



Issue Brief

Hospitals on the Path to Accountable Care: Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization

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The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1625
Vol. 22

ABSTRACT: Accountable care organizations (ACOs) are forming in communities across the country. In ACOs, health care providers take responsibility for a defined patient population, coordinate their care across settings, and are held jointly accountable for the quality and cost of care. This issue brief reports on results from a survey that assesses hospitals' readiness to participate in ACOs. Results show we are at the beginning of the ACO adoption curve. As of September 2011, only 13 percent of hospital respondents reported participating in an ACO or planning to participate within a year, while 75 percent reported not considering participation at all. Survey results indicate that physician-led ACOs are the second most common governance model, far exceeding payer-led models, highlighting an encouraging paradigm shift away from acute care and toward primary care. Findings also point to significant gaps, including the infrastructure needed to take on financial risks and to manage population health.

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OVERVIEW

Accountable care organizations (ACOs)—in which health care providers take responsibility for a defined patient population, coordinate their care across settings, and are held to benchmark levels of quality and cost—are forming in communities across the country. Provider organizations are creating partnerships in order to achieve the triple aim of better care, better population health, and lower costs, while working with purchasers to develop new contracts and payment methods that will promote high performance. The accountable care model is promising because it creates payment incentives to support and sustain delivery system reforms. This issue brief reports on results from a survey—the first of its

kind—that assesses hospitals’ readiness to participate in ACOs. These results provide an important early snapshot—from the hospitals’ perspective—of current trends in delivery of care and payment system transformation. Results clearly show that we are at the beginning of the ACO adoption curve. As of September 2011, only 13 percent of hospitals respondents reported participating in an ACO or planning to participate within a year, while 75 percent reported not considering participation at all.

The majority of the governance reported by hospitals participating or planning to participate in an ACO consists in either a joint venture between physicians and hospitals (51%) or is physician-led (20%). An additional 18 percent of ACOs have a hospital-led governing body; only 2 percent are led by payers. Findings suggest progress in coordination of care across settings and in ensuring safe transitions among care setting. Almost three-quarters (73.4%) of hospitals participating or preparing to participate in an ACO reported sharing clinical information among care settings, including primary care practices, and 53.8 percent reported calling patients within 72 hours of discharge.

Results also suggest substantial room for improvement with regard to a population-based approach to care management. Only one of five hospitals participating or preparing to be part of an ACO reported using predictive tools to identify patients at high risk of poor health outcomes or high resource use.¹ Hospitals also report challenges in responding to new types of financial incentives. Most expect to see a significant drop in revenue from fee-for-service payments over the next three years, with an increase in revenue from shared savings and bundled payments. The majority of respondents reported pursuing a shared-savings model without risk of financial loss (52.1%), while a much lower percentage of hospitals were pursuing global payments (27.2%).

Survey results indicate that not all hospitals have the infrastructure in place to take on risk and manage the care and the cost of a population. Although 84.6 percent of respondents participating or preparing

to participate in an ACO have information systems to track utilization, only 49.7 percent said they think they have the financial strength to accept risk. Around 70 percent have processes in place to continuously monitor the use and costs of services, compared with revenue received or allowed.

ABOUT THE NATIONAL SURVEY OF HOSPITAL READINESS FOR POPULATION-BASED ACCOUNTABLE CARE

As of summer 2012, 154 groups are participating in ACO initiatives sponsored by the Centers for Medicare and Medicaid Services (CMS). Thirty-two organizations have signed contracts to become Pioneer ACOs—a program designed by CMS for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Another 116 organizations have enrolled in the CMS Shared Savings Program, which allows groups of providers to achieve shared savings for Medicare beneficiaries; and six have joined the Physician Group Practice Transition demonstration program, a pay-for-performance initiative that creates incentives for physician groups to coordinate care delivered to Medicare patients. In all, more than 2.4 million Medicare beneficiaries are receiving care from providers participating in these initiatives. There are also numerous other organizations with private payer contracts that include many of the key features of the ACO model. A recent report identified 221 ACOs in 45 states as of May 2012. This number includes both CMS and private sector ACOs.²

There will be variation in how the model is implemented, and it is essential that we gain knowledge from this early phase of adoption. Recent research has underscored the importance of learning how incentives are designed, how providers will assume risk, and how rewards will be shared.³ Further, we must learn how organizations transform their care delivery and infrastructure to enable population-based care management and seamless care. It also will be important to evaluate results on patients’ health and on overall costs.

To track the evolution and impact of ACOs, the Health Research and Educational Trust (HRET) conducted a national survey through the lens of hospitals to assess their readiness to participate in ACOs and to provide accountable, population-based care. The goal of the National Survey of Hospital Readiness for Population-Based Accountable Care was to describe current and expected activities taken to implement coordinated, patient-centered, and efficient care delivery; to explore how new payment models are being tested; and to determine the extent to which fee-for-service reimbursement is being replaced by shared savings, bundled payments, or capitation.

This issue brief uses data from the survey, conducted by the HRET from May to September 2011. The survey was mailed to 4,973 short-term, acute-care hospitals identified by the American Hospital Association Annual Survey. A total of 1,672 hospitals responded (34% response rate). The response rate for

hospitals with more than 300 beds was 47 percent and 52 percent for hospitals with more than 400 beds.⁴

RESULTS

Characteristics of Survey Respondents

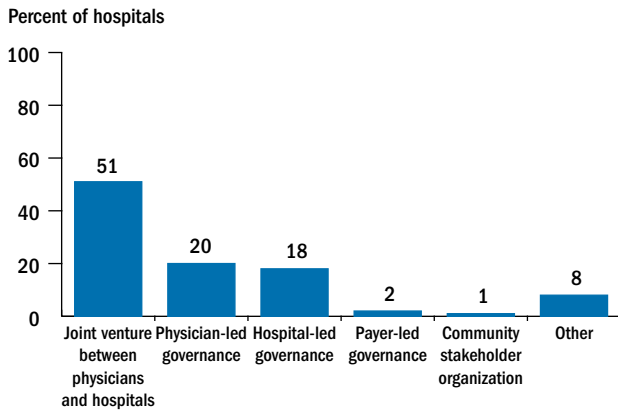
The hospitals were classified into three groups: 1) those participating in an ACO, 2) those preparing to participate in an ACO within one year, and 3) those not planning to participate. Overall, 12.8 percent of hospital respondents said they were either participating (3.2 %) or preparing to participate in an ACO (9.6%). Seventy-five percent said they were not exploring the model at all, and 12 percent were unsure. Hospitals participating or preparing to participate were more likely to be larger, belong to a health system, be located in large urban areas, and be teaching and nonprofit organizations, compared with those not planning to be part of an ACO (Exhibit 1). The most common forms

Exhibit 1. Characteristics of Hospitals Participating and Not Participating in Accountable Care Organizations

Category/Variable	Hospitals participating or planning to participate in an ACO (N=213)	Hospitals not exploring the ACO model (N=1,255)	p-value
Hospital size			
Average bed size	322	173	0.000
Health system			
Part of a multihospital/health system	64%	47%	0.000
Urban status			
Metropolitan (50,000 to 2.5 million people)	54%	40%	0.019
Micropolitan (10,000 to 50,000 people)	9%	21%	0.000
Rural (fewer than 10,000 people)	7%	25%	0.000
Teaching status			
Council of Teaching Hospitals and Health Systems membership	24%	7%	0.000
Type of ownership			
Government	9%	27%	0.000
Not-for-profit	88%	62%	0.000
For-profit	3%	11%	0.000
Federal	0%	0%	0.000
Region			
North	27%	17%	0.000
South	25%	35%	0.000
Midwest	33%	33%	0.917
West	15%	15%	0.903

Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

Exhibit 2. Governance of Hospitals Participating or Planning to Participate in an ACO



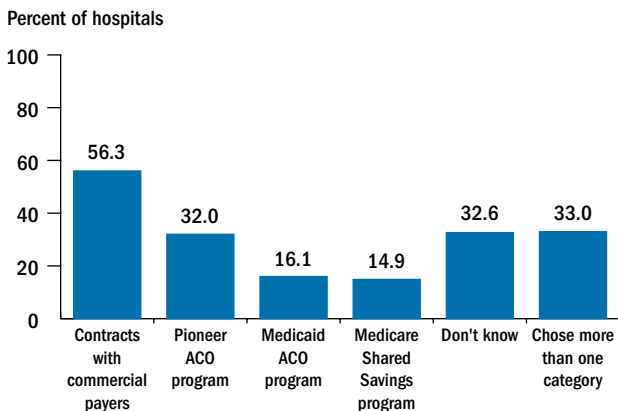
N=182.
Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

of ACO governance were joint ventures between physicians and hospitals (51%) and physician-led governance (20%) (Exhibit 2). Eighteen percent said their ACO adopted hospital-led governance; only 2 percent of the ACOs were payer-led.

Payer Partners and Payment Models

The majority (56.3%) of hospitals participating or planning to participate in an ACO said they were actively pursuing ACO contracts with commercial payers, including self-insured employers (Exhibit 3). Thirty-two percent of those participating or planning to participate were pursuing contracts through CMS’s Pioneer ACO program. Other hospitals were pursuing partnerships with Medicaid ACO programs (16.1%) and the Medicare Shared Savings Program (14.9%). One-third said they were pursuing contracts with more than one payer. It is important to note that the survey was in the field before the final Medicare Shared Savings Program rules were released.

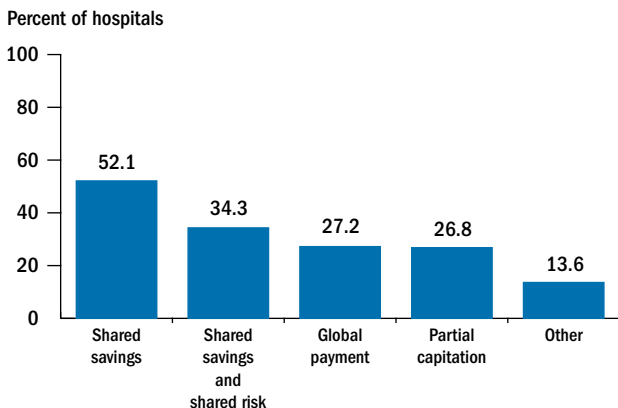
Exhibit 3. Payer Partnership of Hospitals Participating or Planning to Participate in an ACO



N=175.
Note: Hospitals could select more than one type of payer partnership.
Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

The great majority of respondents (52.1%) said they were pursuing a simple shared-savings model, in which the ACO will share the savings it achieves without incurring any financial loss if costs exceed the spending target (Exhibit 4). Other payment models pursued by respondents included shared savings with shared risk, in which the ACO will share savings and also incur loss of revenue if costs exceeds the spending target (34.3%), global payment, in which providers are paid a fixed-dollar amount for the care patients receive in a given time, but also take on financial risk (27.2%); and partial capitation, in which providers are paid a fixed, predetermined payment per patients, but would take one financial risk for some, but not all, of the items and services covered (26.8%).⁵

Exhibit 4. Payment Arrangements of Hospitals Participating or Planning to Participate in an ACO



N=213.
Note: Hospitals could select more than one type of payment arrangement.
Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

Hospitals participating or preparing to participate in an ACO expect to see significant decreases in revenue from fee-for-service payment contracts in the next two years (Exhibit 5). Alternatively, the greatest increase in revenue—of approximately 10 percent—is expected to be in the form of a hybrid of fee-for-service payments plus shared savings. The next-largest

Exhibit 5. Expected Revenue Changes of Hospitals Participating or Planning to Participate in an ACO, by Model of Payment

	Year 1	Year 3	Change in revenue
Fee-for-service			
DRG	65.9%	55.2%	-10.7%
Per diem	24.7%	20.1%	-4.6%
Plus shared savings	9.3%	19.2%	9.9%
Bundled payments (inpatient plus physician)	3.8%	11.9%	8.1%
Partial and global capitation payments	7.6%	12.6%	5.0%

Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

increase in revenue is expected to come from bundled payments.

Managing Financial Risk

Almost 85 percent of respondents participating or preparing to participate in an ACO have information systems to track utilization (Exhibit 6), but only about 50 percent said they currently have the financial strength to accept risk. Almost 70 percent have processes in place to monitor services rendered and costs compared with revenue and almost 60 percent have stop-loss or reinsurance provisions in place to protect against catastrophic claims or expenses.

Population-Based Care Management

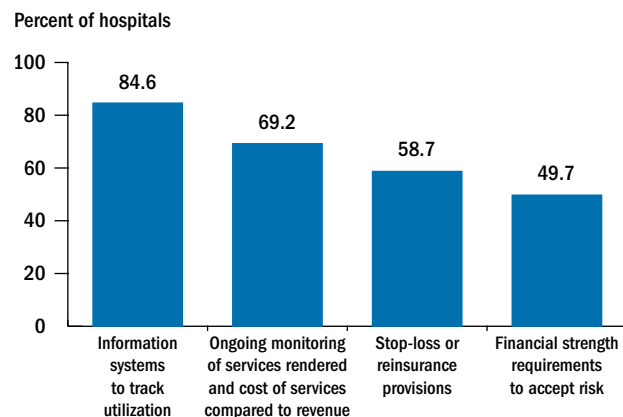
Less than a third of all hospitals have implemented population-based care management approaches to target high-risk patients across the system (Exhibit 7).

Nineteen percent of hospitals participating or preparing to participate in an ACO report using predictive tools to identify patients at high risk of poor health outcomes or high resource use, compared with 9 percent of those not exploring the ACO model. Further, 28.4 percent of those participating or preparing to participate in an ACO report managing high-volume, high-cost patients using experienced case managers, compared with 19.5 percent of those not exploring the ACO model (Exhibit 7).

Care Coordination Across Settings

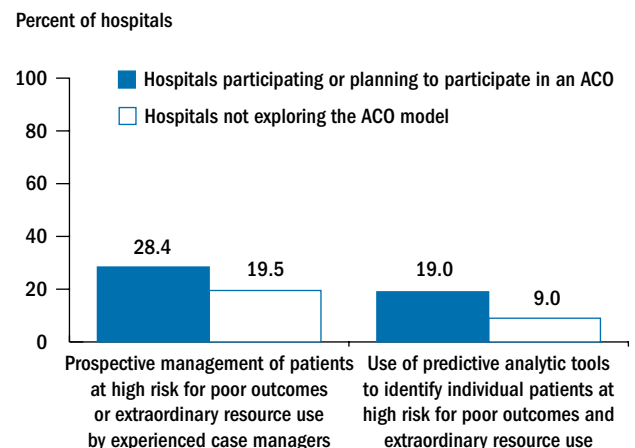
The survey explored the extent to which hospitals engage in several practices aimed at ensuring care coordination across settings. About nine of 10 respondents participating or preparing to participate in an ACO reported conducting medication reconciliation as part of an established plan of care (Exhibit 8). Other

Exhibit 6. Risk Management Features of Hospitals Participating or Planning to Participate in an ACO



Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

Exhibit 7. Population-Based Care Management



Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

practices were used less frequently. About one of three (33.9%) hospitals that are participating or preparing to participate in an ACO assign case managers to follow patients discharged by the hospital who are at high risk of admission and readmission. Home visits by physicians or advanced practice nurses for homebound or otherwise complex patients for whom an office visit would be difficult were arranged by 34.9 percent of hospitals that are participating or preparing to participate in an ACO. More than half (53.8%) of these hospitals called patients within 72 hours of discharge (Exhibit 8).

Ensuring Safe Transitions

The survey also explored the implementation of processes to facilitate safe and seamless transitions. Seven of 10 (70%) hospitals participating or preparing to participate in an ACO have processes in place to identify patients moving between settings of care and thus needing additional attention (Exhibit 9). Similarly, 73.4 percent share clinical information between settings of care, and 70.2 percent provide primary care providers with a discharge summary of the acute-care stay. However, only 34.9 percent have the ability to track whether information has been successfully exchanged.

Tracking Performance Data

Only 50 percent of hospitals currently participating in an ACO track performance data and another half plans to do so within the next three years. There was no difference in the type of performance measures tracked: clinical quality was tracked by 46 percent of hospitals, while patient satisfaction, utilization, and financial measures were tracked by about 40 percent of hospitals (data not shown).

Perceived Challenges

Among hospitals participating in an ACO, the top three challenges reported included reducing clinical care variation, reducing the cost of care, and developing and maintaining a common culture among the various ACO partners (Exhibit 10). For those preparing to participate in an ACO, the top three challenges were different. These included increasing the size of the covered patient population, developing an information system infrastructure, and accessing capital to invest in the ACO model.

When asked more specifically about challenges to participating in the Medicare Shared Savings Program, the top three reasons cited by all hospitals participating or planning to participate in an ACO included: the population attribution methodology

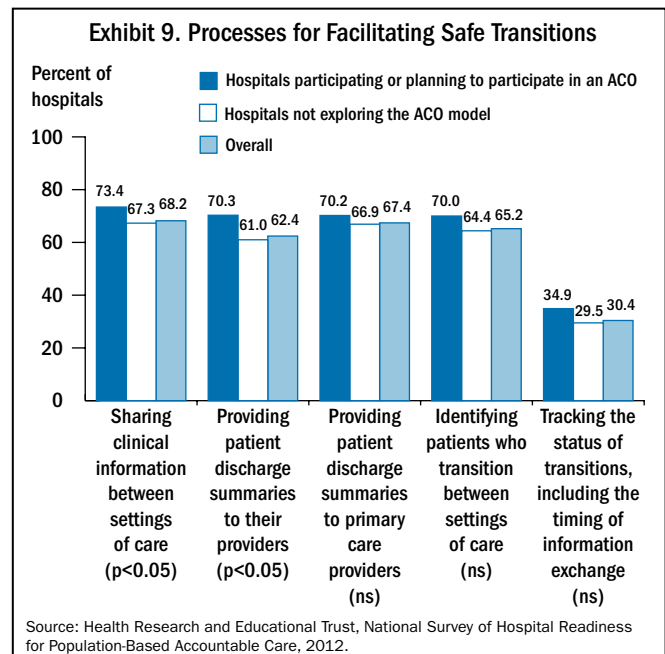
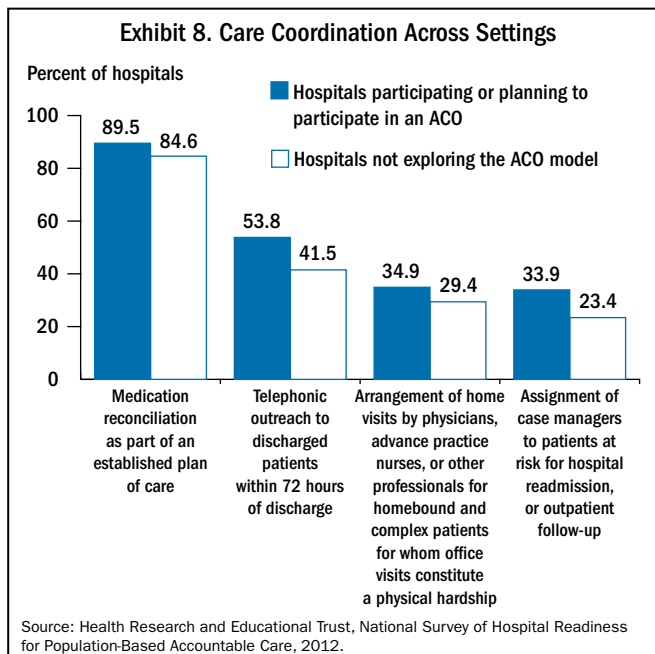


Exhibit 10. Average Score of Perceived Challenges to Becoming an ACO

Type of obstacle	Hospitals participating in an ACO (N=47)	Hospitals planning to participate in an ACO (N=117)
Reducing clinical variation	3.62	3.12
Reducing costs	3.62	2.99
Developing and maintaining common culture	3.55	3.14
Aligning incentives to encourage provider productivity, while minimizing unnecessary utilization of services	3.47	3.05
Motivating physicians to participate in the system	3.37	2.65
Developing clinical and management information systems	3.30	3.63
Resolving issues between primary care providers and specialty physicians	3.21	3.32
Accessing capital and investing on a systemwide basis	2.96	3.62
Increasing the size of the covered patient population	2.89	3.67
Developing physician leadership	2.79	3.50
Raising start-up capital	2.38	3.20
Developing a workable governance structure (e.g., agreeing on the number of physicians and hospital representatives to sit on the board)	2.13	3.33

Note: Average score—1=no challenge; 5=extreme challenge.

Source: Health Research and Educational Trust, National Survey of Hospital Readiness for Population-Based Accountable Care, 2012.

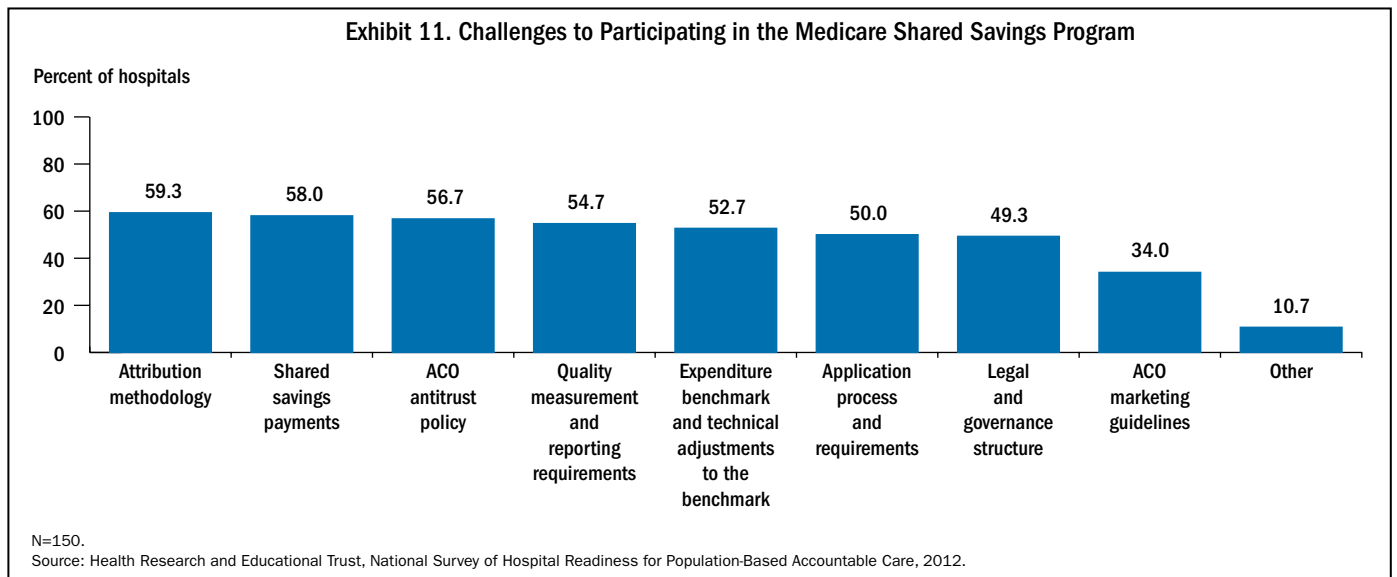
(59.3%), the shared savings payment model (58%), and the antitrust policies (56.7%) (Exhibit 11).

DISCUSSION

The accountable care model will go through different iterations during its implementation, especially as various interventions aimed at redesign of care delivery or payment reform are adopted in diverse community settings. A recent Commonwealth Fund blog post highlights the importance of tracking these evolutionary

changes so we can learn what works and why and make appropriate modifications.⁶ The results of this survey provide an early snapshot of critical issues being addressed by organizations currently participating in an ACO or in the ACO planning phases. As of this summer there are 154 ACOs that have signed contracts with CMS under the Shared Savings, Pioneer, and Physician Group Practice Transition programs. Although the survey was fielded before the Medicare Shared Savings Program final rules were issued, the

Exhibit 11. Challenges to Participating in the Medicare Shared Savings Program



results provide important insights into the challenges providers are facing during this early phase of testing and implementation.

In its report, *High Performance Accountable Care: Building on Success and Learning from Experience*, the Commonwealth Fund Commission on High Performance Health System recommended that ACOs be created with a strong primary care foundation and the concepts of the patient-centered medical home.⁷ In this respect, results of the survey are encouraging. They indicate that the most common form of governance is either a joint venture between physicians and hospitals (51%) or is physician-driven (20%). Another 18 percent of ACOs have a hospital-led governing body, far exceeding payer-led models. In the Pioneer ACO program, 15 of 32 sites are integrated delivery systems; an additional 13 are independent practice associations, and three are physician–hospital organizations.⁸ In April 2012, CMS announced the first 27 Shared Savings Program ACOs and in July 2012, another 89 sites were added. The majority of these ACOs are also physician-led.

It is not surprising that at the time of this survey actual or expected partnerships between providers and commercial payers were much more common than partnerships with Medicare. The final rules for Medicare’s ACO program had not been released, so it is likely that hospital leaders were awaiting them before deciding whether to participate. In fact, the major challenges cited by respondents to participating in the Shared Savings Program (e.g., the shared-savings methodology, the patient-attribution methodology, the quality measurement requirements, and the antitrust policies) were all significantly modified between the proposed and final rules. The Pioneer ACO Program was the second most frequent program being explored. The 32 Pioneer ACOs announced in December 2011 represent a select group of organizations that over time have acquired a greater level of performance and are ready to take on greater responsibilities for the outcomes and costs of the population they serve.

States are exploring the ACO model, as well.⁹ At least 13 have enacted legislation related to studying,

exploring, or implementing ACOs.¹⁰ The survey found that 16 percent of respondents were either participating or planning to participate in a Medicaid ACO. States have taken the lead on the implementation of the medical home model. It will be interesting to see whether and how they integrate these two models of care and payment.

All hospitals—regardless of whether they were participating in ACOs, in planning phases, or not considering the model—indicated they expect an average 11 percent decrease in the percent of their revenue coming from fee-for-service payments in the next three years. Respondents participating or planning to participate in an ACO expect payments that include fee-for-service plus shared savings to account for the largest proportion of revenue gains (10%). Bundled payments (8.1%) and capitation (5%) are expected to account for somewhat smaller increases. Survey results suggest that hospitals are pursuing a path toward global, population-based payment. Partial and global capitation are the least-pursued payment model (26.8%), while the shared-savings model in which the ACO will share the savings it achieves without incurring any financial loss is the most common (52.1%). The two-sided risk model (i.e., shared savings and shared risk) is being pursued by one-third of respondents. These findings support the notion that providers must first establish care coordination and management infrastructure before assuming financial risk for their assigned population. Although many have established ways to mitigate risk (e.g., stop-loss insurance), survey results indicate that effective processes for doing so are still not broadly implemented. For example, less than three-fourths of survey respondents said they have timely information about use of services or track costs incurred against allowed budget allowed. A Commonwealth Fund report proposes a path to accountable care in which the delivery system evolves from focusing on individual services to prioritizing care management to fit the needs of people over the long term.¹¹ Similarly, payment models need to evolve from fee-for-service models toward global payments. Results from the survey suggest that the transformation

of the delivery and payment systems should happen concurrently, rather than sequentially. New models of payment are not likely to be successful if the delivery system is not ready to receive them; alternatively, new delivery approaches must be sustained by payment approaches.

The payment models and shared savings policies will significantly affect whether providers join ACOs, and whether they are successful. How the savings are calculated, what is included in the calculations for total costs of care, and how the savings are distributed are all important factors to consider so that the financial incentives send the right signal to providers and minimize unintended consequences.¹²

Results indicate that the care delivery processes of hospitals engaged in ACOs have both gaps and strengths. In a recent report, the Commonwealth Fund Commission on a High Performance Health System recommended a targeted approach that prioritizes populations with multiple, high-cost chronic conditions.^{13,14} But less than one-third of survey respondents report having implemented population-based care management approaches to target high-risk patients. Only one of five use predictive tools to identify patients who are at high risk for poor health outcomes or high resource use. Yet, excellent predictive tools exist and ACOs using them will be in a good position to create customized care management plans to address the health, cognitive, and social needs of patients and reduce their risk of poor outcomes.¹⁵

There is strong evidence that poor care coordination contributes to poor quality and increases the cost of care.¹⁶ Although one key intervention, medication reconciliation, was adopted by 90 percent of the survey respondents, other interventions were less frequently adopted. About a third of hospitals said they arranged home visits for patients who cannot travel to their primary care physician practice and over half said they follow up via telephone within a three-day period after discharge. There is growing evidence that prompt follow-up can reduce avoidable readmissions, so it is reassuring to see that practice spreading.^{17,18} Results also suggest that communication between

providers across settings is improving, thus enabling more seamless care. Seven of 10 respondents said they had processes in place to track patients in transition and to exchange information from the acute-care setting to the primary-care setting. However, only one of three hospitals monitors the transition process to determine whether patients' information has been successfully transmitted. The capacity for health information exchange (HIE) is growing, as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act that invested \$564 million in state agreements for sustainable HIE. Yet information exchange still presents a significant challenge. According to the 2009 Commonwealth Fund International Survey of physicians, 73 percent of primary care providers in the United States did not receive timely information about a patient discharged from a hospital.¹⁹

The success of the ACO model depends in part on the ability to monitor the impact of ACOs on patient outcomes, experience, and the total costs of care. Yet significant gaps remain. Only half of respondents said their hospitals currently tracked performance in terms of clinical quality, patient experiences, utilization, and costs. Organizations will need to invest in their information infrastructure to successfully manage their patient populations. The programs implemented by the Office of the National Coordinator for Health Information Technology under the HITECH Act are making changes that allow providers and organizations to establish the HIT infrastructure necessary to track performance.

Collaboration in health care has frequently raised antitrust concerns that ACOs could result in a reduced number of competitors in health care markets, which could potentially increase prices and have negative consequences for consumers and purchasers of care.²⁰ Antitrust enforcers are beginning to recognize the need to take a new approach to collaboration. For example, they may consider the characteristics of individual markets in antitrust deliberations—not only taking into account where hospitals are located but also how they differ in terms of the services they offer. The

Federal Trade Commission and Department of Justice guidelines create a “safety zone” in which ACOs that have less than a 30 percent market share for each relevant common service—a specific procedure or test, for example—they provide within a geographic market are highly unlikely to raise antitrust concerns. The guidelines include a “rural exception” that allows ACOs to include one nonexclusive physician or group practice per specialty from each rural area, even if that service exceeds the 30 percent market share.

In addition, federal authorities have given guidance that ACOs formed under the Shared Savings Program will be in compliance with federal antitrust, self-referral, and anti-kickback laws. Initial CMS and Department of Justice guidance has sought to provide safe harbors and opportunities for health care organizations to advance in clinical integration without legal violation. However, as noted by survey respondents, regulatory and legal concerns continue to pose significant barriers.

ACOs will need to be clear and comprehensive when laying out their consolidation plans to justify how they will result in clinical improvement. Furthermore, they will need to supply data on the impact of these consolidation and clinical transformation efforts.

Finally, our knowledge in these early days of evolution of the ACO model is based on the experience and opinions of the innovators and early adopters—a small group of organizations willing to take risks and try the model. It is essential that we learn from the challenges of these early entrants to refine future policies and interventions that can persuade others to adopt the model.

NOTES

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- ⁴ For more information about the survey, please see: Health Research and Educational Trust, *Hospital Readiness for Population-Based Accountable Care* (Chicago: HRET, May 2012), available at <http://www.hpoe.org/resources-and-tools/5330004946>.
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- ²⁰ For a thorough examination of statutory and regulatory restrictions on multiprovider collaborations associated with forming an ACO, see American Hospital Association, *Trendwatch: Clinical Integration—The Key to Real Reform* (Washington, D.C.: AHA, Feb. 2010); and American Hospital Association, *Getting More from Health Reform: Five Barriers to Clinical Integration in Hospitals (and What to Do About Them)* (Washington, D.C.: AHA, Feb. 2010).

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Editorial support was provided by Deborah Lorber.



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