THE IMPACT OF ACCOUNTABLE CARE ORGANIZATIONS

A dissertation submitted to the Caspersen School of Graduate Studies

Drew University in partial fulfillment of

The requirements for the degree

Doctor of Medical Humanities

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Madison, New Jersey

May 2016

ABSTRACT

The Impact of Accountable Care Organizations

Doctor of Medical Humanities Dissertation by

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The Caspersen School of Graduate Studies May 2016
Drew University

This dissertation examines how Accountable Care Organizations [ACOs] are integrating with other types of providers such as social services, behavioral health and long term care organizations to address a full range of patient needs in order to achieve an improvement in the health outcomes of a population of patients. It is a study to determine how ACOs integrate with other providers and what the results are for patients.

The Patient Protection and Affordable Care Act [PPACA] created a new model of health care delivery called the Accountable Care Organization. The ACO is designed to give doctors and hospitals incentives to become accountable for a population of patients and to re-design processes that provide for coordinated care, high quality and efficient service delivery. Personal behavior and social and environmental factors have great impact on overall health. ACOs which are made up of doctor and hospital organizations must look to coordinate and integrate with other types of providers in order to impact overall population health. This is difficult for a number of reasons including sharing financial incentives, communicating and sharing patient health information and overcoming the cultural managerial aspects of different organizations. ACO leaders

describe how they have integrate with other providers and whether the results show an improvement for a population of patients served by their organization.

This research includes a review of the literature concerning how ACOs are achieving integration with other providers and the results of the integration. The result is recommendations on the best practices for achieving provider integration based on evidence of improved patient health.

"But you were always a good man of business, Jacob," faltered Scrooge, who now began to apply this to himself.

"Business!" cried the Ghost, wringing its hands again. "Mankind was my business. The common welfare was my business; charity, mercy, forbearance, and benevolence, were all my business. The dealings of my trade were but a drop of water in the comprehensive ocean of my business."

A Christmas Carol by Charles Dickens

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EXHIBITS

Acknowledgements

On a hot day in the summer of 1975, I met a wonderful girl in Belmar, New Jersey who would change my life. The achievement of this dissertation is possible only through the love and support of my wonderful wife, Karen Joy McDonough.

I am indebted to Dr. Philip Scibilia, Director of the Medical Humanities Program at the Caspersen School of Graduate Studies at Drew University. The support and guidance offered by Dr. Scibilia enabled me to study topics that allowed me to understand why I chose a career as a health care executive. I would also like to acknowledge the faculty within the Medical Humanities Program for the encouragement and support of my efforts.

CHAPTER ONE

INTRODUCTION

The Central Essex Health Plan [CEHP] went out of business in 1978. CEHP was a well-planned closed panel health maintenance organization located in Orange, New Jersey. It had good primary care doctors, affiliations with reliable medical and surgical specialists, a good staff of nurses and support personnel. It was located in a brand new medical office building adjacent to a good community hospital. There was a nice parking lot with easy access to main thoroughfares. The CEHP was fully capitalized on its initial day of business and federal law enabled it to compete with large, well-established health insurance companies.

The message emanating from the CEHP to the insured, working class of the community was one of responsibility. CEHP was willing to accept the clinical and financial responsibility for the care of those persons and families who choose to enroll in it.

Clinical and financial responsibility…comprehensive and collaborative care…one location with ease of access…who could find fault with these concepts? The insured, working public did not accept this concept. The CEHP spent its capital and disappeared.

As a young health care executive, I watched this scenario unfold many years ago. It seemed to me that the CEHP had it right. Health care providers, facilities in one location, who were willing to care for a patient's needs at a fair price. As my career proceeded, I continued to believe that when doctors, nurses, and other health care professionals were placed in one location with appropriate support, the results would be good care with

moderate costs. My dissertation is an attempt to determine if the concept of collaboration in providing health care services can work today.

The Patient Protection and Affordable Care Act [PPACA] of 2010 is a comprehensive attempt at health care reform in America. The PPACA created an Innovation Center within the Centers for Medicare and Medicaid Services to develop new [or not so new] concepts aimed at delivering good quality health care while achieving cost containment. One such concept is embodied in the Accountable Care Organization [ACO].

An ACO is a group of doctors and or hospitals and other health care providers that voluntarily assumes responsibility for the quality and cost of health care for a defined population of patients. The ACO is eligible for financial incentives in the form of a shared savings payment if it can deliver health care services in an efficient manner.

Chapter Two is a historical review of the concept of accountable care. It begins with a description of the founding of the Mayo Clinic in the late nineteenth century. There is a discussion of the early forms of prepaid health care, health insurance and the evolution of managed care. The calls for health care reform and various examples of linkages between quality and reimbursement methods in the twentieth century are discussed as well as some organizations that have bridged that financial – quality gap to produce world-class service.

Chapter Three is a review of the PPACA focusing on the Center for Medicare and Medicaid Innovation, the creation of the Medicare Shared Savings Program and the development of the Accountable Care Organization as embodied in both the federal law and regulation. There is a description of the legal and regulatory framework of a Medicare ACO. The requirements for governance and leadership are examined along

with management, quality measures, financial effectiveness, patient engagement, nursing services and care coordination. The affiliations with other health care organizations are also described in this chapter.

Chapter Four is a description of the need for accountable care organizations for vulnerable populations. The Medicaid Accountable Care Organization is compared to the Medicare ACO. Correctional medicine and the care of the prisoner, probation and parolee populations are also addressed as part of the Medicaid ACO. The efforts in the State of New Jersey and Medicaid ACOs are described in this chapter.

Chapter Five is a description of the Medicare ACOs that are currently approved and operating in the State of New Jersey. This chapter explains the organizational structures and the results of the thirty-three quality measures for eleven NJ ACOs that have publicly reported data. There is specific attention given to the three NJ ACOs that achieved a Medicare shared savings payment in 2013.

Chapter Six considers why the accountable care organization is an important form of health care organization for the individual patient. This chapter discusses medical humanism and health care reform as embodied in the development of an ACO.

Chapter Seven is a discussion of the sustainability of an accountable care organization. It is relatively easy to create, implement and manage an early form of the ACO, especially the Medicare Shared Savings Program type. The question becomes whether this kind of organization is sustainable in the long run or is it a part of a greater transition in how health care is financed and delivered in America.

Chapter Eight is the concluding chapter and my final thoughts on the future of accountable care organizations.

CHAPTER TWO

THE HISTORY OF ACCOUNTABLE CARE

The history of accountable care in America can be traced to the development of the Mayo Clinic in Rochester, Minnesota. Dr. William Worrall Mayo, the founder of the Mayo Clinic, settled his family in the Rochester, Minnesota area as a result of a Civil War appointment. President Abraham Lincoln appointed Dr. Mayo to be the examining surgeon for the Minnesota military enrollment board. Dr. Mayo remained in the Rochester area after the Civil War ended and gained a reputation as a physician/surgeon. In the 1880s, his two sons, William and Charles, joined his practice.

W. Bruce Fye described the historical development of the Mayo Clinic in an article in the Bulletin of the History of Medicine. Dr. Mayo operated infrequently in his office, a patient's home or a hotel room. His sons, however, benefited from a new science and a new model of care. Bacteriology provided a framework for technologies designed to reduce postoperative infections. At the same time, hospitals were changing from static structures that housed the poor and dying into dynamic spaces where trained nurses cared for the sick and doctors performed surgery. During the first decade that the Mayo brothers practiced, controversial antiseptic systems were gradually replaced by aseptic techniques designed to reduce the risk of infection. The Mayo brothers were early adopters of the aseptic techniques.[1]

[1] W. Bruce Fye, "The Origins and Evolution of the Mayo Clinic from 1864 to 1939: A Minnesota Family Practice Becomes an International Medical Mecca." Bulletin of the History of Medicine 84.3 [Fall 2010]:323.

In 1889, the Mayos were given a new hospital as a result of a deadly tornado disaster and the vision of a Catholic nun. Six years earlier, in 1883, a tornado killed more than two dozen people and injured many more. The Mayos treated the trauma victims in a makeshift hospital set up in a dance hall. Some of the injured were taken to the Academy of Our Lady of Lourdes, a private school run by the Sisters of Saint Francis. Mother Alfred Moes, who led the nuns, saw beyond the catastrophe. As the community began to recover, she told the elder Dr. Mayo that her sisters would raise money to build a hospital if he would take charge of it. Dr. Mayo was skeptical but Mother Alfred persisted. Religious orders were building hospitals across the country at that time and the Rochester area had a significant Catholic population. After a four year fund-raising campaign, the Bishop approved building St. Mary's Hospital in Rochester and the forty-five bed institution opened in 1889.[2]

St. Mary's Hospital was a success from the start. Statistics from the hospital's first annual report published in 1893, showed that two-thirds of the patients admitted had surgery with a mortality rate of less than two percent. The Mayo brothers, William and Charles, performed each of the 655 operations in a hospital staffed by sisters who worked seven days a week. Word quickly spread about the brothers' surgical skills and the sisters' compassionate care, provided to all, regardless of resources or religion.[3]

The Mayos considered accurate diagnosis a critical first step in achieving superior surgical results. Between 1895 and 1905, they recruited a dozen doctors who devoted themselves to clinical or laboratory diagnosis. The Mayos moved into the first floor of a new Masonic Temple in Rochester where custom built space included several exam

[2] Fye, 323.
[3] Fye, 323.

rooms, a laboratory, a dark room for x-rays and a surgical dressing suite. In this building, many patients experienced modern medicine for the first time as diagnosticians used different technologies to examine their bodies and bodily fluids.

The Mayo Clinic grew rapidly as a result of word of mouth among the public and more formal communications among physicians. Visiting doctors were impressed by what they saw as efficiency was a recurring theme. The philosophy that distinguished the Mayo Clinic was group practice and the specialization and cooperation of each department within the organization.

Dr. William Mayo discussed the dynamics of specialization and the advantages of group practice in a 1910 commencement address at the Rush Medical College in Chicago. He felt that doctors must think of each patient as a whole patient despite progressive specialization.

Dr. Mayo said:

> The sum total of medical knowledge is now so great…the best interest of the patient is the only interest to be considered…medicine as a cooperative science…the clinician, the specialist and the laboratory workers uniting for the good of the patient.[4]

Multi-specialty group practice was created at the Mayo Clinic in the late nineteenth century. Their mission has been and remains devoted to patient care, accountable care.

There was growing concern in America in the late 1920s about the cost and distribution of medical care. Data from 1929 showed that U.S. health care expenditures had reached 4 percent of the U.S. gross domestic product, a sum that would threaten the

[4] Fye, 324.

country's financial recovery from what was about to become the Great Depression.[5] This concern prompted the formation of a privately funded independent commission known as the Committee on the Costs of Medical Care. The Committee's viewpoint was a belief that medical care needed better organization. There had been great progress in medicine but services were badly organized. After nearly a year of work, the Committee published its findings and recommendations. The first recommendation read as follows:

> Medical services should be more largely furnished by a group of physicians and related practitioners so organized as to maintain high standards of care and to retain the personal relations between patients and physicians.[6]

The Committee reached this recommendation after reviewing evidence that the group practice environment tended to produce higher quality and more efficient care than disaggregated forms of practice. There was no coordination beyond the walls of any particular hospital or clinic. The final report of the Committee called for the promotion of medical group practice and group payment for medical care. This was a recognition of the importance of being accountable for the care of patients. But though it endorsed group payment, the report opposed compulsory health insurance. The Committee believed that a compulsory program would require an unprecedented subsidy from government, employers or both to reach the standards of medical care.[7]

"Health insurance and managed health care are inventions of the 20th century," wrote Peter R. Kongstvedt in "Health Insurance and Managed Care."[8] For a long time, they

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[5] Francis J. Crosson, MD "21st Century Health Care – The Case for Integrated Delivery Systems" New England Journal of Medicine 361.14 [Oct 2009]: 1324.
[6] Crosson, 1324.
[7] Paul Starr, The Social Transformation of American Medicine. [New York: Basic Books, Inc., 1985] 146.
[8] Peter R. Kongstvedt, Managed Care and Health Insurance – what they are and how they work. 4th edition, Jones and Bartlett Learning, Burlington, MA, 2016.

were not considered to be 'insurance' but rather 'prepaid health care.' It was a way of accessing and paying for health care services rather than protecting against financial losses.[9]

The years before World War II saw the development of two models of providing and paying for health care besides the patient simply paying out of pocket. The first model was an early form of the health maintenance organization [HMO]. The HMO model was an organization that charged a preset amount per member per month and provided services through its facilities and staff. This was a combination of financing and delivering health care services. Prepaid group practice formation continued for the following reasons:

- Employers' need to attract and retain employees
- Providers' efforts to secure steady incomes
- Consumers' quest for improved and affordable health care
- Efforts by housing lending agencies to reduce the number of foreclosures caused by health-related personal bankruptcies.[10]

The Western Clinic in Tacoma, Washington, is cited as the first example of prepaid medical group practice. The Western Clinic was started in 1910 and offered, exclusively through its own providers, a broad range of services in return for a premium payment [capitation] of $.50 per member per month. The program, which was offered to lumber mill owners and employees, served to assure the clinic a flow of patients and revenues.

[9] Kongstvedt, 2.
[10] Kongstvedt, 3.

In 1929, Dr. Michael Shadid established a rural farmers' cooperative health plan in Elk City, Oklahoma by forming a lay organization of leading farmers in the community. The participating farmers purchased shares for $50 each to raise capital for a new hospital in return for receiving medical care at a discount.

Also in 1929, Drs. Donald Ross and H. Clifford Loos established a comprehensive prepaid medical plan for workers at the Los Angeles Department of Water and Power. The plan covered physician and hospital services and focused attention on prevention and health maintenance.

The organization that evolved into the Kaiser Foundation Health Plan was started in 1937 by Dr. Sidney Garfield at the behest of the Kaiser Construction Company. The plan sought to finance medical care for construction workers and subsequently ship-building workers.

In 1937, the Group Health Association was started in Washington, D.C. with a goal of reducing the number of mortgage defaults that resulted from large medical expenses.[11]

But by the 1960s and into the early 1970s, HMOs played only a modest role in the financing and delivery of health care. HMOs were a significant presence in just a few communities such as in the Seattle area and parts of California. In 1970, there were less than 40 total HMOs.[12]

The second model of providing and paying for health care was the early Blue Cross and Blue Shield plans which paid for services provided by contracted community doctors and hospitals.[13] In 1929, the original Blue Cross [BC] plan was formed when Baylor

[11] Kongstvedt, 3.
[12] Kongstvedt, 3
[13] Kongstvedt, 2.

Hospital in Texas agree to provide the local teachers with prepaid inpatient care at its hospital. The program was later expanded to include participation by other employers and hospitals. The early BC plans were also considered to offer prepayment for health care services. However, unlike the prepaid group practices, BC relied on providers in independent private practices rather than employing physicians or contracting with a dedicated medical group.[14]

The United States was a country blessed by plenty in the 1960s. American hospitals and their professionals were the envy of the world. Yet gaps and variations in both rhetoric and service were extraordinary. Rosemary A. Stevens in an article in the Health Care Financing Review noted "more than 70 percent of the population had some form of hospital insurance by 1965…but few were insured for primary or out-of-hospital care."[15]

Television, the new vehicle of mass culture in the 1960s, celebrated modern medicine as part of a culture of consumerism. All three of the major television networks carried hospital dramas in the 1960s, centering Americans in the fictional worlds of Dr. Kildare [NBC], Ben Casey [ABC] and the Nurses [CBS]. One the main issues for health policy in this context was to define needy groups as middle class and to ensure that they could behave like middle class consumers by having the means to do so. In this regard, the means was adequate health insurance backed up by public assistance, where necessary.

Titles 18 and 19 of the Social Security Act created the Medicare and Medicaid programs in 1965. Medicare was to be a means of transforming the elderly into paying consumers of hospital services. Medicaid was to cover those who were indigent.[16]

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[14] Kongstvedt, 4.
[15] Rosemary A. Stevens, "Health Care in the Early 1960s" Health Care Financing Review 18.2 [Winter 1996]: 11.
[16] Stevens, 15.

In the 1960s, there was a model to reorganize health care into a system that might have met the needs of changing morbidity and the efficient deployment of expensive technology. This model would have developed self-contained services systems encouraging the development of what were known as health maintenance organizations [HMO] or managed care systems. It was not generally available in the 1960s as only 2 percent of the population was covered through a prepaid group practice.[17]

Clifford H. Kane, a representative from the Kaiser Foundation Health Plan, argued during the Medicare hearings that Medicare would create a disadvantage to the fledgling health maintenance organization movement by encouraging greater use of hospital and nursing homes and greater reliance on them than on other approaches to care. But, it was difficult to conceive of reforming the U.S. health care system in any model that was not based on hospitals, for America had a hospital dominated system. There was not a strong primary care base on which to build comprehensive services. So, many of the problems in medicine that were observed in the 1960s and earlier remained, notably a bias toward the specialist rather than primary care.[18]

By the early 1970s, the record of the Kaiser Health Plan Foundation suggested it was possible to provide high quality prepaid health care at much lower costs than fee for service medicine. Advocates of the 'health team' approach hoped that nurse practitioners, physicians' assistants and other clinicians could improve access and efficiency. For the first time since the Committee on the Costs of Medical Care,

[17] Stevens, 15.
[18] Stevens, 21.

American society seemed ready to bring about changes in the organization of medical care.[19]

Congress enacted the Health Maintenance Organization Act of 1973 to nurture the development of private, not for profit organizations that would compete with traditional fee for service medicine.[20] Health maintenance organizations were a move toward accountable care in that care was coordinated and organized for patients.

As I began to study health care administration in the mid-1970s, my family was given the choice between the large traditional insurance company and two new health maintenance organizations in our area. The health maintenance organizations were contrasting organizations, one being a closed panel organization and the other an independent practice model. The closed panel organization, CEHP as mentioned above, had great control over medical and hospital care. It was affiliated with a small group of physicians and one local hospital. The independent practice association comprised most of the physicians and all of the 20 hospitals in the county. My family opted for the choice of providers given through the independent practice association. Many other families felt the same way and the closed panel organization was out of business within a few years. The closed panel model had the theoretical ability to be much more accountable in that it had greater control over the practice of medicine and the use of a hospital. But, Americans were unwilling to accept and did not trust the change represented by coordinated, managed care.

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[19] Starr, 146.

[20] John K. Iglehart, "The Struggle to Reform Medicare" The New England Journal of Medicine 334.16 [Apr 18, 1996]: 1071.

During the early 1980s, managed care expanded in response to rapid health care inflation. But, there was a trade-off in terms of quality of care, patient satisfaction and access to care that was, at times, given up in exchange for cost containment. HMOs led to lower costs but access and satisfaction seem to have suffered; quality of care has been comparable for all types of plans. Most HMOs did not accomplish what their proponents had promised, that is, changing clinical practice processes and improving quality of care while containing costs for both purchasers and consumers.

Robert Miller and Harold Luft studied various dimensions of health maintenance organization plan performance through a literature review from 1997 through 2001. They focused on studies of quality of care and the relative performance in the areas of access, satisfaction, prevention and health care use and spending. It was found that HMOs lowered the use of hospital and other expensive resources. But, at the same time, HMOs reduced measures of access to care and were associated with lower levels of enrollee satisfaction. Quality of care research results suggested that quality varied among providers and plans and geographic areas.[21]

In 2002, Miller and Luft concluded that three important changes were beginning to occur:

1. A movement in the direction of having purchasers and plans reward quality performance
2. Consumers were increasing their health care knowledge due in part to the Internet

[21] Robert Miller and Harold Luft, "HMO Plan Performance Update: An Analysis of the Literature, 1997-2001" Health Affairs 21.4 [Jul-Aug 2002]:64.

3. Developments in the information technology industry, specifically health IT, meant that advanced clinical systems and electronic medical records systems were becoming much more possible.[22]

In 1988, the Health Care Financing Administration [HCFA, now the Centers for Medicare and Medicaid Services, CMS] decided to determine the value of using bundled payments to physicians and hospitals as a solution to the rising costs of coronary artery bypass surgery. Four hospitals in a demonstration project began receiving bundled payments in June 1991. The demonstration project provided a bundled payment to the participants for all patient care services related to coronary artery bypass surgery with or without cardiac catheterization. Critical to the project was the collaboration of the hospital, the cardiothoracic surgery group and several cardiology groups in designing the methodology for distribution of the revenue, as well as for negotiating the provision of other specialty services. The participating hospitals and physicians were allowed to divide the payment between them in any manner that they agreed upon.

Once the stakeholders agree to participate, they began efforts to improve the process of care and to reduce costs for the involved interventions. There were several major changes in the care processes including earlier postoperative extubations, earlier discharge from the intensive care unit and earlier discharge from the hospital.

Discussions with the hospital led to a closer relationship between the involved physician groups and the hospital administration, as well as increased physician awareness of the tangible benefits of cost efficiency.

[22] Miller, 85.

The demonstration project saved Medicare $17 million in 27 months while improving the margin for coronary artery bypass surgery at the hospitals. Quality data was monitored throughout the demonstration project and improved through the course of the period.

This experience was an example of a successful effort to join hospitals, primary care physicians and specialists using a bundled payment methodology. The success was achieved through the development of collaboration among the previously disparate parties.[23] The experience with the HCFA demonstration project showed the impact of payment incentives on the willingness of disparate parties within the hospital environment to put aside differences and work together. It further showed that such collaboration could have lasting effects. Inexplicably, HCFA discontinued the project in 1996.

In 2001, the Institute of Medicine [IOM] published its report, "Crossing the Quality Chasm: A New Health System for the 21st Century." The report explained how the American health care delivery system was poorly organized, overly complex and uncoordinated. The health care delivery system was described as a series of steps and patient 'handoffs' that slowed down care and decreased rather than improved safety.[24]

The IOM report described how health care organizations operate as separate 'silos' acting without the benefit of complete information about the patient's condition, medical

[23] Bruce J. Genovese, Achieving the Vision: Operational Challenges , Partners in Health: How Physicians and Hospitals Can Be Accountable Together. [San Francisco: Jossey-Bass, 2010], 106.
[24] Crossing the Chasm: A New Health System for the 21st Century. Committee on Quality of Health Care in America, Institute of Medicine [Washington, DC: National Academy Press, 2001], 66.

history, services provided in other settings, and medications provided by various clinicians.[25]

The IOM report formulated ten principles to guide efforts to re-design the health care system. The principles are as follows:

1. Care is based on continuous healing relationships. Patients should receive care whenever they need it and in many forms, not just face to face visits. This implies the use of the Internet and the telephone.
2. Care is customized according to patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.
3. The patient is the source of control. Patients should be given the necessary information and opportunity to exercise the degree of control over health care decisions that affect them.
4. Knowledge is shared and information flows freely. Patients should have unfettered access to their own medical information and clinical knowledge.
5. Decision making is evidence based. Patients should receive care based on the best available scientific knowledge.
6. Safety is a system priority. Patients should be safe from injury caused by the health care system.
7. Transparency is necessary. The health care system should make information available to patients and their families that allows them to make informed

[25] Crossing the Chasm, 66.

decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments.

8. Needs are anticipated. The health care system should anticipate patient needs, rather than by simply reacting to events.
9. Waste is continuously decreased. The health care system should not waste resources or patient time.
10. Cooperation among providers is a priority. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.[26]

These principles are the basis for accountable health care. To initiate the process of change, the IOM report recommended that Congress establish a Health Care Quality Innovation Fund to help produce a public domain portfolio of programs, tools and technologies of widespread applicability.

In 2007, the Institute for Healthcare Improvement launched the Triple Aim initiative. The goals of the Triple Aim were and remain the following:

- Improve the health of a defined population
- Enhance the patient care experience [including quality, access and reliability]
- Reduce , or at least control, the per capita cost of care[27]

The Triple Aim is a challenge to implement. Various forces and traditions have encouraged physicians and hospitals to focus on acute and specialized care over primary and preventive care without considering the health of a population. To achieve the Triple

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[26] Crossing the Chasm, 67.

[27] Carol Beasley. "The Triple Aim – optimizing health, care and cost," Healthcare Executive [Jan/Feb 2009]: 64.

Aim, health care organizations must broaden their focus to organized care to meet the needs of the defined population.[28] This concept calls for an entity that can pull together the resources of numerous organizations to form a system to support a defined population. And, a successful system will, must find ways to link organizations across the continuum of care.[29]

One of the first descriptions of an accountable care organization [ACO] appeared in the New England Journal of Medicine in 2009. In the article, Diane Rittenhouse and others described the ACO as "a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population."[30] The ACO is neither radical nor entirely innovative. As a system of health care delivery, the ACO bears many similarities to the more advanced health maintenance organizations of earlier years. The HMO was a system that achieved care integration but was limited by a lack of information technology and evidence based medical standards. Today's ACO is supported by contemporary information and technology systems and exchanges along with quality metrics that were unavailable during the HMO heyday.

McClellan and others writing in Health Affairs have reported that the ACO model builds on initiatives that Medicare has implemented over the past several years.[31] For example, in 2005, the Physician Group Practice [PGP] demonstration engaged ten

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[28] Douglas McCarthy, MBA and Sarah Klein. "The Triple Aim Journey: Improving Population Health and Patients' Experiences of Care, while Reducing Costs," The Commonwealth Fund Vol 48 [July 22, 2010].
[29] Beasley, 65.
[30] Diane R. Rittenhouse, MD, MPH, Stephen M. Shortell, PhD, Elliott S. Fisher, MD, MPH. "Primary Care and Accountable Care – Two Essential Elements of Health System Reform," The New England Journal of Medicine 361.24 [Dec 10, 2009]: 2301.
[31] Mark McClellan, Aaron N. McKethan, Julie L. Lewis, Joachim Roski, and Elliott S. Fisher. "A National Strategy to put Accountable Care into Practice." Health Affairs 29.5 [May 2010]: 982.

provider organizations and physician networks, ranging from freestanding physician group practices to integrated delivery systems, in a 'shared savings' reform.

The primary purpose of the PGP demonstration was to effect changes in cost efficiency and quality through physician incentive programs. The key elements of the demonstration design involved identifying the PGP's patients, determining whether there were any changes in efficiency and quality of care and assessing whether those changes were due to the incentive payments.[32]

The providers in the demonstration received all of their usual fee-for-service payments. And, they received additional bonus payments if their efforts to improve care through better care coordination and other delivery reforms translated into slower risk-adjusted health spending growth and improved performance on quality measures for the patients they served. Participating providers were also held accountable for a portion of any excessive spending through reductions in future bonus payments.[33]

The PGP demonstration included performance assessments for quality measures, which were introduced over a three year period. The demonstration began with 10 diabetes mellitus measures in the first year; 10 heart failure and 7 coronary artery disease measures in year 2; in the third year, 3 hypertension and 2 preventable care measures were introduced for a total of 32 quality measures.[34]

All ten participating sites achieved success on most quality measures. In the third year of the demonstration, five had achieved sufficient reductions in spending growth to allow them to obtain more than $25 million in shared savings bonuses as their share of a total of

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[32] John Kautter, PhD and others, Evaluation of the Medicare Physician Group Practice Demonstration – Final Report [Center for Medicare and Medicaid Innovation, 2012], ES-4, RTI #0209853.007.005.
[33] McClellan, 983.
[34] Kautter, ES-5.

more than $32 million in Medicare savings.[35] By the fifth performance year, all ten of the physician groups achieved benchmark performance on at least 30 of the 32 quality measures, while 7 achieved benchmark performance on all 32 measures. Seven of the physician groups shared in savings during at least one of the five performance years.[36]

The 2003 Medicare Prescription Drug, Improvement and Modernization Act was remarkable for its focus on effectiveness and improved health outcomes. The Act established the Medicare Health Care Quality Demonstration which tests similar payment and quality improvement reforms in other delivery settings. Under this demonstration, regional provider-led organizations qualify for shared savings payments if they are able to improve the quality of care while slowing health spending for Medicare beneficiaries.[37] An example is the Gunderson Lutheran Health System Advanced Disease Coordination demonstration which is designed for patients who have serious eventually fatal, chronic conditions. This program attempts to establish collaboration among primary care providers, a palliative care program, home health services and hospice services. The goal of the program is reduce hospital stays and readmissions while increasing the use of home health and hospice services, and patient and family satisfaction.[38]

The Beacon Community Health Program was authorized under the 2009 American Recovery and Reinvestment Act. The Beacon Community Program aims to demonstrate

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[35] McClellan, 983.

[36] S. Lawrence Kocot, "How Early Accountable Care Efforts Shaped Payment Reform in the ACA and Bipartisan Reform Ever After," [blog], Brookings Institute, March 23, 2015, http://www.brookings.edu/blogs/health360/posts/2015/03/20-aca-accountable-care-payment-reform-mcclellan.

[37] McClellan, 984.

[38] John Kautter, PhD and others, Medicare Health Care Quality Demonstration Evaluation Gunderson Lutheran Health System Advanced Disease Coordination Final Report [Centers for Medicare and Medicaid Services, 2010], 22, RTI# 0207964.022.000.003.

the potential for health information technology to enable local improvements in health care quality, cost efficiency and population health.[39]

Through the Beacon Community Program, seventeen demonstrations have been funded to determine the potential for health information technology to enable local improvements in health care quality, cost efficiency and population health.

Examples of two large regional 'Beacon' demonstrations implemented in 2010 are the Indiana Health Information Exchange, and Community Care of North Carolina. The Indiana program uses tele-monitoring for high-risk patients after hospital discharge. The Community Care of Southern Piedmont, an affiliate of Community Care of North Carolina uses information technology to improve provider communications and increase patient access to health records These collaborations involve a wide range of providers and multiple payers, including Medicaid, state employee health benefits programs, major private insurers and now Medicare. Yet the underlying principles and program structures are similar to the Physician Group Practice Demonstration. Bonus payments are linked to performance on quality measures and demonstrated slower spending growth for a defined population of beneficiaries.[40]

The Geisinger Health System is an integrated health services organization serving central and northeastern Pennsylvania. It was founded in 1915 through the efforts of Abigail A. Geisinger and has become the nation's largest rural health services organization. The Geisinger Health System is known for its innovative care models. It is interesting to note that Ms. Geisinger hired a physician trained at the Mayo Clinic, Dr.

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[39] Emily R. Maxson and others, "Beacon Communities Aim to Use Health Information Technology to Transform the Delivery of Care" Health Affairs 29.9 [Sept 2010]: 1672.
[40] McClellan, 984.

Harold L. Foss, to be the first surgeon-in-chief at Geisinger. Dr. Foss brought the concept of group practice to central Pennsylvania where physicians of various specialties have worked together for the benefit of their patient for the past one hundred years.[41]

The Geisinger Health System is experimenting with the integration of payer-provider functions in innovations such as its 'warranty' for cardiac surgery. The 'warranty' is a plan wherein the costs of care for complications are included in the basic price.[42] The goal is integrated care, which means getting hospital doctors, general practitioners, nurses and community care workers to collaborate much more effectively and flexibly.

Geisinger ties the salaries of its employed physicians to the care they deliver and, to some extent, the results they achieve in a bundled payment arrangement for cardiac bypass surgery known as ProvenCare. The ProvenCare programs are developed by multi-disciplinary teams that identify care processes that should be reliably performed. For coronary bypass surgery, there are forty processes, including preoperative assessment of appropriateness and early post discharge evaluation. Some incentives are based upon achievement of outcomes such as cardiothoracic surgeons having a goal of 95 percent compliance with the ProvenCare bypass surgery bundle of key ProvenCare processes. Geisinger's emphasis on the improvement of quality and efficiency allows the physicians employed under this system to see more patients and receive higher compensation.[43]

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[41] "History of Geisinger Health System" http://www.geisinger.org/pages/about-geisinger/pages/history.html [accessed April 19, 2015].

[42] Nick Seldon, MPhilo and Thomas H. Lee, MD. "Envy – A Strategy for Reform" The New England Journal of Medicine 368.24 [June 13, 2013]: 2245.

[43] Thomas H. Lee, MD, Albert Boothe and Glenn D. Steele, "Innovation Profile: How Geisinger Structures its Physicians' Compensation to Support Improvements in Quality, Efficiency and Volume" Health Affairs 31.9 [Sept 2012]:2068.

Aparna Higgins and others writing in Health Affairs have reported on new health care delivery and payment models in the private sector that are built upon collaboration between insurance plans and providers. Across the eight health plans that were studied, the key focus of new the accountable care models were the three goals identified in the triple aim strategy: better care, healthy people and communities and affordable care. The plans emphasized the need to improve quality and patient safety and to reduce unnecessary practice variations 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. The health plans and their models represent a subset of the efforts underway in the private sector.[44]

The concept of accountable care is critical to achieving better organization and delivery of health care through aligned financial incentives tied to health outcomes; an emphasis on pro-active and preventive care; and access to the right care in the right setting for a better patient experience. Nonetheless, with notable exceptions, such as the Mayo Clinic, the Geisinger Health System, Kaiser Permanente and other isolated instances of integrated delivery systems based on group practices, the transition that the Committee on the Costs of Medical Care recommended in its 1930s era report has not taken place until now.

[44] Aparna Higgins, Kristin Stewart, Kirstin Dawson and Carmella Bocchino, "Early Lessons from Accountable Care Models in the Private Sector: Partnerships between Health Plans and Providers" Health Affairs 30 [Sept 2011]: 1718.

CHAPTER THREE

LEGAL AND REGULATORY FRAMEWORK FOR MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

The Patient Protection and Affordable Care Act [PPACA] was signed into law by President Barack Obama on March 23, 2010. The intent of the PPACA is to extend health insurance to almost all persons in the United States, make health insurance work better, control the cost of medical care and avoid social, fiscal and political catastrophe.[45] The law also creates incentives that give the health care provider community the opportunity to change the manner in which health care services are delivered. The PPACA is the most comprehensive health care legislation since the enactment of Medicare and Medicaid in 1965. It is an attempt to change the health care system from a "fee-for-service" system into a "fee for health" system.

Part III of the PPACA is entitled "Encouraging Development of New Patient Care Models." Within Part III, Section 3021 calls for the establishment of a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid. The Innovation Center is meant to test innovative payment and service delivery models. The goal is to reduce Medicare and Medicaid program expenditures while preserving or enhancing the quality of care. The models are selected by choosing organizations that have the promise to improve the coordination, quality and efficiency of health care services furnished to individuals.

[45] Thomas E. Getzen, Health Economics and Financing [John B. Wiley and Sons, Inc.]. 408.

Section 3022 of the PPACA created the Medicare Shared Savings Program. Within just a few pages, Section 3022 describes the development and deployment of the Accountable Care Organization [ACO].[46] Section 3022 reads as follows:

> Not later than January 1, 2012, the Secretary shall establish a shared savings program that promotes accountability for a patient population and coordinates items and services under Parts A and B, encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.[47]

The language within the PPACA, Section 3022 says that under such a program, groups of providers of services and suppliers may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization.[48] And, that accountable care organizations meeting quality performance standards will be eligible to receive payments for shared savings.

As noted earlier, one of the first descriptions of an accountable care organization described it as "a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population."[49] The ACO was characterized as a high-performing, organized system of care and financing that could provide the full continuum of care to a specific population over an event, an episode or a lifetime while assuming accountability for clinical and financial outcomes.[50]

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[46] Marc Bard and Mike Nugent, Accountable Care Organizations: Your Guide to Strategy, Design and Implementation [Chicago, IL: Health Administration Press, 2011], 29.
[47] U.S. Congress, House, Patient Protection and Affordable Care Act, 111th Congress, H.R. 3590, January 5, 2010: 277.
[48] Patient Protection and Affordable Care Act, 271.
[49] Rittenhouse, 2301.
[50] Bard, 35.

The ACO is not really an entity as much as it is a contractual relationship that consists of delivery and financing tactics between an organized healthcare delivery system and CMS or another payer to provide measurably high quality care efficiently and to share the benefits of efficient delivery with CMS [and possibly with patients].[51]

The Kaiser Family Foundation describes the ACO as the following:

> Allow providers organized as accountable care organizations that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.[52]

As defined under the law, ACOs are patient-centered teams that deliver comprehensive medical care [hospital, physician, diagnostic, etc.] to more than 5,000 assigned beneficiaries. The ACO agrees to be accountable for overall quality and cost, and thus becomes eligible for a share of any cost savings. There is considerable excitement about the promise of ACOs to deliver better medicine, better patient satisfaction and greater efficiency but the concept is a work in progress.[53]

Section 3022 of the PPACA specified the types of organizations that are legally eligible to be considered ACOs as follows:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospital and ACO professionals

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[51] Bard, 36.
[52] "Summary of the Affordable Care Act" Kaiser Family Foundation, www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/, [accessed June 25, 2015.]
[53] Getzen, 415.

- Hospitals employing ACO professionals
- Other groups of providers of services and suppliers as determined by the Secretary of DHHS

Section 3022 described the requirements for an ACO:

- The ACO must be willing to become accountable for the quality, cost and overall care of the Medicare fee-for-service beneficiaries assigned to it
- There will be an initial three year agreement
- The ACO must have a legal structure that allows the organization to receive and distribute payments for shared savings
- The ACO must include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to it
- The ACO must give the Secretary of DHHS information regarding the ACO professionals participating in the ACO
- The ACO must have a leadership and management structure that includes clinical and administrative systems
- The ACO must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures and coordinate care, through the use of enabling technologies such as tele-health and remote patient monitoring
- The ACO must demonstrate that it meets patient centeredness criteria through the use of patient and caregiver assessments and the use of individualized care plans

Section 3022 further described the payments and treatment of savings for an ACO. Payments are made to providers of services and suppliers participating in the ACO under the Medicare fee-for-service program under Parts A and B in the same manner as they

would otherwise be made. The exception, for the participating ACO, is that it is eligible to receive payment for shared savings. The payment for shared savings is contingent upon whether the ACO meets quality standards; and, if the estimated average per capita Medicare expenditure under the ACO for Medicare fee-for-service beneficiaries for Parts A and B services, adjusted for beneficiary characteristics, is below the applicable benchmark.

The law further states that the government will monitor whether an ACO avoids high-risk patients in order to reduce the likelihood of increasing costs to the organization. If the ACO is found to be avoiding high-risk patients, there may be a sanction imposed including termination of the individual ACO's participation in the program.

The Final Rule implementing the "Medicare Program, Medicare Shared Savings Program, Accountable Care Organizations" was published in the Federal Register on November 2, 2011. In December 2014, the federal government proposed revisions to key policies from the November 2011 rule which incorporated guidance and new policies to support the growth of the program. The effective date for the revised rule was August 3, 2015.

The Final Rule speaks to the following topics with the aim of providing greater clarity for ACO participants and beneficiaries:

- Data sharing requirements
- Eligibility, identification and reporting of ACO providers and suppliers
- Eligibility for beneficiaries
- Processes for coordinating care
- Legal structures for the governing body, leadership and management

- Methodology for ACO financial performance
- Issues related to program integrity and transparency

The CMS has promoted the development of three types of accountable care organizations:

- Medicare Shared Savings Program which allows providers to share in any savings they generate from managing the health care needs of a population of Medicare fee-for-service beneficiaries
- Advance Payment ACO Model which gives physician-owned and rural ACOs access to anticipated savings up front, so they can invest in the infra-structure – such as additional staff and electronic medical records – necessary to improve patient-care coordination
- Pioneer ACO Model designed for organizations with previous experience managing the care of a population of patients in an ACO or similar model. Pioneer ACOs share both upside and downside financial risk[54]

There are over 400 ACOs under federal contract at this time, with over 200 whose contracts are open for renewal this year. The 2015 rulemaking intends to support continued and enhanced participation, to reduce administrative burden for ACOs while facilitating their efforts to improve care outcomes, and to maintain excellence in program operations while bolstering program integrity.

The National Association of Accountable Care Organizations [NAACOS] commented favorably upon the final rule noting that ACOs whose contracts were ending in 2015 and

[54] "Accountable Care Organizations – Testing Their Impact" Robert Wood Johnson Foundation. www.rwjf.org/en/library/research/2015/02/accountable-care-organizations.html [accessed July 5, 2015].

had achieved certain quality thresholds will be given a new three year agreement. And these ACOs, if successful in lowering their costs and achieving savings, will see their historically based benchmarks adjusted in a manner that increase their savings amount.[55]

Craig R. Behm writing in the Journal of Medical Practice Management regarding the final rule breaks it down to the following simple concepts:

- Patient attribution through service location
- Cost benchmarking based on total Medicare Part A and B spending
- Standardized quality metrics
- Physician leadership.[56]

In other words, we want to engage the patients and see how the physicians and other clinicians have collaborated to improve the quality of care and to lower the cost.

Organizational Structures

Stephen M. Shortell and others writing in "Partners in Care" described how physicians and hospitals can be held accountable, describing the accountable care organization as "…an entity that is clinically and fiscally accountable for the entire continuum of care that a given population of patients may need.[57] And, that the ACO concept recognizes the importance of offering hospitals and physicians choices in how they work together. In a study of private sector accountable care organizations that contracted with private health plans, Aparna Higgins and others noted that "in most of the models…participating

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[55] National Association of Accountable Care Organizations, The National Association of ACOs Comments on the Final Regulations for the Medicare ACO Program [Washington, D.C.: National Association of Accountable Care Organizations, 2015]: 1.

[56] Craig R. Behm, "ACOs in Real Life: A Reflection on the Medicare Shared Savings Program," The Journal of Medical Practice Management 30.5 [Mar/Apr 2015]: 313.

[57] Stephen M. Shortell, Lawrence P. Casalino and Elliott S. Fisher, Achieving the Vision-Structural Change, Chapter 3, Partners in Care – How Physicians and Hospitals Can Be Accountable Together [San Francisco: Jossey-Bass, 2010], 52.

providers that contracted with health plans represented legal entities."[58] There are four different organizational entities or models with the potential to provide more effective hospital-physician relationships in ACOs. The four models are as follows:

- Integrated Delivery System
- Multi-Specialty Group Practice
- Physician Hospital Organization
- Independent Practice Association

The Integrated Delivery System [IDS] and the Multi-Specialty Group Practice [MSGP] work with a single health care system and are integrated ACO models. The other two, the Physician-Hospital Organization [PHO] and the Independent Practice Association [IPA] are alignment models that bring physicians and hospitals closer together.

The Integrated Delivery System is an administrative entity that unites a set of organizations to provide a coordinated continuum of services for a defined population. The IDS is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served. This is the same definition for an ACO, except that it recognizes that multiple organizations may need to be brought together as a system. The IDS, by its nature, is a prime candidate to serve as an ACO in that it possesses the administrative and governance structure, data collection analysis and reporting capacity, clinical information technology and work process redesign

[58] Higgins, 1718.

capabilities, and has a significant volume of patients. All of these factors are necessary criteria for a functioning ACO.[59]

There are many Multi-Specialty Group Practices in the United States. The MSGP has the ability to have physicians from multiple specialties work together to care for its patients. This is important given the growing prevalence of chronic illness, frequently requiring multiple providers. Because MSGPs include multiple specialties, they can provide most care that patients need within the group, facilitate patient referral, improve care coordination, and make the group more capable of overseeing all the costs of the patient's care. This is particularly true for those MSGPs that are aligned with hospitals or that have their own hospital.

Large MSGPs have clinical information technology, organized processes to improve care, participate in quality improvement activities and score well on process measures of quality. The MSGP can deliver recommended prevention services and serve as a patient centered medical home. A patient centered medical home is a comprehensive approach to primary care that embodies care coordination, health information technology, enhanced communication and remote monitoring.[60]

The Physician Hospital Organization is an entity that brings together physicians and hospitals in a formal relationship that can provide and contract with health plans for hospital and physician services. PHOs were tied to the expansion of managed care in the past but lacked the ability to provide cost effective care. The potential of the PHO as a vehicle for achieving accountability for cost and quality across the care continuum lies in several elements. Physicians practice within natural referral networks around a hospital.

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[59] Shortell, 53.
[60] Shortell, 54.

Hospitals have an organizational infrastructure and resources that could be used to support clinical integration across inpatient and outpatient sites of care.[61]

Independent Practice Associations serve primarily as vehicles for contracting with health plans. Some IPAs bring together individual, often small, physician practices into a coordinated virtual network of physicians that provides cost-effective patient care rather than merely providing support services for insurance plan contracting.[62]

Virtual IPAs are attractive to smaller medical practices and those in rural areas that lack the infrastructure and resources to create a true IPA and can qualify as an ACO. When medical practices come together into a virtual network of practices, there are economies of scale and capabilities in data collection; analysis and reporting; aggregation of a sufficient number of patients to qualify for incentive payments; and, assistance for implementing electronic health records and supporting work process design. Given that many physicians practice in small groups, IPA and virtual IPA arrangements may be a viable alternative form of an ACO.

In the study of private sector ACOs that had contracted with health plans, Higgins and others reported on one participating entity that was formed "virtually" and established a governing board that was responsible for program oversight, strategy, contracting and funding decisions – all without any one organization "owning" the accountable care organization.[63] It is unlikely that CMS would approve such a "virtual" ACO but, certain health care markets could work in this fashion.

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[61] Shortell, 55.
[62] Shortell, 56.
[63] Higgins, 1719.

As noted earlier, Medicare offers three types of ACO programs. The first ACO program is the Medicare Shared Savings Program. This program will improve beneficiary outcomes and increase the value of care by promoting accountability for care, requiring care coordination across the continuum and requiring investment in infrastructure and improved care processes. These MSSP ACOs will be rewarded for improving costs and improving the patient care experience.

The second ACO program is the Advance Payment Model. This program is designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Through the Advance Payment ACO Model, selected participants will receive upfront and monthly payments, which they can use to make investments in their care coordination infrastructure.

The final ACO model is the Pioneer ACO Model. This program is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It will allow these provider groups to move more rapidly to form a shared savings payment model to a population based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. It is designed to work in coordination with private payers by aligning provider incentives, which will improve quality and health outcomes for patients across the ACO, and achieve savings for Medicare, employers and patients.[64]

According to Shortell and others "the four organizational models – IDS, MSGP, PHO and IPA – have the potential for promoting collaboration between hospitals and

[64] Rick Panning, "Accountable Care Organizations: An Integrated Model of Patient Care Objectives," Clinical Laboratory Science 27.2 {Spring 2014]: 114.

physicians."[65] And, the three ACO programs – Medicare Shared Savings, Advance Payment and Pioneer Programs – will rely upon the ability of hospital and physicians, in one of the various models, to commit to shared goals and to develop the trust to reach these goals.

The structure of an Integrated Delivery System may easily enable the formation of an ACO because the competencies and infrastructure are likely to be in place. Key factors are the ability to manage population health data, and, to have established leadership and legal structures as required under law. In a complementary way, the other models may meet a number of the required competencies including the ability to work with post-acute care provider organizations.[66]

Governance and Leadership

The Final Rule for the Medicare Shared Savings Program and Accountable Care Organizations calls for an ACO to maintain an identifiable governing body with ultimate authority to execute the functions of the ACO. The governing body must oversee the processes that promote evidence-based medicine and patient engagement, reporting on quality and cost measures and the coordination of care.[67] Further, the governing body members have a fiduciary duty to the ACO and must act consistent within that duty.

Section 5 of the Medicare Shared Savings Program 2016 Application states that in order to become an approved ACO, the organization must answer pointed questions about its governing body. The names of the board members and information regarding who has ultimate authority to execute the functions of the ACO are required. The board

[65] Shortell, 57.
[66] Panning, 116.
[67] Code of Federal Regulations, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Title 42, Part 425, 2015, p.543.

members cannot have any relevant financial conflicts of interest and there must be a policy and procedure to remedy any such conflicts. And, interestingly, each ACO board must include at least one Medicare beneficiary who is served by the ACO.[68]

The core functions of the governing body are as follows:

- Establish policies
- Select and evaluate the performance of executive management
- Ensure legal compliance
- Provide input, oversight and approval of performance standards, capital investments and operating budgets.[69]

Board members must be guided by three principles:

- The duty of obedience – they must assure that the ACO adheres to its charter and all applicable laws and regulations
- The duty of care – the trustees must adhere to a 'duty to be informed" about the activities and performance outcomes of the organization
- The duty of loyalty – the trustees must act in the best interests of the ACO and the patients served by it.[70]

The ACO Final Rule also requires the governing body establish the principles of funds flow among the entities within the organization and the principles that govern the distribution of potential shared savings among the participating entities.

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[68] Medicare Shared Savings Program 2016 Application, Centers for Medicare and Medicaid Services. www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/2016-mssp-new-application-form.pdf [accessed July 15, 2015].
[69] Bard, 110.
[70] Bard, 123.

At its core, healthcare transformation is about improving healthcare value. The question for governing boards is how to successfully transition to value-based models of care delivery and payment.[71] Governance of ACOs is critical to the improvement of health care services because it is where the policymaking and oversight responsibilities lie. Jeffrey A. Alexander and Gary A. Young noted in "Partners in Caring" that "hospital boards have not traditionally played a significant role in managing hospitals' relationships with their medical staffs."[72]

The passage of the PPACA and the subsequent approval of the Final Rule concerning ACOs, created a new era for governance. Today, ACO governance is characterized by increased emphasis on the accountability of the board. This emphasis carries over to the activities of both management and the medical staff and other clinicians.

One of the challenges to the ACO is hospital – physician alignment. The historical situation of physicians in most hospitals was that doctors held a quasi-independent status. Physicians assign high value to their professional autonomy and ability to function outside of the traditional bureaucratic controls of the hospital. The governing boards have lacked adequate mechanisms to hold physicians accountable for their performance, even though the board is accountable for that performance. Because physicians will be compensated differently under the ACO model, boards should understand what encourages physicians to accept risk and follow best clinical practices. Effectively engaging physicians as partners within the ACO requires developing physician-led

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[71] John R. Combes, MD and Mary K. Totten, "Leadership for Value-Based Care," Healthcare Executive 30 [May/Jun 2015]: 76.

[72] Jeffrey A. Alexander and Gary J. Young, Overcoming Barriers to Improved Collaboration and Alignment, Chapter 7, Partners in Health – How Physicians and Hospitals Can Be Accountable Together [san Francisco: Jossey-Bass, 2010], 141.

groups that can represent the clinical voices needed when making and implementing decisions.[73]

A second challenge to stronger hospital-physician alignment has been the board members' lack of health care background or clinical expertise. Board members are often selected on the basis of their business experience, professional skills [law, finance], community ties, personal values and time availability. Trustees and directors have been ill prepared to evaluate quality of care and uncomfortable taking action to rectify a quality problem. Management must educate governing body members to better understand risk management and patient population data to determine actionable steps for improving health in specific populations.[74]

Quality improvement is a powerful impetus for the governing board of the ACO. The board must realize its responsibility for ensuring the quality of care provided by the ACO. If the board is to emphasize quality improvement, it must incorporate extensive clinical input. This means that the ACO board must include physicians and possibly nurses and other clinicians. Information about physician outcomes and clinical quality must be available to the board members on a regular basis. And, the quality information cannot be overly technical or too clinical for their understanding, appreciation and action.

The ACO is a health care delivery system that is a complex operation made up of many sub-enterprises. Its composite origins create unique challenges for its governing board. Board membership will include trustees from each of the participating organizations as well as members of the community. Another challenge is that board members may have stronger loyalty to their legacy organizations than to the ACO. The

[73] Combes, 76.
[74] Combes, 77.

ACO board can direct the recruiting effort for clinicians to reflect a dual goal of keeping patients healthy and a shared responsibility for all care. The evolving ACO models require a great deal of flexibility from all participants especially during the initial contract period with CMS.

The ACO is an approach to hospital and medical staff collaboration that will succeed if the physician [clinician] power is organized and exercised to improve quality and reduce costs. The governing board can strike a balance between respecting physicians' [clinicians] control over medical practice, quality assurance and quality improvement activities while insuring the mission and goals of the ACO are not diverted.

Alexander and Young note that "the governing body must work to enhance the communications between its board members and the physicians at large. The board must be conscious of decisions in areas that may not strike them as relevant to the doctors but may have implications for clinical practice."[75] These include issues related to strategic planning, manpower planning, budgeting, and capital expenditures, all of which may carry implications for change in the clinical culture of the organization.

The crucial question is who will control the ACO, who are the board members? There are essentially two scenarios: one of physician controlled ACOs [MSGP and IPA], with physicians affiliating and contracting with hospitals and controlling the flow of funds on the marketplace; and, one of hospital-controlled ACOs [PHO and IDS] that will employ physicians. The entity that moves first effectively is likely to assume the momentum and

[75] Alexander and Young, 156.

dominate the local market.[76] How the board chooses to function – the way it allocates its attention, time and energy – will determine its performance and success.

Health care services are delivered locally. The ACO is a reflection of its community. In a sense, it is a community driven organization. This is a great opportunity to take control of how care is delivered by putting more control into the hands of the providers. Governance is the glue that binds the ACO structure together and will make the organization effective.[77]

Management

The management of an accountable care organization is the responsibility of an executive. This individual may have a professional background in health care administration, medicine or surgery, law or another applicable field. Regardless of the executive's background, he or she is expected to be effective. In the words of the late Peter Drucker, "the executive is expected to get the right things done and this is simply that he or she is expected to be effective."[78]

Physician leadership is integral to sound management and to meeting the quality requirements and engaging patients. There may be a paired management team in an ACO with hospital and medical staff leadership. It is imperative that the appointed pair function at a high level. Any tension that develops at the executive level will create destructive friction throughout the organization.

The ACO's leaders will likely already be members of the health care delivery system. Singling out physician management in an organization whose message is "integration"

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[76] Robert Kocher, MD and Sahni R. Nikhal, BS. "Physicians Versus Hospitals as Leaders of Accountable Care Organizations," The New England Journal of Medicine 363.27 [Dec 30, 2010]: 2580.
[77] Alexander and Young, 158.
[78] Peter F. Drucker, The Effective Executive [New York, Harper and Row, 1967], 1.

seems to be inconsistent. Bard and Nugent note it to be "a paradox" in that physicians naturally favor autonomy and self-determination.[79] When physicians become leaders in their health care organizations, this cultural bias can dominate their management philosophy and style. One way to deal with it is to select physicians for leadership positions who have good peer relationships with other physicians. This assures individual doctors that if they have a problem with a particular decision they can go to someone with whom they have a personal relationship.

Bard and Nugent further write that "the executive's role is to translate the ACO's strategy into action through coordinated, integrated operating and care delivery models to optimize clinical and business performance."[80] Behm notes that "accountable care organizations develop from the idea that physicians can better manage the cost of care if there are rewards in place." [81] And, the Final Rule contains three broad concepts:

- Standard quality metrics
- Cost benchmarking
- Patient attribution and experience

The health care executive can focus his or her efforts on these three broad areas of concern in order to effectively manage an ACO. An executive with the Hackensack Alliance ACO noted that the three most important quality metrics in an ACO are readmission rates, total expenditures per assigned beneficiary and the patient caregiver experience. In other words, the quality of care, financial effectiveness and patient engagement are the means by which to judge effectiveness. The contract between the

[79] Bard and Nugent, 130.
[80] Bard and Nugent, 105.
[81] Behm, 315.

individual ACO and CMS outlines how to measure the executive's effectiveness. It is both the starting and ending point.

Quality

Quality can be seen in two distinct yet inter-related areas. The first being the credentials of the providers; and the second in the quality measures. The Final Rule requires the ACO to give the Secretary of DHHS information regarding the professionals participating in it. The ACO executive has a twofold responsibility in selecting providers: credentials and willingness to change. This is the age old task of staffing. Management must hire or make selections based on the respective strengths of various providers. The organization's purpose is to use the respective strengths of its staff as building blocks for performance.[82]

Collaboration among providers is the core of an accountable care organization. Hospitals, physicians and other clinical providers must work side by side in an integrated approach to improve outcomes, achieve cost effectiveness and improve satisfaction of both the providers and the beneficiaries of the ACO. The ability of the providers to succeed in new ACOs will depend on their capacity to organize their delivery of care to achieve performance and accountability requirements. Higgins and others wrote that "providers must be ready to implement the types of changes within their organizations to ensure sustainable care delivery in the long term."[83] Therefore, the selection of the provider members within an accountable care organization becomes a key exercise in the early formation of the organization.

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[82] Drucker, 71.
[83] Higgins, 1720.

Modern medicine is complex. A physician caring for a patient in the hospital setting is only one of several physicians who attend to the patient. And a variety of caregivers such as diagnostic technicians, clinical pharmacists, physical therapists, nurses, care coordinators and others are also part of the health care team.

Genovese writes, "The effectiveness of such a team can be quite dependent on the milieu in which it works."[84] He describes the care of a patient who has suffered a myocardial infarction and how lifestyle counseling should begin while the patient is still in the hospital. To be effective, such cardiac rehabilitation should be a seamless experience for the patient. This is likely to occur if the physicians and all of the other caregivers, both in the hospital and later, are working together. The ACO facilitates this type of coordination by recruiting for the dual strengths of clinical credentials and a willingness to collaborate.

The ACO, through its emphasis on collaboration among providers, can discourage the use of high-cost diagnostic studies by physicians and hospitals. Genovese gives the following example:

> Single photon emission computed tomography imaging, coronary computerized tomographic angiography, positron emission tomography scans, cardiac magnetic resonance angiography and nuclear coronary scans all can be used to diagnose coronary problems. These tests are useful, expensive and rarely does an individual patient need all of them.[85]

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[84] Bruce J. Genovese, Achieving the Vision-Operational Challenges and Improvement, Chapter 5, Partners in Health – How Physicians and Hospitals Can Be Accountable Together [San Francisco: Jossey-Bass, 2010], 94.

[85] Genovese, 96.

The coordinated care managerially afforded through an ACO leads to a reduction in unnecessary diagnostic studies and can maintain accuracy in diagnosis while lowering overall costs.

Improved patient safety in the hospital setting is a cooperative effort between the hospital and the physicians who practice there. Mutual goals, appropriate incentives and the breakdown in organizational barriers produce results in patient safety with speed and efficiency. In this regard, Genovese provides another example, "the operating room patient safety innovation known as the preoperative checklist requires involvement and support by the medical staff, the nursing staff and the hospital administration to be applied."[86] It often requires a cultural realignment for surgeons and other physicians and nurses who may remain unconvinced of its value because the errors that the checklist seeks to prevent are rare. This is where the incentives resulting from collaboration of physicians, hospital staff in the mutual organization of an ACO can have an impact on the likelihood of such adjustments becoming permanent.

The second major responsibility of the ACO executive is to report and act upon quality-related performance measures to the DHHS. The Final Rule for ACOs established thirty-three core quality measures that must be realized before an ACO can participate in any shared savings.[87] The quality measures are contained within four domains as follows:

- Patient/caregiver experience [7 measures]
    1. Getting timely care, appointments and information

[86] Genovese, 97.
[87] Code of Federal Regulations, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Title 42, Part 425, 2015, p.543.

2. How well your providers communicate
3. Patients' ratings of providers
4. Access to specialists
5. Health promotion and education
6. Shared decision making
7. Health status/functional status

- Care coordination/patient safety [6 measures]
  1. Risk standardized all condition readmission
  2. Chronic obstructive pulmonary disease or asthma in older adults
  3. Heart failure
  4. Percent of primary care physicians who successfully qualify for an electronic health record program incentive payment
  5. Medication reconciliation
  6. Falls: screening for future fall risk
- At-risk population [5 measures and 2 composites]
  1. Diabetes: hemoglobin A1c poor control
  2. Diabetes all or nothing composite
  3. Controlling high blood pressure
  4. Ischemic vascular disease: complete lipid panel and LDL control
  5. Ischemic vascular disease: use of aspirin
  6. Heart failure: beta blocker therapy
  7. Coronary artery disease: lipid control

8. Coronary artery disease: angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy

- Preventive care [8 measures]
  1. Breast cancer screening
  2. Colorectal cancer screening
  3. Influenza immunization
  4. Pneumonia vaccination for older adults
  5. Body mass index screening and follow-up
  6. Tobacco use screening and cessation intervention
  7. Screening for high blood pressure and follow-up
  8. Screening for clinical depression and follow-up

ACO programs are designed to decrease cost while emphasizing quality and patient-centeredness. An ACO demonstrates quality through the 33 quality measures. Submitting quality measures is a difficult task for an ACO. Successful reporting requires new documentation with oftentimes manual extraction, and is dependent upon the receipt of claims data from CMS. There is a time lag in receiving this data making it a significant challenge for providers.[88]

The 33 quality measures are reported through a combination of CMS claims and administrative data, a data base designed for practice [or ACO] level clinical quality measure reporting and a patient experience of care survey.

Results of these measures are public information and influence patient and physician choices. The successful fulfillment of these requirements and incentives rely upon the

[88] Behm, 315.

cooperation between physicians and hospitals. This cooperation is inherent within the ACO where incentives for performance are aligned.

Elliott S. Fisher and others writing in Health Affairs note that "It is clear that distinguishing formation and implementation activities from performance is important. For some organizations, performance could begin to improve simply through anticipation of and preparation for a future ACO contract.[89] There are three distinct populations that could be affected by the ACO model:

- Patients under the ACO model
- Patients care for by the organization but not covered by the contract
- The community as a whole

The importance of understanding the impact on all three populations has implications for how to track the overall impact of an ACO.[90]

A core tenant of ACO organizational design is to give management a broad span of control to promote standardization. This offers the opportunity for cross-functional integration across disciplines, sites and professions. Yet it flies in the face of the unwillingness of physicians to cede control to non-peers. An ACO, to become high-functioning must find a way to honor both higher level and local operational decision making.

Bard and Nugent describe a meeting where a group of surgeons sought to redesign the surgical booking process to improve its efficiency. The most vociferous opponent was a urologist who advocated for an alternative model from the one being favored by the rest

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[89] Elliott S. Fisher, Stephen M. Shortell, Sara A. Kreindler, Aricca D. Van Citters and Bridget Larson. "A Framework for Evaluating the Formation, Implementation and Performance of Accountable Care Organizations," Health Affairs 31.11 [Nov 2012]: 2369.
[90] Fisher, 2370.

of the group. A vote was taken and his option was not selected. After the vote, the urologist became an enthusiastic supporter of the new system. He told his colleagues that he had every chance to raise his objections and to sway the vote, he wasn't able to do so and he accepted the decision.[91] This is the way that the ACO must operate if it is to function in a collaborative manner.

The ACO must have effective health information technology from registries to electronic health records that can influence both care provision and performance measurement. The extent and effectiveness of care management processes in primary care, in specialty care and across the care continuum affect the ACO's ability to coordinate and improve care.

An effective ACO will have a firm grasp on its provider network. The use of analytic tools can measure and monitor provider efficiency. Risk adjustment levels the playing field by explaining how much of the cost and utilization is likely driven by illness burden and how much by physician practice patterns. Risk adjustment can enable the ACO management to make better decisions about which provider groups to invite into the network and how to compensate them. It is critical for the ACO to evaluate ongoing performance for reasons of quality assurance and compensation, as well as pinpointing best practices and those that need a closer look.

Meanwhile, the ACO will need to ensure that its network is populated with the most clinically effective and efficient providers in order to meet quality standards and survive economically in an environment in which better – not more – care is rewarded.

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[91] Bard and Nugent, 132.

To succeed, the ACO must maintain a close-up and a long distance view of both its patient population and its provider network. The use of analytics will help the ACO to understand its risks and then engage and manage individuals and populations successfully.[92] The ACO executive will be effective when he or she manages both the individual behavior and the overall performance of the organization.

Financial Effectiveness

The ACO executive is expected to be financially effective. The Final Rule mandates the creation of an administrative structure for an ACO. Inherent in any such structure is the requirement to create viable operating and capital budgets. The ACO must have received or will receive in the case of a newly formed organization, initial capital to recruit staff, equip offices, retain legal advice, obtain insurance and acquire information technology. Once these managerial requisites are in place, the ACO can then go about the work of reducing the cost of care for its beneficiaries.

As any ACO executive can attest, there are many things on his/her to-do-list. There is the formation of the organization, establishing governance and administrative structures, creating a clinically integrated network, developing a data sharing strategy and more. The management of an ACO must make sound decisions that affect its clinical, financial and performance management.

The ACO is where the clinical and financial stars align to support the installation and use of the electronic medical record. A benefit of the physician-hospital integration afforded by the ACO is the ability to share patient care information. An integrated

[92] Matt Siegel. "Demand and Supply Management in Accountable Care." Health Management Technology 35.8 [Aug 2014]: 20.

electronic medical record, fully available to both the physician office and at the hospital, saves physician and patient time and enhances the effectiveness of patient care.

Genovese writes, "access to the full clinical story, as contained in the electronic medical record, can help guide decision making in the emergency department to help prevent an unnecessary readmission, such as for fluid overload in a patient with chronic congestive heart failure."[93]

Cooperative efforts to reduce unnecessary length of stay can lead to mutual benefits for the patient, the physician and the hospital under the ACO model. For many years, the hospital has received reimbursement through the Medicare diagnosis-related-group payment system. The DRG payment system sets a price for inpatient admissions and specifies an average length of stay giving the hospital an incentive to discharge the patient as soon as safely possible. The ACO model, while continuing to pay physicians on a fee-for-service basis and hospitals on a DRG basis, recognizes and rewards length of stay reductions through the shared savings incentives.

Hospitals face significant expenses related to the breadth of physicians' demands for specific supplies and equipment. The dynamic afforded by the ACO can be different. The ACO management structure provides a platform for convening physicians in a particular specialty in order to identify specific supplies and equipment where the potential for cost savings exists. The specialist can debate the merits of narrowing the range of these items to be purchased by the hospital, thus increasing the hospital's purchasing volume and its negotiating strength with suppliers. The ACO may also participate in the savings in certain situations.

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[93] Genovese, 95.

ACOs are accountable for all Medicare Part A and B costs incurred by their attributed population. Savings are calculated by comparing performance year spending to a benchmark determined by the actual spending from the preceding three years. The amount is then risk adjusted to account for ACOs that may have sicker or healthier patients than national averages.

Benchmarking is an imperfect science. Some ACOs have found that the initial benchmark has been set too low to allow for significant improvement or that external forces erode ACO cost decreases. Most ACOs in the Medicare Shared Savings Program split the savings with CMS 50/50 to avoid a downside risk.

The heart of the new payment system is the contract itself which includes the following items:

- Thresholds for quality and cost targets
- Arrangements for sharing savings and allocating risk
- Mechanisms for linking quality to shared savings
- Definitions of the total cost of care
- Allowances for modifications in contract terms

These elements have implications for ACOs and the ways in which they allocate resources toward caring for patients and improving care.

Provider organizations that are able to obtain ACO contracts range from newly organized legal entities to fully integrated health care delivery systems that are already operating with risk-adjusted contracts that hold them accountable for the total cost of care. These groups differ in the degree of influence over the operations of the ACO

exerted by physicians versus hospitals. It is important that the ACO engage physicians and other clinicians in the new model of care and payment.

Matt Siegel writes that "the ACO can make better decisions through analytics."[94] The ACO asks its physicians to look beyond their waiting rooms to the many patients who rarely visit the office. These patients can include the emergency department frequent flier, the chronically ill but non-compliant patient and the relatively well person who could benefit from a better diet and more exercise. The ACO must understand where the demand is likely to come from across its patient population.

To be accountable for an entire population, the ACO must understand its patients in new ways. Claims data can feed population health analytics and predictive modeling tools. The use of claims data can identify risk, in a way of forecasting which patients will likely be high cost users of the medical resources in the near term. Claims data provides a comprehensive record of the interactions that a patient has had across the health care system. And, claims data are relatively standard.

Financial success will pivot on the ability of the ACO to reduce total cost for groups of beneficiaries, starting prior to delivery of primary care and moving through acute and post-acute. Care. The ACO will not rely on the traditional definitions of success of filling beds or generating procedures but rather demonstrating to its customers [payers], the ability to manage care at a lower cost. The impetus for this change comes from CMS and commercial payers, which are migrating toward a payment system based on per capita spending.[95]

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[94] Siegel, 21.

[95] William R. Edmondson, FACHE. "The Per Capita Payment Model," Journal of Healthcare Management 60.1 [Jan/Feb 2015]: 15.

The growth of ACOs represents a strong move in the direction of per capita payment models. The framework for value based payments lays out a progression that transitions from fee-for-service to population based payments such as per member per month payments. Fee-for-service will become an after-thought as margins are generated by creating customer value for the whole health care system. Just short of a full capitation model, the ACO concept applies shared savings against a set target for a group of attributed lives, blending the best of capitation and payments that add a bonus to fee-for-service rates. Setting limits on total spending and encouraging providers to offer a bundle of services within a budgeted cap is being considered as a future payment model. The ACO executive is expected to manage total spending across a broad range of services and thereby will be considered effective.[96]

Patient Engagement

The ACO executive is responsible for defining the patient population and implementing mechanisms to engage the patients in their personal care and to measure the experience of the patient population. Delos Cosgrove and others write, "The move toward engaging patients in their own care is simply the right thing to do."[97] It is becoming the norm amid growing evidence that patient-engaged care is associated with better health outcomes, better care experience for patients and lower health care costs.[98] There is also a recognition of the patient's role in attaining better health and reducing cost.

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[96] Edmondson, 16.
[97] Delos M. Cosgrove, Michael Fisher, Patricia Gabow, Gary Gottlieb and George C. Halvorson. "Ten Strategies to Lower Costs, Improve Quality and Engage Patients: The View From Leading Health Systems CEOs." Health Affairs 32.2 [Feb 2013]: 322.
[98] Cosgrove, 324.

Aside from the PPACA's Medicare Shared Savings Program, private health plans can and do use incentives to support the patient's role. This is accomplished through the use of choice in health plan benefit design specifically from the open access design of a preferred provider organization to a more controlled environment of a health maintenance organization.

There are three distinct patient-focused incentives or benefit design approaches under accountable care arrangements. One type of patient incentive involves a reduction in health insurance premiums for members who receive care from providers taking part in such an arrangement. Another approach is to offer an accountable care option that has lower premiums and copayments because the care is coordinated through a narrow network of providers. A final alternative is the use of tiered networks with different member copayments around providers that perform better than market average on quality and cost. This approach allows patients open access benefit design while promoting patients; choice of high-quality providers.[99] Private health plans therefore, can and do provide economic incentives to enrollees to manage both their selection of health plan and their personal health status.

In Medicare ACOs, patients who receive the majority of their care from participating providers have been assigned to an ACO through "invisible enrollment," with no notification or awareness by the patients that they are associated with an ACO. The provider-based accountability model is dis-connected from the way patients seek care and may fail to achieve its cost-saving and quality goals. There has been little discussion about binding Medicare patients to ACOs because the freedom to use one's providers is

[99] Higgins, 1718.

highly valued in U.S. health policy. The managed care backlash and the rise of preferred provider organizations in the late 1990s are partially the cause of patients' unwillingness to accept closed physician networks. The consumer preferences suggest that policymakers should focus on creating incentives to build patients' loyalty to an ACO.[100]

The Medicare Shared Savings Program has not yet incorporated changes or patient incentives into the Part A and B benefit design for accountable care organizations. The initial need has been to focus on changing provider payment incentives to allow the ACO concept to proceed. And, the desire to allow Medicare beneficiaries to continue to have their choice of providers. Given the broad choice of providers available to Medicare beneficiaries, mechanisms need to be built into the Medicare Shared Savings Program to ensure beneficiaries accountability. The ACO has an appropriate concern with patients seeking care outside of the network.

One of the key elements for accountable care organizations involves determining which specific groups of patients a participating provider is held accountable. The assignment of responsibility for patients' quality, cost and experience of care to specific providers is called patient attribution. This assignment of responsibility is an important issue, especially when patients can freely choose providers.

In developing rules for attribution, the approach begins with prospective attribution where each quarter program participants [ACOs] receive a list of patients prospectively attributed to their accountable care organization based on the most recent twelve months of data. These are lists of patients who are likely to be attributed to a given ACO. Assignment is regularly updated to include new patients in practices and to remove

[100] Anna D. Sinaiko PhD and Meredith B. Rosenthal, PhD. "Patients Role in Accountable Care Organizations," The New England Journal of Medicine 363.27 [Dec 30, 2010]: 2583.

patients who are no longer receiving care from the ACO's providers – a process referred to as retrospective reconciliation. The final reconciliation takes place at the end of the performance year based solely on patients' use of services in that performance year.[101]

An executive with the Barnabas Health ACO noted, "Patient attribution or determining which patients should be included in shared savings programs is complicated."[102] ACOs do not have assigned provider networks as do managed care plans. Medicare beneficiaries are not limited in their care choices, and there is no financial consequence for the patients if they choose to seek care out of their ACO network. It is critical that physicians in an ACO understand how patients are assigned and who is assigned. The patient attribution occurs retrospectively at the end of each performance year. ACOs may be unaware of who is "in" the network and, therefore, target management resources inappropriately.

Effective population-based preventive care is enabled through the collaboration efforts within an ACO. Patients and families are ill-equipped for this responsibility. Joint prevention efforts can be organized, effective and less costly in the setting of the ACO. It becomes a one-stop-shopping experience benefiting patients, families and the overall community it serves.

The approach that ACOs take to patient engagement may vary across markets. Some ACOs will encourage patients to choose a primary care physician within the ACO. Others may determine whether patients are cared for by a specific organization by tracking where they get their care.

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[101] Valerie A. Lewis, Asha Belle McClurg, Jeremy Smith, Elliott S. Fisher and Julie Bynum. "Attributing Patients to Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests," Health Affairs 32.3 [Mar 2013]: 587.

[102] John F. Bonamo, MD, interviewed by author, West Orange, NJ, United States, April 23, 2015.

Patient centered communication is associated with faster recovery, improved clinical outcomes, a better care experience and fewer diagnostic tests and referrals. Patient centered care is also linked to decreased use of health services and lower annual charges. Well-informed patients are less likely to choose more aggressive and costly courses of treatment. Efforts to encourage patients to manage their own health and engage in healthy behavior are particularly effective when they are tailored to patients' needs and meaningfully address patients' goals.[103]

It is important for the ACO to understand its local environment including the degree of market concentration, the extent of collaboration and competition among providers and the presence of local stakeholder initiatives. Local context includes experience with health delivery system payment reforms such as pay-for-performance, bundled payments and patient centered medical homes; public reporting; current level of per capita spending and utilization which could affect the likelihood of achieving shared savings; and state policy concerning the uninsured and Medicaid populations.[104]

Predictive modeling alone cannot provide an ACO with the holistic view of patients needed to deliver proactive, effective care. Predictive risk scores must be augmented with clinical data, diagnoses, complications and gaps in care to illuminate opportunities with high risk patients.

Siegel writes, "This enables a physician to rethink prescribing a beta blocker to a 60-year-old diabetic man with heart disease once he sees that the patient is asthmatic."[105] [Certain beta blockers exacerbate airway constriction]

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[103] Cosgrove, 322.
[104] Fisher, 2374.
[105] Siegel, 21.

Another key element for the ACO management is segmenting its patient population in the near, medium and long term. Examples are patients who are diabetics and use the ED for primary care or elderly patients with non-specific complaints who go from specialist to specialist without getting better.[106] These patients reveal where the system is breaking down and require immediate targeted interventions.

Reducing ED visits, hospitalizations and excessive use of specialists are the ACO's goals for such patients. This can be achieved through the ACO's use of care coordination methods. The ACO can only go so far with acquiring a data driven view of its patient population. Then, the ACO must turn to 'art' in the form of physician extenders to comprehend what the data reveals about individual patients. The 'art' of ACO management is in designing effective interventions. Siegel writes that an example of such interventions could be:

> Reaching out to the diabetic with elevated glucose levels to schedule an appointment or running a weight loss group of patients who are morbidly obese.[107]

The ACO measures patient experience through the patient experience of care measures. This is accomplished through the Consumer Assessment of Healthcare Providers and Systems Survey. Each ACO is responsible for selecting and paying for a CMS-approved vendor to administer the CAHPS survey for the ACO. The patient experience survey focuses on how patients experience or perceive key aspects of their care, not how satisfied they are with their care. The patient experience survey asks patients whether or how often they experience critical aspects of health care, including

[106] Siegel, 21.
[107] Siegel, 21.

communication with their doctors, understanding their medication instructions and the coordination of their health care needs. The survey does not focus on amenities.[108]

Recognizing the transformative potential of patient-engaged care, new methods of organizing and paying for health care tie reimbursement to performance based measures of patient satisfaction and engagement. For example, to be eligible for Medicare's Shared Savings Program, ACOs must define, establish, implement and update processes to promote patient engagement. Each ACO must conduct a needs assessment of its patient population, effectively communicate medical evidence to patients and engage both providers and patients in shared decision making.

The question for the ACO executive is how to build a patient-centered health care system and deliver high-quality care in ways that are beneficial for both their patients and their bottom lines. The Hackensack Alliance ACO attempts to engage the patient at every point of the continuum of care. The approach is to use RN care coordinators especially when the patient is transitioning from one care setting to another. The emphasis is placed on the appropriateness of the new care setting and communication regarding it.

Each ACO must make meaningful patient engagement possible by building a role for patients and their families into the organization's systems and processes.[109] An example is for medical practices within the ACO to offer increased office hours and or services designed specifically for patients who have chronic care needs.

Nursing and Care Coordination

[108] Consumer Assessment and Healthcare Providers and Systems Survey 2015, Centers for Medicare and Medicaid. www.cms.gov/research-statistics-data-and -systems/research/cahps/index.html [accessed July 16, 2015].
[109] Cosgrove, 325.

"The major effect of the Affordable Care Act on nurse practitioners [NP] has been the publicity," writes Carolyn Buppert.[110] Nurse practitioners [NPs] have been deemed as an answer to what ails health care and viewing NPs as the solution to a problem is not new. The concept of the nurse practitioners was introduced in 1965 as an effort to deal with a physician shortage. The PPACA did not anoint NPs with any special powers or authority. What the PPACA did was to expand the opportunity for health insurance for millions of individuals and include NPs as providers in many sectors of the law. For example, the PPACA laid the groundwork for Accountable Care Organizations, which could house opportunities for NPs as clinicians, case managers and evaluators.[111]

Nurses were the original servant leaders at the patient's bedside and in communities. Today, they are perfectly positioned to take their experience with leadership to a heightened level. Nursing practice barriers have traditionally been drawn by national policies and state licensure laws and regulations. And, practice barriers have been the result of organizational cultures that were neither nurse nor patient care centric. The ACO model removes obstacles to practice by promoting a culture of inter-professional teamwork, including nurses on teams to solve quality and safety problems, and by designing improvements in the patient experience.

A transformational change in culture is seen in the deployment of nurses and nurse practitioners throughout an accountable care organization. Nursing leadership allows the individual nurse to contribute to decisions with their physician colleagues. Nurses would do well to focus their leadership on the aspects of care that matter to patients, the essence

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[110] Carolyn Buppert. "What hat the Affordable Care Act Meant, So Far, for Nurse Practitioners," The Journal for Nurse Practitioners 11.3 [Mar 2015]: 367.
[111] Buppert, 367.

of nursing. It is the little things, the small details that contribute to quality patient care. ACO leaders can remove barriers to collaborative care in order to allow more focus on the details of the patient experience. This will allow the nurse to provide high-quality patient care.

Health care is delivered by teams within and across settings. Nurse clinicians must learn to practice alongside physicians and other health care professionals. Nurses have always been innovators, taking ideas and translating them into interventions to improve patient care. The essential driving force of innovation in patient care is redesigning health systems.

The PPACA mandates healthier individuals and communities and nurses play a central role in teams whose boundaries are changing to put the needs of the patient first. Again, this is the servant leadership that nurses have always delivered. What is different now is that nurses are out front and center and are recognized to have the power to improve the health status of populations.[112]

Accountable care organizations are a force for good if they make teamwork their unshakeable cultural priority. This demands a recognition of the challenge embedded in the resistant nature of established patterns of behavior throughout health care. To fully achieve improved care, improved service and reduced cost, ACOs need to acknowledge that integrated care requires genuine teamwork. ACOs must promote and implement teamwork that is both cultural and structural. Cultural teamwork emerges from the values of team members: people in high performing teams want to collaborate to be part of something bigger than themselves. Structural tools such as payments plans,

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[112] Kenneth R. White. "The Future of Nursing Leadership: A Commentary," Frontiers of Health Services Management 31.2 [Winter 2014]: 27.

information technology and organization charts facilitate teamwork but do not alone constitute it. An ACO cannot rely solely on incentives to convince clinicians to be teammates if the teamwork is to be authentic and lead to meaningful results.[113]

Quality improvement and cost control rely on effective coordination of patient care. Registered nurses across the continuum of care play an essential role in care coordination. Greater health care efficiencies can be realized through coordination of care centered on the needs and preferences of patients and their families. Health care reform supports quality improvement and cost control to transform the health care delivery system, functions that are reliant on effective care coordination. Nursing possesses a unique set of skills to contribute to the care coordination role that could lead to higher quality care as well as cost reductions. The RN care coordinator fills a role that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions and sites are met over time. Care coordination is the deliberate organization of patient care activities between two or more participants [including the patient] involved in a patient's care to facilitate the appropriate delivery of health care services. It is a mechanism to assess the effectiveness of the care trajectory and makes adjustments to avoid an unexpected outcome with a subsequent increase in cost.[114]

The RN care coordinator completes a needs assessment, outlining an exhaustive list of services required, further defining those services preferred by the patient and family, and confirming that the services are delivered as outlined in the care plan. There are also various societal and cultural factors that are taken into account by the care coordinator.

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[113] Berry L. Leonard, PhD and Dan Beckham. "Team-Based Care at Mayo Clinic: A Model for ACOs," Journal of Healthcare Management 59.1 [Jan/Feb 2014]: 9.

[114] Stacey Cropley, DNP RN CPN and Ellerene Duis Sanders, PhD RN NEA BC. "Care Coordination and the Essential Role of the Nurse," Creative Nursing 19.4: 189.

These factors include such things as health literacy, direct-to-consumer drug marketing, cultural influences, ethical dilemmas, documentation across care providers, aging of the population and cases requiring long term care. The RN care coordinator must seek out resources and pertinent knowledge to enhance understanding of the patient's perspective fostering patients' engagement in the care. This ensures collaboration among inter-disciplinary care team involved.[115]

At the Hackensack Alliance ACO, there is a team of eleven well-trained registered nurses serving as Patient Care Coordinators. They are considered the key ACO liaisons. Each is charged with directing clinical interventions to assist high-risk patients through the continuum of care. The Patient Care Coordinators are supplemented by five Transition Assistants who are trained as medical assistants. The Transitions Assistants address the care coordination efforts for low-risk patients. They are viewed as part of the overall strategy for population health management.

RN care coordination is not a new concept to professional nursing. Historically, the nurse has assumed the role as partner with patients and families, using patient and family needs and preferences as guiding factors in the provision of patient centered care. The care coordination process is one part of professional practice through which nurses at every level influence patient care.[116]

A trustee of the Meridian ACO in explaining how Meridian achieved a shared savings payment in 2013 remarked, "we isolated the heaviest users of health care resources in our patient population and let the care coordinators go to work."[117]

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[115] Cropley, 189.
[116] Cropley, 190.
[117] Joseph Lemaire, phone conversation with author, Randolph, NJ United States, July 30, 2015.

It seems inevitable that RN care coordinators, will emerge as experts at navigating and coordinating resources to improve care. These clinical care coordinators may work in wellness care, acute illness care and chronic maintenance and will be critical members of the primary care team because they operate at the intersection of care delivery and resource utilization.[118]

As Carolyn Buppert notes that in our current era of health care reform, "it is a good time to be a nurse."[119]

Patient Centered Medical Homes, Post-Acute Providers and Others

Success in the world of ACO management depends on the ability of the ACO to reduce total costs for a population of patients. The ACO is cognizant of the full continuum of care for its population of patients. The starting point is the delivery of primary care then the move into and through acute care to post-acute services.

The proliferation of accountable care organizations is a strong move in the direction of per capita payment models. The framework for value-based payments is a progression that transitions from fee-for-service to population-based payment. In the future, margins will be generated by creating customer value for the whole health care dollar.

The ACO can take a strategic and tactical approach to reshape the health care enterprise by seeking affiliations with patient centered medical homes [PCMH] for primary care, hospitals for acute care [if the ACO is not already hospital based], skilled nursing facilities for rehabilitation services, retail and walk-in centers for non-urgent matters and the use of remote applications.[120]

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[118] Bard and Nugent, 140.
[119] Buppert, 368.
[120] Edmondson, 15.

The first principle is that every patient cared for by the ACO should have a contact who services as the patient's portal to the entire health care system.[121] The ACO must have a strong primary care delivery structure. Traditionally, this occurred through primary care physician groups, and such groups may be affiliated with an ACO; or, through an affiliation with a patient centered medical home.

There must be a movement initiated by the ACO to engage patients in their own care. The reason being that patient engagement is the growing evidence that patient engaged care is associated with better health outcomes, better care experience for patients and lower health care costs. One means to effect this change is through the presence of a patient centered medical home.

A patient centered medical home is a restructured approach to medical care that establishes the primary care practice as the patient's medical 'home,' one which is responsible for knowing the patient's full history, staying on top of their preventive care needs and coordinating and sharing data between any necessary specialists within that patient's network to avoid redundancy.

It is difficult to envision an ACO in which the principle point of access is not primary care – particularly primary care that embraces the patient centered medical home model as the assessor, organizer, provider and manager of care. This model transforms primary care into a team of care providers. The team includes physicians, physician extenders, nurses, social workers, navigators, care coordinators, nutritionists, clinical educators public health population analysts, home care providers, psychologists, clinical pharmacists, volunteers and support staff.[122] The PCMH transforms the provision of care

[121] Bard and Nugent, 137.
[122] Bard and Nugent, 137.

from a reactive operation when the patient calls or comes in the door, to a proactive and managed one. Each patient is assigned a customized care plan that is consistent with their individual needs.

In primary care settings, patient-centered communication is associated with faster recovery, improved clinical outcomes, a better care experience and fewer diagnostic tests and referrals. Well-informed patients are less likely to choose more aggressive and costly courses of treatment. Efforts to encourage patients to manage their own health and engage in healthy behavior are effective when they are tailored to patients' needs and address patients' goals.

New tele-health capabilities also improve patient engagement. Structured help lines, tele-monitoring of physiological data such as weight and blood pressure and tele-coaching can provide patients with structured after-care contact with clinicians improving patients' confidence and satisfaction.

ACOs are to define, establish, implement and update processes that promote patient engagement. ACOs conduct needs assessments of their patient populations, communicate medical evidence to patients and engage both providers and patients in shared decision making. A question for ACO management is how to build a patient centered health care system and deliver high-quality care in ways that are beneficial for both their patients and their bottom line. The ACO has to build patient centered care into its organization for patients and their families. The presence of a patient centered medical home within the organizational capacity of the ACO is one means to obtain engagement with patients and their families.[123]

[123] Cosgrove, 325.

Health Endeavors, LLC is an example of a technology company focused on cloud-based data management solutions. It provides a software solution for the effective management of ACOs. The components of its ACO Center software are a beneficiary data base, a quality measures tool and population analytics. An individual ACO, such as the Hackensack Alliance ACO can monitor its total cost of care, measure and improve quality and patient engagement and schedule the activities of care coordination.[124]

Another example of a creative application is the service provided through Purple Binder, Inc. based in Illinois. Purple Binder is a clinical and non-clinical computer application that identifies all of a community's resources and merges them into a master list. Their clinical application is designed for use by care coordinators and others who make community referrals. The firm's public application is designed to be accessible from any internet-connected device. It is tailored for use by lay people seeking services for themselves and their families. The two applications can be integrated to a care coordinator to create an online 'binder' of services for an individual or family.[125]

The ACO will also need to have affiliations with rehabilitation hospitals, sub-acute rehabilitation facilities, home health agencies, hospices and others to coordinate care across settings. These affiliations may be in place with existing IDS, MSGPs, IPAs and PHOs. One of the major difficulties, according to a post-acute services executive, is the varying degrees of the availability of electronic health records systems within these types of health care organizations and the resultant ability to communicate with an ACO. RN care coordinators through daily [hourly] contact with post-acute providers can achieve the right level of care for each patient.

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[124] Health Endeavors, LLC. ACO Center, https://www.jointheendeavor.com. [accessed August 20, 2015].
[125] Purple Binder, Inc. www.purplebinder.com/services/patient-tracking [accessed July 17, 2015].

CHAPTER FOUR

MEDICAID ACCOUNTABLE CARE ORGANIZATIONS

AND

VULNERABLE POPULATIONS

Safety net hospitals, public health agencies, state Medicaid programs and Medicaid Accountable Care Organizations are being brought together under the rubric of accountable care.

"Safety net hospitals and clinics have a unique mission to provide care to all who need it, regardless of ability to pay," writes Benjamin K. Chu in "Partners in Health."[126] Financial support for hospital operations, physician and other professional services, equipment, treatments and medications comes from disparate sources. The stability of funding depends on community commitment to the moral and ethical obligations to care for those in need. For the safety net, recruitment and retention of physicians in the face of such fiscal uncertainty is a huge problem. In addition, many communities served by safety net facilities are poor. High rates of poverty and population turnover in these communities present additional problems in recruiting physicians interested in caring for a stable group of patients.[127]

Safety net hospitals and clinics, particularly public hospitals, trace their origin to the almshouse. By necessity, institutions serving the poor needed to provide medical care to vulnerable populations whose economic circumstances predisposed them to ill health.

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[126] Benjamin K. Chu. Achieving the Vision – Special Issues for Safety net Hospitals and Clinics, Chapter 9, Partners in Health – How Physicians and Hospitals Can Be Accountable Together [San Francisco: Jossey-Bass, 2010], 185.
[127] Chu, 185.

The earliest models relied on physician volunteerism. A sense of civic duty and altruism was a strong underlying motivation.[128]

In 2006, the National Association of Public Hospitals and Health Systems published the results of a survey that shed light on the models of physician staffing for the public safety net and the strategies employed to align physicians to the larger mission of safety net institutions. Public hospitals employ three primary models to secure physician medical services.[129]

There is an integrated model of direct employment of medical staff physicians by the hospital. Physicians are integral parts of the operations, culture and administration of the hospital. Second, there is a contracted service model in which medical staff physicians are employed by a school of medicine, an independent group or a faculty practice plan. The public hospital contracts with the medical school, academic medical center or physician group for services at a rate that covers the physicians' salary expenses for clinical services. And finally, there is an alliance model that relies on physician billing for services to provide the financial backbone for physician compensation. There are limits on these mechanisms to finance physician services, given the burdens of uninsured and under-reimbursed services in public safety net settings.[130]

Regardless of the model, there are several issues. First, collecting and reporting data on the key elements of a physician group's business – clinical activity, service and quality – is critical to running a productive and efficient practice. Next, careful accounting for a collection of physician time and effort data by clinical service, teaching,

[128] Chu, 186.
[129] Chu, 187.
[130] Chu, 187.

research and administration is essential to understanding the benefits of an academic relationship. And finally, the dependence on mission driven and academic incentives for recruitment and retention of physicians masks the underlying difficulties in offering competitive compensation. Recruitment efforts that capitalize on an individual physician's desire to serve a larger social mission have their limitations especially when market forces are pushing the doctor in a different direction.[131]

"In an ideal world, teaching, research and patient care should come together to provide for the best service to the public safety net clinics," concludes Benjamin K. Chu.[132]

Public health agencies [PHA] can participate in ACO partnerships with state Medicaid agencies. Because of an ACO's population health orientation and need for related expertise, there is a role or market niche for state and local public health agencies with ACOs.

For example, writes Julia F. Costich and others in the American Journal of Public Health:

> The surveillance function of a public health agency can identify persons at risk for having costly health problems, particularly communicable conditions such as tuberculosis and sexually transmitted infections. Public health agencies maintain registries of groups of hard to serve populations that could incur disproportionate costs as ACO members, such as persons with cancer, stroke, infants with birth anomalies, vulnerable populations needing attention during emergencies.[133]

However, although public health competencies are used to address the health of all those residing in a public health agency's jurisdiction, the attributed population in an

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[131] Chu, 188.
[132] Chu, 190.
[133] Julia f. Costich, Douglas F. Scutchfield and Richard C. Ingram. "Population Health, Public Health and Accountable Care: Emerging Roles and Relationships," American Journal of Public Health 105.5 [May 2015]: 846.

ACO includes only individuals who receive primary care from ACO member providers and is thus a small subset of the population served by a public health agency.

Considering the distinction between the populations served by public health agencies and accountable care organizations, Costich and others ask, "Why would ACO collaboration be of interest to a public health agency?"[134] One answer is that government public health programs have undergone repeated funding cuts at all levels since 2008 and are thus under pressure to identify alternative revenue sources such as ACOs.

Public health agencies could also be interested in collaboration with accountable care organizations because their core mission is to improve the health of populations they serve. When a PHA helps an ACO improve its members' health, it raises the health status of its own population.[135]

Safety net hospitals and health care systems that dominate local markets are likely to have some interaction with their local public health agency. A safety net hospital or health care system that serves a larger share of the population in its geographic area, its identification of target populations is similar to those of the local public health agencies.[136]

Medicaid is the nation's public health insurance program for low-income Americans, covering close to 60 million children, families, seniors and people with disabilities. Approximately two out of three Medicaid beneficiaries are enrolled in a comprehensive form of managed care. In recent years, states have turned to managed care in response to

[134] Costich, 848.
[135] Costich, 849.
[136] Costich, 850.

a growing interest in improving care for beneficiaries with complex needs and to address ongoing budget pressures.[137]

State Medicaid programs provide health care and social supports to beneficiaries through a complex array of care delivery arrangements and authorities. These care delivery arrangements are a result of states' efforts to address the complicated health care needs of diverse beneficiary populations including low-income pregnant women, people with physical and mental disabilities, people with chronic diseases and seniors.[138]

Facing ongoing economic challenges, many states are under considerable budget pressure and seek immediate savings. Because Medicaid programs account for a large share of state spending, they are often the focus of state cost-containment efforts.

Interest in Medicaid ACOs appears to be fueled by a belief that ACOs have the potential to both deliver higher quality care and to improve efficiency and value. Most states applying the ACO concept in Medicaid have focused on strategies designed to increase provider engagement and accountability for care and to realign financial incentives over time.[139]

The primary difference between a Medicare ACO and a Medicaid ACO is the reason for hospital admissions and readmissions. In the Medicare ACO, admissions are the result of medical problems while in the Medicaid ACO, admissions are often due to behavioral and or social problems.

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[137] Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, Emerging Medicaid Accountable Care Organizations: The Role of Managed Care Organizations [Washington, DC: Kaiser Family Foundation, 2012], 2.
[138] Kaiser, 4.
[139] Kaiser, 7.

Medicaid ACOs are likely to include PHAs a providers or strategic partners. Both the origin of the Medicaid ACOs and the populations they serve are closely aligned with the roles of state and local PHAs. Christopher Dadlez writes of accountable care communities as an example of the future for ACOs, "Accountable care communities are a multi-sector, community-based collaborative effort to transform health care."[140] The Medicaid ACO is an example of shared responsibility for the health of a community.

New Jersey has begun to explore the possibility of implementing accountable care organizations in Medicaid along with four other states: Colorado, Oklahoma, Oregon and Utah.

In New Jersey, most Medicaid beneficiaries are enrolled in risk-based managed care organizations [MCOs]. The New Jersey ACO initiative arose independently from the provider-based community. For example, in Camden, NJ a local coalition, the Camden Coalition of Healthcare Providers, focused on high utilizers to reduce emergency room use and improve outcomes. Those who are frequently in hospitals, known as 'super users,' comprise about one percent of the inpatient population and about thirty percent of hospital billings. According to the Camden Coalition, of the 79,000 residents in the city, 386 patients accounted for the top one percent of emergency department visits in 2011.[141]

"We are knee deep in housing policy," said Dr. Joseph Brenner, founder of the Camden Coalition, "we have built the most expensive homeless shelters when we put these patients in hospital beds…we are spending money in the wrong places. We medicalize social problems in America and we see that every day."[142]

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[140] Christopher Dadlez, FACHE. "Population Health Management: The Intersection of Concept and Reality," Frontiers of Healthcare Management 30.4 [Summer 2014]: 34.
[141] The Star-Ledger [Newark], 2 July 2015.
[142] The Star-Ledger [Newark], 2 July 2015.

In August 2011, the State of New Jersey approved a law requiring its Department of Human Services, Division of Medical Assistance and Health Services to establish a three year Medicaid Accountable Care Organization demonstration project. Progress was delayed by practical challenges associated with integrating the ACO concept into the current Medicaid program and with figuring out how to structure the related regulations.

In New Jersey, the legislature authorized a grass roots provider-based ACO initiative. The state wished to retain its intensive network of risk-based Managed Care Organizations [MCO], which have the authority to specify the terms of provider contracts [including any gainsharing component]. Though the state envisioned that the MCOs would contract directly with the ACOs, the legislation did not address the structure of these contractual relationships in detail. The ensuing legislation made MCO participation in the initiative voluntary.[143]

There is a three year demonstration project for community based ACOs that serve 5,000 or more beneficiaries and contract with at least 75 percent of providers, 100 percent of hospitals in the region and four mental health providers. The ACOs will be eligible for shared savings if they meet quality metrics. The ACO initiative is similar to population-based high cost enrolled case management.

The Medicaid ACO demonstration project provides the New Jersey Medicaid program an opportunity to explore innovative system re-design including the following:

- Testing the ACO as an alternative to managed care
- Evaluating how care management and care coordination can be delivered to high risk, high cost utilizers

[143] Kaiser, 9.

- Stretch the role of Medicaid beyond just medical services but to integrate social services
- Testing payment reform models including pay for performance metrics and incentives

The NJ Medicaid ACO Demonstration project is intended to:

1. Increase access to primary care, behavioral health care, pharmaceuticals and dental care by Medicaid recipients residing in defined regions
2. Improve health outcomes and quality as measured by objective metrics and patient experience of care
3. Reduce unnecessary and inefficient care without interfering with patients' access to their health care providers or the providers' access to existing Medicaid reimbursement system

The NJ Medicaid ACOs are to develop relationships with primary care, behavioral health, dental, pharmacy and other health care providers. The Medicaid ACO demonstration project providers continue to receive Medicaid payments from managed care organizations and directly from the Medicaid system. The applicants for participation in the demonstration program must be nonprofit corporations with a governing board consisting of local health care providers, patients, social service agencies, and consumer organizations. The Medicaid ACO demonstration project is attuned to the local nature of health care delivery in inner city areas.

A NJ Medicaid ACO must have a process for the receipt of and distribution of gainsharing payments in accordance with a quality improvement and gainsharing plan which is approved by the state Department of Human Services. The gainsharing plan

calculates savings through the identification of expenditures per Medicaid recipient during a benchmark period compared to a benchmark payment calculation to amounts paid by Medicaid fee-for-service residents. Gainsharing is the split of savings between the State and the Medicaid ACO. The gainsharing plans are due to be submitted to the State by June 30, 2016.

Interestingly, the Department of Human Services retains the right to consider using a portion of any savings generated to expand the nursing, primary care, behavioral health care and dental workforces and services in the area served by the ACO. And, the gainsharing plan must include an assessment of the expected impact on revenues of the participating hospitals. This reflects concern about whether participation in the demonstration project could impact the financial stability of any hospital.

The New Jersey Medicaid ACO demonstration project quality metrics reflect similar concerns as the federal Medicare ACO quality metrics. The broad categories are:

- Prevention and effectiveness of care
- Acute care [only RSV, respiratory syncytial virus, in neonates < 35 weeks]
- Behavioral health
- Chronic conditions
- Resource utilization
- CAHPS satisfaction

There are also two voluntary quality measures reflecting preventive and chronic conditions. The difference is more of an emphasis on neonatal care, HIV/AIDs care and dental care. As noted by Denise Rodgers, Trustee of the Health Greater Newark ACO,

"…focus on preventing and reducing chronic illnesses in children and on providing access to prenatal care to reduce the number of low-birth weight babies."[144]

Eight organizations applied to become Medicaid Accountable Care Organizations in various locations throughout New Jersey.[145] As of July 1, 2015, there are three certified Medicaid ACOs in New Jersey. These ACOs are as follows:

- Camden Coalition of Healthcare Providers, Camden, NJ
- Healthy Greater Newark ACO, Newark, NJ
- Trenton Health Team, Trenton, NJ

The New Jersey Medicaid Accountable Care Organizations are preparing gainsharing plans for submission to the State Department of Human Services. These organizations will become operational thereafter and it remains to be seen whether the Medicaid ACOs will somehow become affiliated with the Medicare ACOs. Both types of ACO have overlap in the affiliations with the acute care hospitals.

Correctional Medicine

A tangent to the Medicaid ACO is the presence of the national prisoner population. The steady rise of the mass incarceration of the elderly is problematic in America. As of 2009, prisoner population rates per 100,000 were 276 in the USA. Of the 2. 3 million persons in custody in the USA, 16 percent are aged 50 and older. Tina Maschi and others writing in the International Journal of Prisoner Health note that "the major reason for the

[144] The Star-Ledger [Newark], 23 July 2015.
[145] New Jersey Department of Human Services, Division of Medical Assistance and Health Services, Accountable Care Organizations. https://www.state.nj.us/humanservices/dmahs/info/aco.html [accessed July 8, 2015].

rise in aging prison populations in twofold: increases in the aging population coupled with the long-term aftermath of stricter sentencing policies in the 1980s."[146]

The prison system is not prepared to address the growing numbers of the incarcerated aging in prison, especially those aged 65 and older, which increases the likelihood that costs for specialized long-term care will continue to strain budgets and resources.

Providing disease prevention programs and consistent medical care while incarcerated and anticipating transitions to community-based care, including patient centered medical homes for Medicaid beneficiaries, and or accountable care organizations for elderly who suffer from chronic conditions, are critical for removing health barriers that prevent released prisoners from seeking employment, housing or renewed family and community relationships.

Improving care while incarcerated is an important step toward reducing overall costs of incarceration and re-entry; costs for care while incarcerated are two to eight times higher for those between the ages of 55 and 80.[147]

Traditional clinical prevention interventions and practice-based population measures involve data that can be captured in the routine manner of a one-to-one encounter of a patient with a clinician and then aggregated across a practice or a system. Total population measures involve data predominantly collected by local, state or federal health officials. Community level care and context changing interventions often involve what may be referred to as process measures as well as outcome measures. These measures aim to positively influence the conditions in specific communities or in certain settings,

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[146] Tina Maschi, Deborah Viola, Mary T. Harrison, William Harrison, and Lindsay Koskinen. "Bridging Community and Prison for Older Adults: Invoking Human Rights and Elder and Intergenerational Family Justice," International Journal of Prisoner Health 10.1: 55.
[147] Maschi, 60.

such as prisons, resulting in the widespread prevention of illness and injury. Such measures are most feasible for sizable organizational entities such as accountable care organizations.[148]

Expansion of affordable health insurance is one of the three primary goals of the Patient Protection and Affordable Care Act. A substantial subset of the population that is now eligible for Medicaid coverage consists of individuals who are incarcerated, on probation or on parole. As many as 2.86 million, or 22 percent, of the anticipated 13 million adults newly eligible for Medicaid will be 'justice-involved' persons.

Understanding the demographic and epidemiologic features of this segment of the Medicaid population is essential for the understanding how to target enrollment efforts, anticipated health care needs and prepare the delivery system to meet those needs.

The 'justice-involved' population has a higher disease burden then the general population. Many of these people lack health insurance at the time of their release from incarceration. This disparity between disease burden and access can drive up the cost of health care, result in worse outcomes, and cause patients to seek care later than appropriate and in care settings that are often isolated and lack care coordination.

Successful integration into community care for this population requires systems that effectively engage and clinically integrate users of the health care system. Newer models of care such as accountable care organizations and patient centered medical homes incorporate cultural competencies that deal with the social determinants of health. ACOs in particular present an opportunity for providers to work across settings to meet financial

[148] John Auerbach. "Creating Incentives to Move Upstream: Developing a Diversified Portfolio of Population Health Measures Within Payment and Health Care Reform," American Journal of Public Health 105.3 [Mar 2015]: 427.

and quality benchmarks for an attributed population of patients. There is great potential for collaboration between criminal justice and community based health systems.[149]

[149] Kavita Patel, Amy Boutwell, Bradley W. Brockmann and Josiah D. Rich. "Integrating Correctional and Community Health Care for Formerly Incarcerated People Who Are Eligible for Medicaid," Health Affairs 33.3 [Mar 2014]: 464.

CHAPTER FIVE

NEW JERSEY MEDICARE EXPERIENCE

Dr. David J. Shulkin, the Chief Executive Officer of the Atlantic Health System in Morristown, New Jersey referred to the Atlantic ACO saying, "We started our ACO because we needed to create a health care delivery system that allows physicians, hospitals and other health care organizations to better address the health needs of our community."[150]

New Jersey is not known for integrated health care. Physicians and hospitals tend to be economically and clinically isolated, with trends in physician employment and toward integrated models of care lagging well behind the nation.[151] New Jersey residents have a 25 percent greater chance of staying in an intensive care unit, a 50 percent greater rate of physician visits and a 75 percent greater use of specialists; more than 46 percent of patients have 10 or more doctors in the last 6 months of life. And, New Jersey leads the nation in health care costs in the last 2 years of life.[152]

The Patient Protection and Affordable Care Act, through the Medicare Shared Savings Program and the development of Accountable Care Organizations has given New Jersey a catalyst for change. The development of ACOs represents a market force that promotes systems of care; collaboration among health care professionals; coordination of community based resources; public engagement; innovative models of health care delivery; system-wide metrics on cost, quality and services; and aligned incentives.

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[150] David J. Shulkin, MD. "Building an Accountable Care organization for All the Wrong Reasons," Mayo Clinic Proceedings 87.8 [Aug 2012]:721.
[151] Shulkin, 721.
[152] Shulkin, 721.

There are nineteen Accountable Care Organizations listed on the CMS website as approved to serve beneficiaries in the State of New Jersey.[153] All of the New Jersey ACOs are in the Medicare Shared Savings Program.

The New Jersey ACOs are organized either through hospital-physician arrangements or as multi-specialty group practices. The organizational structures for each of the NJ ACOs have boards of trustees along with medical and administrative responsibilities within each organization.

The following ACOs are sponsored by hospitals or health care systems:

- Atlantic ACO
- Hackensack Alliance ACO
- Barnabas Health ACO North
- Central Jersey ACO
- Meridian Accountable Care Organization
- Capital Health Accountable Care Organization
- AtlantiCare Health Solutions
- JFK Population Health Company
- HNMC Hospital/Physician ACO
- LHS Health Network
- RWJ Partners

The following ACOs are multi-specialty group practices:

- Allegiance ACO

[153] Medicare Shared Savings Program: Accountable Care Organizations. https://data.cms.gov/browse?category=aco&ut8= [accessed July 21, 2015].

- Optimus Healthcare Partners
- Advocare Well Network
- Chrysalis Medical Services
- NJ Physicians ACO
- Partners in Care ACO
- Inspira Care Connect
- VirtuaCare

The nineteen New Jersey Medicare ACOs do not include the three certified New Jersey Medicaid ACOs.

Of the nineteen New Jersey Medicare ACOs, eleven of them reported results in the most recent reporting year. The following comments will focus on those eleven ACOs for which information is obtainable from the CMS website.

Three of the eleven New Jersey ACOs reported an achievement of positive savings of total benchmark expenditures minus total assigned beneficiary expenditures in 2013. The percentage savings amounted to between three and four percent of the difference between the benchmark and the actual number. The three ACOs that generated financial savings for Medicare were: Hackensack Physician-Hospital Alliance; Meridian ACO; and, Optimus Healthcare Partners. The federal government announced in September 2014 that Optimus saved Medicare $17.03 million and received a shared savings payment from the federal government of $8.34 million; Meridian saved Medicare $14.89 million and received $7.30 million; Hackensack saved $10.75 million and received $5.27

million.[154] The savings were distributed among the physicians participating in the respective ACOs.

The number of attributed Medicare beneficiaries for the eleven New Jersey ACOs ranged from a low of 10,276 beneficiaries to a high of 73,694 beneficiaries. An ACO must have a minimum of 5,000 attributed patients to receive federal approval. The Hackensack Physician-Hospital Alliance reported 16,383 attributed beneficiaries; Meridian ACO reported 40,133 attributed beneficiaries; and Optimus Health Care Partners reported 34,542 attributed beneficiaries. The New Jersey ACO with the most attributed beneficiaries is the Atlantic ACO in the Morristown area with 73,694 beneficiaries. The Atlantic ACO is the second largest in the country. The attributed Medicare patients in New Jersey ACOs represents a small percentage of the 1. 4 million Medicare recipients in the state.

All eleven of the ACOs reported on the thirty-three quality measures in the most recent period. The first seven quality measures encompass the patient/caregiver experience. This experience is an essential component to the short and long term success or failure of an ACO. Providers can receive a financial reward for putting their patients first. As a result, providers are paying increased attention to how they can retain patients by making every patient interaction with the provider as engaging, positive and meaningful as possible. To be successful in delivering an experience that is relevant to the needs of both the patient and care giver.

The means to measure the patient/caregiver experience is the Consumer Assessment of Health Care Providers Survey. Each ACO contracts with a federally approved vendor

[154] New Jersey Biz [Trenton], 8 January 2015.

to conduct the survey. The survey contains the seven ACO patient/caregiver measures as follows:

- ACO 1 Getting timely care, appointments and information
- ACO 2 How well your doctors communicate
- ACO 3 Patients' ratings of doctors
- ACO 4 Access to specialists
- ACO 5 Health promotion and education
- ACO 6 Shared decision making
- ACO 7 Health status/functional status

ACO providers who are successful in achieving positive results on the survey know the key interactions that drive patients' perceptions of service delivery. They put their patients at the center of their day-to-day operations. It is important to provide personalized service, health and wellness education that the patient and care giver can easily understand and an overall good experience. All eleven of the New Jersey ACOs scored at or above the national mean in the patient/caregiver measures.

Optimus Health Partners, a multi-specialty group practice ACO, scored above all of the mean scores. For Optimus, its highest scores in the patient/caregiver experience category were in ACO-2 and ACO-3, 'how well your providers communicate' and 'patient rating of provider.' And, as noted above, Optimus received the largest shared savings payment.

The eleven New Jersey ACOs reported on the six quality measures for the care coordination/ patient safety. These measures are as follows:

- ACO 8 Risk standardized all conditions readmissions

- ACO 9 Chronic obstructive pulmonary disease and asthma in older adults
- ACO 10 Heart failure
- ACO 11 Electronic health record meaningful use
- ACO 12 Medication reconciliation
- ACO 13 Falls screening

ACO-8 is the measure of re-admissions to the hospital within 30 days of discharge. Readmission following an acute hospitalization is a costly and often preventable event. Hospital readmission is also disruptive to patients and caregivers. Readmission puts patients at additional risk of hospital-acquired infections and complications. Some readmissions are unavoidable, but readmissions may also result from poor quality of care, inadequate coordination of care or lack of effective discharge planning and transition care.

Most hospitals in New Jersey will pay a penalty for failing to prevent readmissions among elderly patients within 30 days of discharge based on information up to June 30, 2014. A total of 63 hospitals will forfeit an average of 0.73 percent on every Medicare reimbursement beginning in October 2015. This is higher than the national average of 0.61 percent. The fines are part of the PPACA and are meant to encourage sound discharge planning and follow-up care.[155] In 2011, New Jersey ranked 50th out of 53 districts nationally in the 30-day all readmission category.

ACO-8 is the all condition readmission quality measure. ACOs have incentives under the Medicare Shared Savings Program to manage the range of medical care, coordination of care and other factors affecting readmission rates for their assigned beneficiaries.

[155] The Star-Ledger [Newark], 5 August 2015.

Of the eleven New Jersey ACOs reporting on ACO-8, three ACOs reported readmission rates below the mean score of 14. 89. The range for the New Jersey ACOs was a low of 13.73 recorded by Meridian Accountable Care Organization to a high of 17.96 reported by the Balance ACO. Interestingly, Optimus Health Partners recorded a readmission score of 15.14 slightly above the mean. Optimus was the most successful ACO in terms of receiving a shared savings payment from CMS.

ACO-11 is the measure of primary care physicians who successfully qualify for an electronic health record program incentive payment. The American Recovery and Reinvestment Act of 2009 provides an incentive payment for Medicare and Medicaid providers who adopt, implement, upgrade or meaningfully use certified electronic health records technology. These incentives are intended to improve health care processes and outcomes. Health information technology has been shown to improve quality of care by increasing adherence to guidelines, supporting disease surveillance and monitoring and decreasing medication errors through decision support and aggregation capabilities.

The mean score for ACO-11 is 65.03. The New Jersey ACOs had a range from a low of 25.48 at Balance ACO to a high of 81.94 reported by Advocare Well Network. Both Balance ACO and Advocare are multi-specialty group practices showing a wide variation on the meaningful use of electronic health records. The three ACOs that received shared savings program payments reported ACO-11 results near or above the mean score, with Optimus Health Partners recording the highest score of 75.81. This is an indication that Optimus also has made a meaningful effort to use electronic health records.

ACO-13 is concerned with the risk of falls among the elderly, and specifically the screening of elderly patients for the risk of falling. Falls are a major health problem among the elderly. Catarina L.N. Pereira and others wrote that:

> Thirty percent of people aged 65 and older living in the community fall at least once a year. As life expectancy increases, there is a higher number of less healthy and less fit elderly people living longer with their infirmities…consequently, the risk of falls and their consequences is now greater than before.[156]

The mean score for ACO-13 falls assessment is 38.2. The eleven New Jersey ACOs reported a range of scores form a low of 6.88 at Virtua Care to a high of 72.22 at Advocare. Of the three New Jersey ACOs that received a shared savings payment only Optimus Health Partners with a score of 39.44 was higher than the mean score.

There are eight quality measures in the preventive care category as follows:

- ACO 14 Influenza immunization
- ACO 15 Pneumonia vaccination
- ACO 16 Body mass index screening and follow-up
- ACO 17 Tobacco use screening and cessation intervention
- ACO 18 Clinical depression and follow-up plan
- ACO 19 Colorectal screening
- ACO 20 Breast cancer screening
- ACO 21 Blood pressure screening

ACO-19 is the quality measure for colorectal screening. Colorectal cancer is the second leading cause of cancer-related deaths in the United States. It places significant

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[156] Catarina L.N. Pereira, Peter Vogelaere and Fatima Baptista. "Role of Physical Activity in the Prevention of Falls and Their Consequences in the Elderly," European Review of Aging and Physical Activity [2008] 5:51.

economic burden on society; treatment costs over $6.5 billion per year. Unlike other screening tests that only detect disease, some methods of colorectal cancer screening can detect pre-malignant polyps and guide their removal which can prevent the cancer from spreading. Systematic screening can reduce mortality from colorectal cancer screening and may also lower mortality by allowing detection of cancer an earlier stages.[157]

The eleven New Jersey ACOs conducted colorectal screening from a low score of 43.46 at Advocare to a high score of 67.38 at Hackensack Alliance ACO. The mean score was 59.32 for the eleven ACOs.

ACO-20 is the quality measure for breast cancer screening. Breast cancer is the second most common type of cancer among American women with approximately 178,000 new cases reported each year. It is most common in women over 50. Women whose breast cancer is detected early have more treatment choices and better chances for survival.[158]

The eleven New Jersey ACOs conducted breast cancer screening recording scores from a low of 38.06 at Advocare to a high of 67.97 at Balance ACO. The mean score was 61.72. Hackensack Alliance and Optimus Health Partners recorded scores of 65.22 and 61.09 respectively.

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[157] Agency for Healthcare Research and Quality, Quality Measures. http://www.qualitymeasures.ahrq.gov/content.aspx?id=48604&search=adult+screenings [accessed July 28, 2015].

[158] Agency for Healthcare Research and Quality, Quality Measures. http://www.qualitymeasures.ahrq.gov/content.aspx?id=48604&search=adult+screenings [accessed July 28, 2015].

The At-Risk Population category of ACO quality measures includes the following measures two of which are composites scores ACO 22-26 for diabetes and ACO 32 -33 for coronary heart disease.

- ACO 22 – 26 Diabetes composite
- ACO 27 Diabetes
- ACO 28 Hypertension
- ACO 29 Lipid profile and LDL control
- ACO 30 Aspirin use
- ACO 31 Beta-blocker use
- ACO 32 and 33 coronary heart disease

The At-Risk Population domain for ACO quality measures contains a composite measure that combines five metrics that reflect the care and treatment of diabetic patients. Diabetes is a high impact clinical condition, a leading cause of death and a significant risk factor in developing cardiovascular disease and stroke, non-traumatic lower extremity amputations, blindness, and end-stage renal disease. Most people who have diabetes have other risk factors such as high blood pressure and cholesterol that increase the risk for heart disease and stroke.

An approach to diabetes care that includes emphasis on blood pressure, lipids, glucose, aspirin use and the non-use of tobacco can maximize health outcomes more than a strategy that is limited to just one or two clinical domains.

The three New Jersey ACOs that received shared savings payments, Hackensack, Meridian and Optimus, out-scored the mean in the diabetes composite quality measures.

The only abnormality in this comparison was a decrease in aspirin use from 2012 to 2013 for the patients served by Optimus Health Partners.

The New Jersey Medicare ACO experience to date is early and limited. The ACOs are challenged with specific quality measures that when achieved have a good chance to result in cost containment. Three New Jersey ACOs received a shared savings payment from the federal government. However, the total Medicare population covered by ACOs in New Jersey is small. This population is also largely unaware that they are receiving care through an accountable care organization. And, this population is not bound to remain in their accountable care organization [provider network.] There is room for growth in the total number of covered lives within the various ACOs; and in the use of comprehensive primary care and evidence-based medicine. These factors should result in significant improvements in the quality of care and a reduction in cost over time.

CHAPTER SIX

MEDICAL HUMANISM

AND

ACCOUNTABLE CARE ORGANIZATIONS

The development of accountable care organizations is an attempt to walk a line between the delivery of high-quality cost-effective health care while respecting the rights of the individual patient. Solomon Benatar writing in Perspectives in Biology and Medicine notes:

> The humanistic attributes associated with good medicine could be conceived as including a way of keenly observing patients and applying scientific knowledge, medical technology and care in a manner that reflects understanding of the personalized suffering of each individual patient, while inspiring confidence, trust and hope.[159]

Two major movements have emerged in medicine, both intended to improve patient care. Drs. Pamela Hartzman and Jerome Groopman describe these movements as medical humanism and evidence-based medicine.

> The medical humanism movement seeks to understand the patient as a person, focusing on individual values, goals and preferences with respect to clinical decisions. The second movement is evidence-based practice, which aims to put medicine on a firm scientific footing; experts evaluate the best available data and develop clinical guidelines designed to standardize procedures and therapies.[160]

The two movements are reflected in the development of accountable care organizations, and in a greater sense, health care reform.

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[159] Solomon Benatar and Ross Upshur. "Virtue in Medicine Reconsidered: Individual Health and Global Health," Perspectives in Biology and Medicine 56.1 [Winter 2013]: 127.

[160] Pamela Hartzband, MD and Jerome Groopman, MD. "Keeping the Patient in the Equation – Humanism and Health Care Reform," New England Journal of Medicine 361.6 [Aug 6, 2009]: 554.

There is a kinship between medicine and baseball that is found in the recent struggles of both fields to use evidence in practice. Christopher J. Phillips in comparing the use of data in the game of baseball, as described in the book Moneyball to that of medicine notes:

> The architects of the new evidence-based baseball have developed metrics to assess the performance of players in terms of the value they add to the overall team effort. Similarly, the architects of new value based approaches to health care delivery have attempted to develop metrics to evaluate the performance of therapeutic strategies, individual practitioners and organizations.[161]

In both medicine and baseball, advocates of evidence-based approaches argue for the enhanced use of statistical techniques to reveal what tradition or habit obscures. Statistical power can be as relevant as opposite-field hitting power in the assessment of players. Early proponents of controlled medical trials similarly pointed to how difficult it was for an individual practitioner to determine a treatment's efficacy or distinguish real effects from apparent ones after seeing only a small number of clinical cases. Mathematical measurements and calculations are meant to push practitioners away from naïve visual biases – a player who looks right or a therapy that seems to work.[162]

Critics of the "money-ball" approach in baseball and the use of evidence-based guidelines in medicine emphasize the way in which perspective can be distorted, not enhanced, by statistics. Individuals and individual scenarios can always be idiosyncratic on some level.

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[161] Christopher J. Phillips, PhD, Jeremy A. Greene, MD, PhD and Scott H. Podolsky, MD. "Moneyball and Medicine," New England Journal of Medicine 367.17 [Oct 25, 2012]: 1581.
[162] Phillips, 1581.

The development of accountable care organizations represents an important test of the 'moneyball medicine' concept in practice. If ACOs can demonstrate the delivery of high-value care at lower costs, that would hold a promise for a revolution in medicine. Demanding evidence of value in medicine does not need to be at odds with the values of medical humanism, much as demanding attention to numerical logic need not be at odds with recognizing the important of clinical judgment.[163]

"What does humanity in modern medicine mean?" asks Andrew Miles in writing about patient centered medicine. He questions whether it is possible to practice a form of medicine that is without humanity.[164] Modern medicine is increasingly practiced in a de-personalized fashion, where the patient is understood not as a unique human individual, a person, but rather as an object in the manner of a complex biological machine. Medicine has become distracted from its duty to care, comfort and console as well as to ameliorate, attenuate and cure. The development of medicine's scientific knowledge is the cause.

Miles describes patient centered care, evidence-based medicine and the patient centered model in an argument that attempts to reverse the de-personalization of clinical care.[165] Patient centered care is a model for the doctor-patient interaction with a focus on the individual patient, attention to patient satisfaction with the process and the outcome of health care intervention. It is an effort to place the patient and his or her needs and circumstances at the center of clinical consultations. It is not technology centered, doctor centered, hospital centered or disease centered. Evidence-based medicine places a de-emphasis on intuition and unsystematic clinical experience as grounds for clinical-

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[163] Phillips, 1582.
[164] Andrew Miles. "Science, Humanism, Judgement, Ethics: Person-Centered Medicine as an Emergent Model of Modern Clinical Practice," Folia Modica 55.1 [Jan-Mar 2013]: 6.
[165] Miles, 7.

decision making. It prefers the use of scientific evidence from clinical research as the basis of practice.

Miles further describes the patient centered model. Medicine has the unalterable imperative to care, comfort and console as well as to ameliorate, attenuate and cure. He notes that 'it is vital to maintain these two triads in functional integration rather than allowing them to drift apart."[166] The ability to successfully integrate these functions is precisely that which distinguishes medicine from all of the other professions – its ability to care for the patient as well as to apply technical expertise in attending to the biological dysfunction of illness. The patient centered model reconnects the science, humanism and ethics of medicine and it is at the intersection of these three components that patient-centered medicine is found.[167]

The core principles of medical humanism are the dignity for individuals and families and the autonomy for them to make decisions about their own health. This approach represents a shift from the traditional paternalistic role in which doctors simply told the patient what to do without factoring in the patient's wishes. At the same time, the application of scientific evidence rather than anecdote to clinical practice has extended to virtually every area of medicine.

Health care reform brings underserved populations and the disadvantaged into the medical system. These groups are disproportionately composed of poor Americans, members of racial and ethnic minorities, recent immigrants and young adults. Complex psychological, sociological and cultural factors challenge the successful integration of these groups into the health care system. The skills associated with medical humanism

[166] Miles, 15.
[167] Miles, 17.

are more important in helping physicians and other clinicians understand these patients' values and needs, which will have to be taken into account if prevention and treatment guidelines are to be successful.[168]

It is here that medical humanism and evidence-based medicine must coalesce. Outright collisions between medical humanism and evidence-based guidelines for standardized care can be avoided as long a clinical guidelines remain recommendations rather than mandates.[169]

Mandated rather than recommended treatment guidelines are part of health care reform. The guidelines can have the unintended consequences of misaligning the goals of doctors and patients. Physicians can find themselves financially motivated to pressure patients into accepting a mandated treatment, regardless of whether it is compatible with their values or preferences, or to avoid caring for patients who refuse mandated treatment.

Hartzman and Groopman write "the remedy for this situation is shared decision making as a central change resulting from the current health care reform initiatives."[170] In the debate over health care reform, much has been made of the World Health Organization's ranking of the United States as 37th in health care overall. What is not emphasized is that we are ranked first in responsiveness – that is, providing patients with choices that are meaningful to them.

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[168] Hartzman and Groopman, 555.
[169] Hartzman and Groopman, 555.
[170] Hartzman and Groopman, 555.

Retaining our advances in shared decision making will allow us to ethically combine the contributions of medical humanism and evidence-based guidelines while addressing the imperative of cost containment.

The accountable care organization is an attempt to arrest and reverse the depersonalization of clinical practice into a moral enterprise. The ACO is a model of care based on clinical collaboration, patient engagement and the use of data through evidence-based medicine. It can represent the most human of sciences and the most scientific of the humanities.

CHAPTER SEVEN

SUSTAINING AN ACCOUNTABLE CARE ORGANIZATION

Health care reform has given us the accountable care organization. On the local or community level, there is a federally approved organization, the ACO, with a legitimate governing body, professional management, contractual relationships with primary care and specialty physicians, a hospital[s], and a host of other health care professionals and organizations.

In the first year of operation, the ACO achieves savings from our total health expenditures compared to a federally established benchmark. How do we sustain this momentum, this initial success?

Dr. David Shulkin, CEO of the Atlantic ACO believes, "the strongest motivator of physician behavior change is providing actionable data in a setting of strong financial incentive."[171] But will money alone, in the form of the distribution of the shared savings remain the motivational force for sustained excellence in an ACO?

Jim Collins wrote, "A great organization is one that delivers superior performance and makes a distinctive impact over a long period of time…for a social sector organization [an ACO] performance must be assessed relative to mission not financial returns."[172] The ACO executive must continue to deliver superior performance through its many collaborators for a large patient population over a period of time. How this challenge may be accomplished might be understood through a look back in time.

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[171] Shulkin, 722.

[172] Jim Collins, Good to Great and the Social Sectors, monograph, Good to Great – Why Some Companies Make the Leap and Others Don't [New York: Harper Collins Publishers, 2001], 5.

Anyone who has taken Psychology 101 knows the name of Dr. Abraham Maslow and his theory of the "hierarchy of needs." People, Dr. Maslow found, strive to fulfill progressively higher levels of needs, from nourishment, safety, love, and esteem to self-actualization. It is less known that Dr. Maslow delved into management. During a summer sabbatical, he set up shop in a southern California electronics plant and produced a farsighted journal applying the concept of self-actualization to the workplace.

Dr. Maslow observed that the owner of the electronics plant had discovered that his workers were most productive at the end of the assembly line, where the finality of assembly provided a sense of accomplishment. So, the owner of the firm broke his work force into teams, each responsible for an entire product.

Dr. Edward Hoffman, in a biography of Dr. Abraham Maslow described Maslow's incredulity over the spirit and productivity of the plant. He noted that Maslow coined the phrase "enlightened management" to describe the working conditions leading to self-actualization, or the achievement of one's full potential: trust, teamwork and recognition. Teams, Maslow found, made better workers and better workers made better teams. Creativity flowed from ambiguity, knowledge bred knowledge."[173]

Maslow sought a label for these self-reinforcing processes and turned to a term used for cooperation within a culture: synergy. The principle was fraught with paradox but full of value. Maslow wrote, "The more influence and power you give to someone else in the team situation the more you have yourself."[174] Hospitals and physicians and other health care professionals and organizations have operated in separate silos for

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[173] Edward Hoffman. The Right to be Human – A Biography of Abraham Maslow [New York: St. Martin's Press, 1988], 276.

[174] Abraham H. Maslow. Eupsychian Management [Homewood, Il: Richard D. Irwin, Inc. and the Dorsey Press, 1965], 125.

generations. The emerging concept of accountable care is not a chain of causes and effects but rather can be a web in which every part is related to every other part.

Maslow thought that business suffered from generally accepted accounting principles, a fixation on the short term and the non-human. This has been the management style in health care organizations for many generations. He foresaw a day when companies would record human capital [ACO staffing] and customer good will [ACO patient engagement] in their financial statements.

Health care can be viewed as a financial and technological industry. The ACO concept, more importantly, ACO leadership and management reflect a return to Maslow's observations. The collaboration of formerly disparate entities to achieve the goal of a healthy patient, and a healthy population, may be the means to provide the sense of accomplishment that Maslow observed so long ago in the southern California electronics plant.

A great organization is one that delivers superior performance and makes a distinctive impact over a long period of time. Jim Collins wrote that "for a social sector organization performance must be assessed relative to mission, not financial returns…the critical question is how effectively do we deliver on our mission and make a distinctive impact relative to our resources."[175] The accountable care organization must make an impact on the care given to a defined population which, if successful, leads to a combined clinical and financial success.

The power structures common in social sector organizations have two types of leadership skills: executive and legislative. In executive leadership, the individual leader

[175] Collins, 5.

has enough concentrated power to simply make the right decisions. In legislative leadership, no individual leader – not even the nominal chief executive officer – has enough structural power to make the most important decisions by himself or herself. Legislative leadership relies more upon persuasion, political currency and shared interests to create the conditions for the right decisions to happen.[176]

Today's health care executives face highly mobile knowledge workers. They do not have the concentration of executive power once enjoyed by previous generations. The ACO executive must lead in a manner that gets people to follow when they have the freedom not to.

Jim Collins described the efforts of the Center for Homeless in South Bend, Indiana in breaking the cycle of homelessness. He quoted Drew Buscareno, the Center's Executive Director noting:

> …homelessness is a profound disconnectedness from self, family and community…this insight fueled everything we did. We structured our organization around connecting people – homeless people, benefactors, volunteers and staff – to self, family and community. Aggressively pursuing government money does not make any sense with this type of thinking, but aggressively connecting volunteers and local donors on a personal level with homeless people makes absolute sense.[177]

Accountable Care Organizations are not profit seeking ventures per se. The ACO is designed to "aggressively connect" patients with health care providers. The shared savings, offered by the federal government, is an incentive to get these organizations underway with the necessary physician support. The concept of delivering health care services to a defined population will be the measure of the ACO's ultimate success.

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[176] Collins, 11.
[177] Collins, 22.

In building a great organization, there is no single defining action, no grand program, no one killer innovation, no solitary lucky break nor a miracle moment. The momentum of the physicians and other health care providers in an ACO is sustained through attention to lines of communications and the availability and use of information systems. This provides quick snapshots of the efforts needed to close gaps in patient care.

The reputation of an ACO will be based upon its tangible results and emotional share of heart. The thirty three quality metrics are transparent to the public. More importantly, the day-to-day interactions between patients and members of the ACO's network will build it reputation thereby enhancing its mission.

It is comparable to pushing a giant, heavy flywheel. You push with great effort and the flywheel inches forward slowly building momentum and, at some point, it begins to build upon previous work, compounding the investment of effort. The ACO with its ongoing collaboration among various health care providers, its attention to the patient/caregiver experience and evidence-based medicine is similar to the effort of pushing the flywheel forward.

The Atlantic ACO is pushing the flywheel as noted by Dr. Shulkin:

> We can hear a change in the conversations among our doctors, our hospital leaders and our patients. Our ACO meetings are filled with discussions about finding better ways to deliver care, using resources more efficiently, tackling tough issues like futile care and holding each other accountable for performance. With each problem addressed, each solution crafted, we are creating a culture of working together and of problem solving.[178]

People want to feel the excitement of being involved in something that just flat out works. When they begin to see tangible results – shared medical savings based on quality

[178] Shulkin, 722.

measures attained through evidence-based medicine - most people line up to throw their weight against the flywheel and push.

CHAPTER EIGHT

CONCLUSION AND FINAL THOUGHTS

This paper has explained the history of accountable care and the workings and results of today's innovative accountable care organizations. I have described the relationship between medical humanism and ACOs. And, I have advocated the characteristics of an organization that is sustainable over time.

Patients will be healthier and the cost of health care will be lower [or, at the least contained] if physicians and health care organizations coordinate their efforts. We knew this axiom to be true in the 1970s, earlier in fact as illustrated by the success of the Mayo Clinic. Today is different due to the creation of the Medicare and Medicaid Innovation Center and the incentives for the development of various new models for delivering health care services. Electronic health records, information technology, evidence based medicine and an evolving transition away from fee-for-service payment also are in large measure bringing about change.

Donald Berwick and others wrote of the Triple Aim as a means to improving the American health care system. Specifically, the Triple Aim is the simultaneous pursuit of:

> …improving the experience of care, improving the health of populations and reducing the per capita cost of health care…[179]

The ACO sets the conditions for these goals through its identification of a defined population, a commitment to the members [patients] coupled with an organization that accepts responsibilities for the three aims for the population.

[179] Donald Berwick, Thomas W. Nolan, John Whittington. "The Triple Aim: Care, Health and Cost." Health Affairs 27.3 [May/June 2008]: 759.

The CMS has published information about the Next Generation ACO Model. This model will build upon the experience from the Pioneer ACO Model and the Medicare Shared Savings Program. It will allow providers to accept higher levels of financial risk and reward than have been available. The goal is to test whether strong financial incentives for ACOs, coupled with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for Medicare beneficiaries.[180]

This is in accordance with the Triple Aim approach and toward paying providers based on the quality rather than the quantity of care they providers to patients.

If the Central Essex Health Plan had survived, there may not be a discussion of accountable care today. The CEHP model was a closed panel health maintenance organization that may still not be the preferred model for much of America today. However, the means by which providers are reimbursed is changing along with a movement toward integration of services. This is the path toward the Triple Aim. The patient can only stand to benefit as we continue to travel along this journey.

[180] Centers for Medicare and Medicaid Services, "Next Generation ACO Model." http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/ [accessed August 20, 2015].

EXHIBIT ONE

INTERVIEWS

1. John F. Bonamo, MD
   Executive Director
   Barnabas Health ACO

2. Jeffrey Brown
   Executive Director, QI Collaborative
   New Jersey Health Care Quality Institute

3. Jeanne Bulan, MD
   Trustee
   Barnabas Health ACO

4. Michael Dardia
   Executive Director
   Hackensack Alliance ACO

5. Andrea Ducas, MPH
   Program Officer
   Robert Wood Johnson Foundation

6. Theresa Edelstein, MPH, LNHA
   Vice President, Post-Acute Care Policy and special Initiatives
   New Jersey Hospital Association

7. Susan Lawler, PhD
   Vice President, Division of Professional Development
   American College of Healthcare Executives

8. Joseph Lemaire
   Trustee
   Meridian ACO

9. Pamela Orton, RN, MSN
   Director, Office of Delivery System Innovation
   New Jersey Department of Human Services

10. Barry Ostrowsky
    President and Chief Executive Officer
    Barnabas Health

11. John Slotkin

Vice President, Graduate Medical Education Policy and Teaching Hospital Issues
New Jersey Hospital Association

12. Lisa D. Taylor, Esq.
Inglesino, Webster, Wyciskala and Taylor, LLC

EXHIBIT TWO

NEW JERSEY MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

Advocare Well Network	2 Eves Drive, Suite 109, Marlton, New Jersey 08053
Allegiance ACO	40 Fuld Street, Suite 305, Trenton, New Jersey 08638
Atlantic ACO	475 South Street, Morristown, New Jersey 07962-1956
AtlantiCare Health Solutions, Inc.	2500 English Creek Avenue, Building 500, Suite 501, Egg Harbor Twp., New Jersey 08234
Barnabas Health ACO-North, LLC	95 Old Short Hills Road, West Orange, New Jersey 07052
Capital Health Accountable Care Organization, LLC	750 Brunswick Avenue, Trenton, New Jersey 08638
Central Jersey ACO LLC	95 Old Short Hills Road, West Orange, New Jersey 07052
Chrysalis Medical Services, LLC	2106 New Road, Linwood Commons - Suite F-1, Linwood, New Jersey 08221
Hackensack Alliance ACO	30 Prospect Avenue, Hackensack, New Jersey 07601
HNMC Hospital/Physician ACO, LLC	718 Teaneck Road, Teaneck, New Jersey 07666
Inspira Care Connect, LLC	165 Bridgeton Pike, Mullica Hill, New Jersey 08062
JFK Population Health Company, LLC	80 James Street, Edison, New Jersey 08820
LHS Health Network, LLC	1600 Haddon Avenue, Camden, New Jersey 08103
Meridian Accountable Care Organization, LLC	1350 Campus Parkway, Neptune, New Jersey 07753
NJ Physicians ACO	25 Mule Road, Suite B8, Toms River, New Jersey 08755
Optimus Healthcare Partners, LLC	95 Summit Avenue, 4th Floor, Summit, New Jersey 07901
Partners In Care ACO, Inc.	2 Tower Center Boulevard, Tower 2, 12th Floor, East Brunswick, New Jersey 08816
RWJ Partners LLC	1 Robert Wood Johnson Place, New Brunswick, New Jersey 08903
VirtuaCare	50 Lake Center Drive - # 400, 401 Route 73 North, Marlton, New Jersey 08053

EXHIBIT THREE
NEW JERSEY MEDICAID ACCOUNTABLE CARE ORGANIZATIONS

Camden Coalition of Healthcare Providers	800 Cooper Street, Camden, NJ 08102
Healthy Greater Newark ACO	274 S. Orange Avenue, Newark, NJ 07103
Trenton Health Team	218 N. Broad Street, Trenton, NJ 08608

EXHIBIT FOUR	Patient/Caregiver Experience						
	ACO-1	ACO-2	ACO-3	ACO-4	ACO-5	ACO-6	ACO-7
Advocare Well Network	80.92	94.45	92.61	81.1	60.26	73.85	69.43
Atlantic ACO	79.31	93.74	93.31	84.04	58.65	73.53	73.39
AtlantiCare Health Solutions, Inc.	79.53	94.33	92.69	84.02	56.97	73.33	72.5
Balance ACO	77.21	91.29	90.45	85.27	63.69	71.49	66.75
Barnabas Health ACO-North, LLC	83.44	93.83	92.38	86.19	58.03	73.35	70.22
Central Jersey ACO LLC	83.69	95.09	92.9	83.88	58.68	80.18	72.53
Hackensack Alliance ACO	81.5	93.3	91.58	86.5	55.85	74.14	73.84
HNMC Hospital/Physician ACO, LLC	82.45	93.33	92.96	86.21	61.07	73.55	71.06
Meridian Accountable Care Organization, LLC	83.69	94.84	92.8	85.46	59.4	76.84	70.43
Optimus Healthcare Partners, LLC	82.47	94.61	92.63	85.79	55.92	75.3	72.6
VirtuaCare	83.62	94.23	92.36	85.22	56.68	74.91	71.98
Mean Score	81.03	92.79	91.82	85.22	53.13	74.42	70.84

ACO-1	Getting timely care
ACO-2	How well your doctor communicates
ACO-3	Patients' rating of doctor
ACO-4	Access to specialists
ACO-5	Health promotion and education
ACO-6	Shared decision making
ACO-7	Health status/functional status

EXHIBIT FIVE

Care Coordination/Patient Safety

	ACO-8	ACO-9	ACO-10	ACO-11	ACO-12	ACO-13
Advocare Well Network	16.35	1.68	1.45	81.94	100	72.22
Atlantic ACO	15.37	1.13	1.22	52.86	86.8	36.12
AtlantiCare Health Solutions, Inc.	14.83	0.85	1.51	76.92	81.15	19.9
Balance ACO	17.96	1.96	1.32	25.48	90.87	63.28
Barnabas Health ACO-North, LLC	14.51	1.55	1.54	57.38	50.76	21.71
Central Jersey ACO LLC	15.43	1.27	1.2	64.37	70.44	12.2
Hackensack Alliance ACO	15.52	1.07	1.05	69.01	87.38	35.95
HNMC Hospital/Physician ACO, LLC	15.77	1.45	1.35	39.47	80.12	29.28
Meridian Accountable Care Organization, LLC	13.73	1.06	1.17	63.12	5.29	8.14
Optimus Healthcare Partners, LLC	15.14	1.04	1.13	75.81	90.03	39.44
VirtuaCare	14.98	1.56	1.38	75.58	89.91	6.88
Mean Score	14.89	1.17	1.21	65.03	74.91	38.2

ACO-8	All conditions readmissions
ACO-9	COPD or asthma
ACO-10	Heart failure
ACO-12	HER incentive payment
ACO-13	Screening for falls risk

EXHIBIT SIX	Preventive Care							
	ACO-14	ACO-15	ACO-16	ACO-17	ACO-18	ACO-19	ACO-20	ACO-21
Advocare Well Network	44.44	60.24	74.87	93.06	19.86	43.46	38.06	49.69
Atlantic ACO	60.14	54.24	63.47	87.36	23.59	60.23	53.15	84.38
AtlantiCare Health Solutions, Inc.	67.31	42.55	72.61	94.56	26.12	55.98	44.32	70.29
Balance ACO	61.24	46	77.87	89.93	58.02	56.9	67.97	90.48
Barnabas Health ACO-North, LLC	52.57	33.16	55.71	88.73	19.31	56.09	49.16	91
Central Jersey ACO LLC	57.25	36.98	64.31	88.26	13.59	58.21	49.46	89.96
Hackensack Alliance ACO	66.78	62.44	73.28	92.69	35.31	67.38	65.22	94.73
HNMC Hospital/Physician ACO, LLC	57.47	40.41	41.53	59.86	11.7	59.25	45.24	71.43
Meridian Accountable Care Organization, LLC	45.55	42.08	52.32	86.59	7.39	57.28	50.66	33.41
Optimus Healthcare Partners, LLC	58.54	57.66	71.55	90.98	34.73	61.23	61.09	82.35
VirtuaCare	66.5	62.25	75.55	93.03	0.38	53.58	56.59	65.78
Mean Score	56.37	54.19	62.37	84.65	30.22	59.32	61.72	76.39

ACO-14	Influenza immunization
ACO-15	Pneumonia vaccination
ACO-16	Body mass index screening and follow-up
ACO-17	Tobacco use screening and cessation intervention
ACO-18	Clinical depression and follow-up plan
ACO-19	Colorectal cancer screening
ACO-20	Breast cancer screening
ACO-21	Blood pressure screening

EXHIBIT SEVEN

At-Risk Population

	ACO-22	ACO-23	ACO-24	ACO-25	ACO-26	ACO-27	ACO-28	ACO-29	ACO-30	ACO-31	ACO-32	ACO-33
Advocare Well Network	65.57	53.38	77.56	64.8	1.71	24.56	77.61	51.95	9.84	18.18	54.29	27.41
Atlantic ACO	74.18	59.09	74.55	75.27	83.06	19.27	71.72	63.86	89.48	94.57	86.61	77.78
AtlantiCare Health Solutions, Inc.	73.3	62.38	72.33	85.19	83.87	16.75	68.55	61.07	80.05	60.23	76.26	56.82
Balance ACO	64.18	50	73.88	71.64	83.42	27.24	71.26	56.17	81.97	80.51	88.92	90.56
Barnabas Health ACO-North, LLC	63.44	50.22	70.7	83.92	79.02	26.65	65.66	51.57	83.02	90.11	67.45	69.46
Central Jersey ACO LLC	69.4	48.73	68.03	80.9	85.29	22.22	68.06	55.53	79.23	92.98	73.47	72.86
Hackensack Alliance ACO	76.1	62.37	77.12	87.29	91.75	14.58	78.23	61.1	83.81	88.27	79.93	82.2
HNMC Hospital/Physician ACO, LLC	69.61	51.78	69.79	57.79	61.76	21.76	67.83	50.59	73.14	83.16	74.65	72.59
Meridian Accountable Care Organization, LLC	76.68	60.25	72.08	78.8	82.61	13.78	69.21	64.8	78.91	74.58	77.24	72.49
Optimus Healthcare Partners, LLC	71.27	58.03	73.72	82.8	65.99	20.79	72.4	59.37	78.11	91.35	85.16	78.52
VirtuaCare	71.28	63.22	80.56	83.71	75.88	17.86	79.06	69.66	89.48	96.24	85.81	73.72
Mean Score	68.53	54.53	69.81	63.21	75.28	22.85	68.15	55.4	76.9	80.7	72.17	69.72

		Diabetes composite 22-26
ACO-22	Diabetes A1c	
ACO-23	Low density lipoprotein	
ACO-24	Blood pressure < 140/90	
ACO-25	Tobacco non-use	
ACO-26	Aspirin use	
ACO-27	Diabetes hbA1c poor control	

ACO-28	Hypertension BP < 140/90	
ACO-29	Lipid profile and LDL control	
ACO-30	Aspirin use	
ACO-31	Beta-blocker	
ACO-32	Drug therapy to lower LDL	CAD composite 32-33
ACO-33	ACE inhibitor to CAD	

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