improvement, eg, the routine use of “plan-do-study-act” quality improvement cycles to more sophisticated approaches involving lean production, including the Six Sigma techniques used in other industries. Developing effective teams to work with patients with chronic illness will also be needed. This would require assistance in such team-building skills as assessing who should be assigned to teams, working with status differences among team members, establishing the norms, roles, and responsibilities of the team, managing conflict, improving communication, and deciding how performance should be measured and rewarded.

In allocating and implementing the \$19 billion for EHRs, funds could be set aside to be used by ACOs in implementing EHRs with interoperability that links all participating physicians and hospitals within the ACO. This assistance

must go beyond that being provided to individual hospitals and physician practices to implement EHRs.

In addition, many practices that desire qualifying as ACOs will need considerable support in developing the required clinical and managerial leadership. Leadership is particularly important in times of uncertainty and change. Many of the success stories of established IDSs and MSGPs can be partially attributed to the leadership in these organizations from their early founding. The same is true of many of the currently successful PHOs, IPAs, and small physician practices. The challenge now is to develop a broader base of clinical and managerial leadership across the country. Evidence-based frameworks of effective leadership development are available built on a set of transformational, executional, and interpersonal competencies.⁷ On-site leadership programs are needed. Such assistance can be provided not only by the private sector but by the Medicare Quality Improvement Organizations.⁸ Established IDSs and MSGPs and organizations such as the Council of Accountable Physician Practices can also provide technical assistance. Using this “organizational mentoring” or “twinning” concept, CMS could provide technical assistance bonuses to organizations for providing such assistance.

Other challenges to implementing ACOs include the often strained relationship between hospitals and physicians, legal barriers, and issues involving performance measurement and reporting. However, the ability to meet these challenges will depend most importantly on the basic qualification criteria that are set and the quality and scope of the technical assistance provided.

The US health delivery system is now at a critical juncture. With informed implementation from both the public and private sectors, it should be possible to spread ACOs of various forms, adjusted to local circumstances, across the country. Once sufficient scale has been achieved, more Americans are likely to receive higher-quality care at a relatively lower rate of increase in cost.

Financial Disclosures: None reported.

Additional Contributions: We thank Elliott Fisher, MD, MPH (Center for Health Policy Research and Dartmouth Medical School, Lebanon, New Hampshire) for comments on a draft of this article.

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