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# KEY TO HEALTH CARE REFORM: CHANGING HOW CARE IS DELIVERED

STEPHEN M. SHORTELL\*

## I. INTRODUCTION

History will record that the singular achievement of the Obama administration was passage of the Patient Protection and Affordable Care Act (PPACA)<sup>1</sup> of 2010, which extended health insurance coverage to thirty two million more Americans, encompassing near-universal coverage for all citizens.<sup>2</sup> The United States was the last industrialized country to do so. Whether history will also record that such coverage could be sustained over time and at an affordable cost to the American public is an open question. As other contributors to this Issue have noted,<sup>3</sup> the PPACA contains relatively few provisions for controlling the rising costs of health care. These costs are almost certain to grow given the likely increase in demand on the part of those with the new and/or expanded financial coverage.

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 25 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.) [hereinafter PPACA]. For ease of reference, PPACA as used here also includes amendments made to it by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

2. See Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker of the House, U.S. House of Representative, at tbl.2 (Mar. 18, 2010), <http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf> (Preliminary Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872, the Reconciliation Act of 2010).

3. See, e.g., Benjamin S. Carson, Sr., *Rational Health Care Reform: Reflections of a Practitioner*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 387 (2011); Clark C. Havighurst & Barak D. Richman, *Who Pays?, Who Benefits? Unfairness in American Health Care*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 493 (2011); Newt Gingrich & Vincent L. Frakes, *Incomplete Reform: How the Patient Protection and Affordable Care Act Fails to Achieve True Health Transformation*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 329 (2011); Paul Ryan, *Health Care Reform: The Way Forward*, 25 NOTRE DAME J.L. ETHICS & PUB. POL'Y 337 (2011).

The concern is not just with the growing cost of care but also with assessing the impact of expanded coverage on the quality and outcomes of care, including patients' experience with their care. Currently, while we spend more than any other country in the world (seventeen percent of GDP, or \$2.7 trillion) most of our health statistics, such as life expectancy and infant mortality, along with patient satisfaction scores, are generally in the lower half of industrialized countries.<sup>4</sup> Thus, successful health care reform must address this "triple aim": improving the quality, outcomes, and experience of care for patients; improving the overall health of the population; and slowing the growth of health care costs.<sup>5</sup>

The PPACA does contain a few provisions that begin to address the "triple aim." These include the following: the establishment of a Shared Savings Program within Medicare for the creation of Accountable Care Organizations (ACOs);<sup>6</sup> the establishment of an Innovation Center within CMS to stimulate new payment and organizational models, such as patient-centered medical homes;<sup>7</sup> and funds for the adoption and implementation of electronic health records in hospitals and physician practices.<sup>8</sup> The PPACA also establishes an Independent Payment Advisory Board (IPAB).<sup>9</sup> The Board is authorized to reduce payments to doctors and hospitals if health care expenditures exceed the overall growth in the GDP by greater than one percent.

The key to avoiding these potentially draconian cuts lies in the extent to which patient care can be delivered in a more cost-effective way (that is, with greater value) than currently occurs. Can hospitals, physicians, and other health professionals organize themselves in such a way as to respond to the new payment incentives that reward outcomes of care and not volume of procedures or services delivered? Can they adopt and use electronic health records to interact more continuously with their patients,

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4. See U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2011, HEALTH AND NUTRITION, at 99 tbl.130 (2011), <http://www.census.gov/prod/2011pubs/11statab/health.pdf>; DEP'T OF ECONOMIC & SOCIAL AFFAIRS, UNITED NATIONS, WORLD POPULATION PROSPECTS: THE 2006 REVISION 80-89 (2007), [http://www.un.org/esa/population/publications/wpp2006/WPP2006\\_Highlights\\_rev.pdf](http://www.un.org/esa/population/publications/wpp2006/WPP2006_Highlights_rev.pdf).

5. Donald M. Berwick, Thomas W. Nolan & John Whittington, *The Triple Aim: Care, Health, and Costs*, 27 HEALTH AFF. 759, 759-69 (2008).

6. PPACA, Pub. L. No. 111-148, § 3022, 124 Stat. 119, 395-99 (2010).

7. *Id.* § 10306, 124 Stat. at 939-40.

8. *Id.* § 2041, 124 Stat. at 791-94 (establishing the "Certified EHR Technology Grant Program").

9. *Id.* § 3403, 124 Stat. at 489-507.

to receive feedback on results to improve care, to share information with each other, and to provide data to external parties—including the public at large—for purposes of accountability? Can physicians learn to work effectively in teams within real and virtual organizations? Can state professional practice laws be changed to allow competency-based licensing for nurses, physician assistants, and new types of community health workers, to provide services now restricted to only physicians? Answers to these and related questions will involve fundamental changes in hospital behavior, physician behavior, and patient behavior as these groups interact within the context of regulatory and legal policies and continual advances in medical technology. To address this challenge, an organizing framework based on an understanding of incentives, capabilities, and accountability is needed. This framework may be expressed as: INCENTIVES<sup>10</sup> x CAPABILITIES<sup>11</sup> + ACCOUNTABILITY<sup>12</sup> = FUNDAMENTAL CHANGE IN HEALTH CARE DELIVERY.

## II. THE FRAMEWORK: INCENTIVES

The dominant form of payment for physicians is fee for service; for hospitals, it is a set amount based on a given diagnosis called a Diagnosis Related Group (DRG). Simply put, physicians make more money for more services, tests, visits, treatments, and drugs prescribed. Hospitals make more money the more patients they admit; although some are, of course, more “profitable” than others, depending on the DRG rate established for a given condition. There is no incentive to contain costs or to refrain from providing care that may not be supported by the best evidence. Patient pressure and legal concerns often result in the practice of “defensive medicine” on the part of many physicians.<sup>13</sup> Most importantly, fee for service creates no incentive for physicians to do things differently; to learn from each other; to try new approaches to care that might provide greater value to patients. Thus, a major provision for change in the PPACA is to move away from fee for service payment and toward paying physicians and hospitals based on creating a common set of economic incentives, such as bundled payments for given conditions, epi-

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10. See *supra* Part II.

11. See *infra* Part III.

12. See *infra* Part IV.

13. See Catherine A. Martin & Tamara R. Tenney, *Preparing for Quality-Based Payments: Trends and Legal Barriers to Successful Implementation*, 2 J. HEALTH & LIFE SCI. L. 1, 3 (2009) (“[T]he pervasive risks of malpractice litigation, from both a financial and reputational perspective, may encourage physicians to order more tests and services than medically indicated.”).

sode of care-based payments, partial capitation payments, and total capitation payments.

Bundled payment involves the establishment of a fixed payment to *both* hospitals and physicians for treating patients for a given condition, such as total hip replacement, total knee replacement, or coronary artery bypass graft surgery.<sup>14</sup> By establishing such an umbrella payment, hospitals and physicians have every incentive to work together across the entire episode of illness, including pre-hospital care, hospital care, and post-discharge care. Provided established quality criteria are met, hospitals and physicians will then share in any savings that result from providing the care below the negotiated rate. To the extent possible, the negotiated rates would take into account differences in patient severity of illness and regional differences across the country in the cost of living index and other inputs into the provision of medical services.

Episode of illness-based payment results in a single payment for managing the care of patients with specific conditions—such as diabetes or asthma—whether or not such conditions involve hospitalization.<sup>15</sup> Again, providers who can manage a given population of patients with these conditions within a set episode-based payment would receive savings, provided that selected quality criteria are met.

In capitated payment, providers receive payment per member or per patient, per month.<sup>16</sup> In partial capitation, the payment may be based only on ambulatory care, only on hospital care, or only for certain conditions, but not for the total amount of care for all conditions. In total capitation, the payment to providers is established for the entire population of patients to be treated for all conditions. In effect, for a given provider organization, total capitation for all patients based on all care amounts to a global budget for that organization.

These new forms of payment, moving away from fee for service, represent a landmark change in American health care delivery and payment. Incentives are created for providers to manage the health of their patients and to assume the risk, in varying degrees, of being able to provide quality care within the financial incentives. Providers are no longer rewarded for the amount of care they provide but rather for providing the most cost-effective care based on current knowledge and best judgment.

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14. 42 U.S.C.A. § 1395cc-4 (West Supp. 2011).

15. 42 U.S.C.A. § 1395cc-4(a)(2)(D)(i) (West Supp. 2011).

16. PPACA, Pub. L. No. 111-148, § 2705, 124 Stat. 119, 324–25 (2010).

Additional incentives include paying more for achieving high quality scores and/or improvements in quality over time.<sup>17</sup> Such “pay for performance” programs have generally been associated with modest gains in quality.<sup>18</sup> They also depend greatly on a number of implementation issues, including the number and types of measures used, the ability to take into account differences in patient severity of illness and differences in socioeconomic and cultural backgrounds, and the amount of dollars needed to incentivize changes in behavior.<sup>19</sup> Public reporting of cost and quality data and formal recognition and reward programs can also serve as incentives for changing behavior.<sup>20</sup>

### III. THE FRAMEWORK: CAPABILITIES

Changes in incentives alone will do little to change behavior. Hospitals, physicians, other health professionals, and patients themselves also need the capability to respond to the new incentives. There is great variance across the United States in the ability of these groups to respond. Many hospitals, including those belonging to large multi-hospital systems, still lack electronic health records,<sup>21</sup> particularly in the ability to track patients after they are discharged from the hospital. The majority of physicians still work in solo practices, partnerships, or small groups of five or fewer doctors.<sup>22</sup> Most of these, and even many of the larger physician organizations, lack the necessary capital, finan-

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17. See, e.g., *Id.* § 3001, 124 Stat. at 353–63; *Id.* § 3006, 124 Stat. at 372–73; *Id.* § 3007, 124 Stat. at 373–76; *Id.* § 10326, 124 Stat. at 961–62.

18. Cheryl L. Damberg et al., *Taking Stock Of Pay-For-Performance: A Candid Assessment From The Front Lines*, 28 HEALTH AFF. 517, 517–25 (2009).

19. Meredith B. Rosenthal & R. Adams Dudley, *Pay-for-Performance: Will the Latest Trend Improve Care?*, 297 J. AM. MED. ASS’N 740, 740–44 (2007).

20. For examples of ranking systems that are based on disclosed information, see NAT’L COMM. FOR QUALITY ASSURANCE, NCQA’S HEALTH INSURANCE PLAN RANKINGS 2010–2011 (2010), [http://www.ncqa.org/portals/0/health%20plan%20rankings/2010/HPR2010\\_Plan\\_Ranking\\_Summary\\_Report\\_Private10.26.pdf](http://www.ncqa.org/portals/0/health%20plan%20rankings/2010/HPR2010_Plan_Ranking_Summary_Report_Private10.26.pdf) (assessing the performance of health plans in 2010); *Hospital Compare*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <http://www.hospitalcompare.hhs.gov> (last visited May 23, 2011); *State Scorecard*, THE COMMONWEALTH FUND, <http://www.commonwealthfund.org/Maps-and-Data/State-Data-Center/State-Scorecard.aspx> (last visited May 23, 2011); THE DARTMOUTH ATLAS OF HEALTHCARE, <http://www.dartmouthatlas.org> (last visited May 23, 2011).

21. For more information about issues related to medical health records, see Jacqueline Klosek, *Exploring the Barriers to the More Widespread Adoption of Electronic Health Records*, 25 NOTRE DAME J.L. ETHICS & PUB. POL’Y 429 (2011).

22. See ESTHER HING & CATHARINE W. BURT, NAT’L CTR. FOR HEALTH STATISTICS, U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE-BASED MEDICAL PRACTICES: METHODS AND ESTIMATES FROM THE NATIONAL AMBULATORY MEDICAL CARE SURVEY (2007), <http://www.cdc.gov/nchs/data/ad/ad383.pdf>.

cial, organizational, leadership, and managerial expertise to make the necessary changes.

To address this fragmentation in the current delivery system, PPACA contains provisions for the creation of Accountable Care Organizations (ACOs)<sup>23</sup> and incentive payments for supporting Patient Centered Medical Homes (PCMHs).<sup>24</sup> Accountable Care Organizations are entities that accept responsibility for the quality and cost of all care provided to a given population of patients and that provide data on performance. PPACA requires that they provide care to a population of at least five thousand. Provider organizations enter into contracts for at least three years and have a designated administrative/legal governance structure for accepting payment and distributing such payment to providers. Most ACOs will include physician practices and at least one hospital, and many will probably include nursing homes, home health agencies, and other provider organizations. Specific examples include integrated delivery systems, such as the California-based Kaiser Permanente,<sup>25</sup> the Henry Ford Health System in Detroit,<sup>26</sup> and the Geisinger Health System in Western Pennsylvania;<sup>27</sup> multi-specialty group practices, such as the Mayo Clinic<sup>28</sup> and the Cleveland Clinic;<sup>29</sup> Physician Hospital Organizations (PHOs), such as Advocate Health Care in Chicago,<sup>30</sup> Banner in Phoenix,<sup>31</sup> and Middlesex in Middletown, Connecticut;<sup>32</sup> and independent practice associations, such as the Hill Physicians Group in Northern California<sup>33</sup> and Health Partners<sup>34</sup> and

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23. PPACA, L. No. 111-148, § 3022, 124 Stat. 119, 395-99 (2010).

24. *Id.* § 3022, 124 Stat. at 395-99; *Id.* § 3502, 124 Stat. at 513-15.

25. KAISER PERMANENTE, <https://www.kaiserpermanente.org> (last visited May 23, 2011).

26. HENRY FORD HEALTH SYSTEM, <http://www.henryfordhealth.org> (last visited May 23, 2011).

27. GEISINGER HEALTH SYSTEM, <http://www.geisinger.org> (last visited May 23, 2011).

28. MAYO CLINIC, <http://www.mayoclinic.org> (last visited May 23, 2011).

29. CLEVELAND CLINIC, <http://my.clevelandclinic.org/default.aspx> (last visited May 23, 2011).

30. ADVOCATE HEALTH CARE, <http://www.advocatehealth.com/default.cfm> (last visited May 23, 2011).

31. BANNER GOOD SAMARITAN MEDICAL CENTER, [http://www.bannerhealth.com/Locations/Arizona/Banner+Good+Samaritan+Medical+Center/\\_Banner+Good+Samaritan+Medical+Center+Home.htm](http://www.bannerhealth.com/Locations/Arizona/Banner+Good+Samaritan+Medical+Center/_Banner+Good+Samaritan+Medical+Center+Home.htm) (last visited May 23, 2011).

32. MIDDLESEX HOSPITAL, <http://middlesexhospital.org> (last visited May 23, 2011).

33. HILL PHYSICIANS, <http://www.hillphysicians.com/Pages/Default.aspx> (last visited May 23, 2011).

34. HEALTHCARE PARTNERS, <http://www.healthcarepartners.com> (last visited May 23, 2011).

Monarch in Southern California<sup>35</sup> along with more loosely organized “virtual” organizations similar to Community Care of North Carolina.<sup>36</sup> A major issue for ACOs will be to work out the distribution of power and influence among hospitals, primary care physicians, and specialists in making important decisions regarding all aspects of ACO operation and resources.<sup>37</sup>

A key factor in the likely success of the ACO concept will be the ability to manage patient-care risk under new financial incentives. Rather than an “approve/not approve” or “one-size-fits-all” set of rules and regulations for establishing ACOs, it may be better to establish three different tiers which appropriately recognize the different ability of current providers to respond to the financial incentives.<sup>38</sup> At entry Level 1, providers might participate in a shared savings program in which there is relatively little or no downside risk. They would receive shared-saving bonuses if they met quality benchmarks and reduced per-member spending below the agreed-upon target. They would be required to report a basic set of performance measures based largely on available administrative data.

Level 2 ACOs would be eligible to receive a greater proportion of savings below target but also be at risk for spending above the target. In addition, they would be eligible for bundled payments for certain conditions and partial capitation payments. They would be required to provide a more comprehensive set of performance measures, including patient experience and clinical performance data for defined chronic illnesses. Given the increased level of risk involved, they would also be required to meet specific standards for financial reporting, including cash reserves and financial projections.

High Level 3 ACOs could be reimbursed through a greater percentage of patients covered by partial capitated payments, a greater set of conditions for which bundled payments are used, or be paid by total capitation. In return, they would be required to publicly report a comprehensive set of performance measures

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35. MONARCH HEALTHCARE, <http://www.monarchhealthcare.com> (last visited May 23, 2011).

36. COMMUNITY CARE OF NORTH CAROLINA, <http://www.communitycarenc.com> (last visited May 23, 2011).

37. See William B. Weeks et al., *Higher Health Care Quality and Bigger Savings Found at Large Multispecialty Medical Groups*, 29 HEALTH AFF. 991, 996 (2010). See generally PARTNERS IN HEALTH: HOW PHYSICIANS AND HOSPITALS CAN BE ACCOUNTABLE TOGETHER (Francis J. Crosson & Laura A. Tollen eds., 2010).

38. See Stephen M. Shortell, Lawrence P. Casalino & Elliott S. Fisher, *How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293, 1295–96 (2010).



drawn largely from electronic health records that would include health-related outcomes and quality of life indicators. They would also be required to meet more stringent standards for financial reporting and would be required to hold larger cash reserves. The key idea behind this proposal is to match the capabilities of the evolving delivery system with the degree of risk assumed. Practices could begin at low levels of developing the needed capabilities and advance to higher levels over time with the associated risk-reward relationship adjusted accordingly.

There is an emerging body of evidence that at least certain types of ACOs can provide more cost-effective care, more preventive care, more recommended elements of care for patients with chronic illness, demonstrate greater improvement over time in the use of recommended care management processes, and provide higher quality of care than other care delivery systems in the same market area.<sup>39</sup> There appears to be no single formula or “silver bullet” associated with the success of these organizations. Rather, some common elements appear to be: depth of physician leadership;<sup>40</sup> a culture focused on meeting patient needs;<sup>41</sup> the ability to deliver care in teams (including nurse practitioners, physician assistants, pharmacists, social workers, nutritionists, and others);<sup>42</sup> and the ability to redesign the practice of medicine through the use of various quality improvement systems and engineering tools, such as statistical process control, Plan, Do, Study and Act (PDSA) cycles, quality functional deployment, lean production, and the growing implementation of electronic health records.<sup>43</sup>

ACOs also emphasize managing care between visits with use of the electronic medical record. Other mechanisms used include home-based monitoring, home-based caregivers, and

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39. See Robin R. Gillies et al., *The Impact of Health Plan Delivery System on Clinical Quality and Patient Satisfaction*, 41 HEALTH SERVICES RES. 1181 (2006); Stephen M. Shortell et al., *Improving Chronic Illness Care: A Longitudinal Cohort Analysis of Large Physician Organizations*, 27 MED. CARE (2009); Weeks, *supra* note 37.

40. See, e.g., Robert J. Reid, *The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers*, 29 HEALTH AFF. 835, 836, 841 (2010).

41. See, e.g., Ronald A. Paulus, Karen Davis & Glenn D. Steele, *Continuous Innovation In Health Care: Implications Of The Geisinger Experience*, 27 HEALTH AFF. 1235, 1237, 1239–42 (2008); Reid, *supra* note 40, at 835.

42. See, e.g., Gillies, *supra* note 39, at 1183–84, 1193; Weeks, *supra* note 37, at 996.

43. See, e.g., Paulus, *supra* note 41, at 1239; Reid, *supra* note 40, at 836, 841.

telemedicine linkages, particularly in rural areas.<sup>44</sup> There is also emerging evidence that PCMHs provide higher quality care at the same or lower cost than the current, largely fragmented, system of providers.<sup>45</sup>

Most ACOs will be based on the foundation of Patient Centered Medical Homes. PCMHs are comprised of primary care physicians who take responsibility for providing comprehensive, coordinated care to patients for the entire continuum of care, working with specialists and other providers as needed. Under PPACA, they would be paid additional money for providing such care coordination and could also qualify for additional bonus payments for meeting quality targets.<sup>46</sup>

There are many challenges to the development of ACOs and PCMHs beyond matching payment incentives to the degree of risk that these organizations are able to bear. These include: how patients are to be linked or attributed to ACOs or PCMHs; patient acceptance of these new forms of organization; and a number of legal and regulatory barriers. Regarding patient linkage, each patient might be given a choice of provider, with most undoubtedly selecting a physician with whom they currently have a personal relationship. For the currently uninsured, and those without a designated personal physician, assignment could be made based on the provider from which the person has received the majority of their care. Systems that care for the uninsured, such as public hospitals and Federally Qualified Health Centers, could create safety net ACOs that could facilitate the assignment process. The question that arises is whether patients would be allowed to seek care outside their designated ACO. One approach would be for patients to be “locked in” for one year and then be free to choose a different ACO at the end of the year. If, for a given condition, a specific ACO cannot provide the care to the patient, a referral outside of the ACO network would be needed. In such cases, the “home-base” ACO would still be responsible for the overall cost and quality of care for the patient. This would create appropriate incentives for the ACO to choose referral physicians that meet desired cost and quality criteria.

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44. Arnold Milstein & Elizabeth Gilbertson, *American Medical Home Runs*, 28 HEALTH AFF. 1317 (2009).

45. See Paulus, *supra* note 41; Reid, *supra* note 40; Beat D. Steiner, *Community Care of North Carolina: Improving Care Through Community Health Networks*, 6 ANNALS OF FAM. MED. 361 (2008).

46. PPACA, Pub. L. No. 111-148 § 3022, 124 Stat. 119, 395–99 (2010). See also Diane R. Rittenhouse & Stephen M. Shortell, *The Patient-Centered Medical Home: Will It Stand the Test of Health Reform?*, 301 J. AM. MED. ASS'N 2038 (2009).

The second challenge involves promoting public acceptance of ACOs. The problem arises because of patient and public reaction to the managed care of the late 1990s in which insurers often required prior approval for a number of procedures and services, and for referrals to specialists.<sup>47</sup> If ACOs are simply seen as a new version of “cost cutting” by managed care organizations, there is likely to be a repeat of prior negative reaction. Thus, it will be important to communicate that ACOs are being created to better meet the needs of patients, to better coordinate care across the entire continuum of care that is needed, and to be paid based on the quality of the results achieved in addition to the ability to slow the increase in costs. Advances in the ability to measure the patients’ experience with their care and to measure aspects of the technical quality of care along with the emergence of electronic health records make it more possible to demonstrate the benefits of such care than was possible ten or fifteen years ago.

There are also a number of legal and regulatory barriers, particularly in regard to ACO formation. These include antitrust laws<sup>48</sup> and Stark laws against kickbacks and referrals to organizations in which physicians may have an economic interest.<sup>49</sup> There is concern that as physicians group together to form larger entities, they will have greater ability to set prices, particularly in their negotiations with private insurers. Providers that can meet financial integration criteria involving the sharing of substantial financial risk and clinical integration criteria regarding the coordination and quality of care may be able to proceed with their plans. But these criteria will need to be defined by the Department of Justice and the Federal Trade Commission.

Current anti-kickback statutes prohibit physicians and hospitals from entering into financial relationships that might induce the referral of patients to the hospital.<sup>50</sup> Center for Medicare & Medicaid Services (CMS) and the Inspector General’s office have

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47. See generally RAND HEALTH, FACT SHEET, THE MANAGED CARE BACKLASH: DID CONSUMERS VOTE WITH THEIR FEET? (2005), [http://www.rand.org/content/dam/rand/pubs/research\\_briefs/2005/RAND\\_RB9121.pdf](http://www.rand.org/content/dam/rand/pubs/research_briefs/2005/RAND_RB9121.pdf).

48. See Sherman Act, 15 U.S.C. §§ 1–7 (2006); Clayton Act, 15 U.S.C. §§ 12–27 (2006); Federal Trade Commission Act, 15 U.S.C. §§ 41–58 (2006).

49. See Stark Law, 42 C.F.R. § 411.350–411.389 (2010).

50. See STEPHEN M. SHORTELL, LAWRENCE P. CASALINO & ELLIOTT FISHER, BERKELEY CTR. ON HEALTH, ECON. & FAMILY SEC., ADVANCING NATIONAL HEALTH REFORM POLICY SERIES: IMPLEMENTING ACCOUNTABLE CARE ORGANIZATIONS (2010), [http://www.law.berkeley.edu/files/chefs/Implementing\\_ACOs\\_May\\_2010.pdf](http://www.law.berkeley.edu/files/chefs/Implementing_ACOs_May_2010.pdf); Maria T. Currier & Morris H. Miller, *Medicare Payment Reform: Accelerating the Transformation of the U.S. Health Care Delivery System and Need for New Strategic Provider Alliances*, 22 HEALTH LAW. 1 (2010).

the authority to create safe harbors, but how these will be implemented remains to be seen.<sup>51</sup> In addition, seven states (California, Colorado, Texas, Illinois, Iowa, New York, and New Jersey) have corporate practice of medicine laws preventing hospitals from employing physicians in the provision of out-patient services.<sup>52</sup> These laws will constrain the forms that ACOs may take in those states. Further, as previously noted, practice and licensing laws will need to be re-examined if full use is to be made of the emerging competencies of non-physician health professionals, such as nurse practitioners, physician assistants, and community health workers.

To address the above and related challenges, considerable technical assistance will be needed in many physician practices and community hospitals across the country. Such help may come not only from private sector consulting firms and quality improvement organizations, such as Boston-based Institute for Health Care Improvement,<sup>53</sup> but also from creative approaches which link current well-established ACOs, such as some of the country's leading integrated delivery systems and multi-specialty group practices, with less developed practices throughout the country. For example, such organizations might receive technical assistance payments from CMS for partnering with organizations requiring assistance in developing an effectively-functioning ACO. This "twinning" idea is currently being explored by some organizations throughout the country, including the Council of Accountable Physician Practices made up of more than thirty of the country's leading multi-specialty group practices.<sup>54</sup>

#### IV. THE FRAMEWORK: ACCOUNTABILITY

The third component of the framework for fundamentally changing health care delivery is accountability. Accountability has both an internal dimension for purposes of providing feedback to continuously improve care and an external component

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51. Safe Harbor for Federally Qualified Health Centers Arrangements Under the Anti-Kickback Statute, 42 C.F.R. § 1001 (2007).

52. See MARY H. MICHAL ET AL., CTR. TO ADVANCE PALLIATIVE CARE, CORPORATE PRACTICE OF MEDICINE DOCTRINE: 50 STATE SURVEY SUMMARY (2006), <http://www.nhpc.org/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf>.

53. *About Us*, INSTITUTE FOR HEALTH CARE IMPROVEMENT, <http://www.ihc.org/ihc/about> (last visited May 23, 2011).

54. Stephen M. Shortell, Lawrence P. Casalino & Elliott S. Fisher, *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 HEALTH AFF. 1293 (2010).

related to providing the basis for results-based payment, recognition, and review by external bodies. Key questions become accountability to whom, for what, and how?<sup>55</sup> In regard to the “whom” question, ACOs and PCMHs have multiple stakeholders, including patients, payers, and the public at large. In regard to “what,” the relevant dimensions are cost, clinical process, and outcome measures of care and patients’ experience with care. A reliable and valid portfolio of measures is emerging to provide such assessment.<sup>56</sup>

In regard to “how,” major reliance must be placed on the further diffusion of electronic health records to be able to provide both real time data to physicians and their patients as well as data that can be stored and aggregated up to various levels of accountability. Aggregation levels could include: individual patients; groups of patients in a practice or within an ACO or PCMH; groups of patients within a given market, region or state; and ultimately patients on a nationwide basis. This capability will emerge slowly and will require national agreement on data platforms, open source technologies, and standardization. Only through a well-defined, transparent system of accountability, will the American public and the various stakeholders involved be able to determine whether or not the goals of health care reform are being achieved.

## V. CONCLUSION

Incentives, capabilities, and accountability provide a framework for thinking about and assessing the extent to which fundamental changes in how health care is delivered in the United States can be achieved. The framework underscores the complexity of the processes involved and the overall need for alignment among incentives, capabilities, and accountability. It also provides a basis for developing an evaluation framework for tracking the progress of delivery system reform over time. Data from multiple sources will be needed to assess the impact of

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55. Elliott S. Fisher & Stephen M. Shortell, *Accountable Care Organizations: Accountable for What, to Whom, and How*, 304 J. AM. MED. ASS’N 1715 (2010).

56. See INST. OF MED., PERFORMANCE MEASUREMENT: ACCELERATING IMPROVEMENT (2005), <http://www.iom.edu/~media/Files/Report%20Files/2005/Performance-Measurement-Accelerating-Improvement/ReportBriefPerformanceMeasurementAcceleratingImprovement.pdf>; NAT’L QUALITY FORUM, MEASUREMENT FRAMEWORK: EVALUATING EFFICIENCIES ACROSS PATIENT-FOCUSED EPISODES OF CARE (2009), available at [http://www.qualityforum.org/Publications/2010/01/Measurement\\_Framework\\_Evaluating\\_Efficiency\\_Across\\_Patient-Focused\\_Episodes\\_of\\_Care.aspx](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework_Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx) (follow “Download the Publication” hyperlink).

changes in payment incentives on the capabilities of ACOs, PCMHs, and related entities to deliver more cost-effective care to various populations across the country.<sup>57</sup>

It is unlikely that results will come quickly. Most likely, it will take three to five years to lay the new foundation for health care delivery that incorporates the essential incentives, capabilities, and accountability. At that point, we may be able to see some significant, measurable improvements in quality of care and a diminishing percentage increase in the growth of the cost of care. Whether or not we will have the patience or can afford to wait this long remains an open question. As Atul Gawande wrote, “[O]ne truly scary thing about health care reform: far from being a government takeover, it counts on local communities and clinicians for success. We are the ones to determine whether costs are controlled and health care improves . . . .”<sup>58</sup>

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57. LAURA A. TOLLEN ET AL., KAISER PERMANENTE INST. FOR HEALTH POLICY & THE COMMONWEALTH FUND, DELIVERY SYSTEM REFORM TRACKING: A FRAMEWORK FOR UNDERSTANDING CHANGE (forthcoming 2011).

58. Atul Gawande, *Now What?*, NEW YORKER, Apr. 5, 2010, at 21.

