

ORIGINAL ARTICLE

The March to Accountable Care Organizations—How Will Rural Fare?

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Abstract

Purpose: This article describes a strategy for rural providers, communities, and policy makers to support or establish accountable care organizations (ACOs).

Methods: ACOs represent a new health care delivery and provider payment system designed to improve clinical quality and control costs. The Patient Protection and Affordable Care Act (ACA) makes contracts with ACOs a permanent option under Medicare. This article explores ACA implications, using the literature to describe successful integrated health care organizations that will likely become the first ACOs. Previous research studying rural managed care organizations found rural success stories that can inform the ACO discussion.

Findings: Preconditions for success as ACOs include enrolling a minimum number of patients to manage financial risk and implementing medical care policies and programs to improve quality. Rural managed care organizations succeeded because of care management experience, nonprofit status, and strong local leadership focused on improving the health of the population served.

Conclusions: Rural provider participation in ACOs will require collaboration among rural providers and with larger, often urban, health care systems. Rural providers should strengthen their negotiation capacities by developing rural provider networks, understanding large health system motivations, and adopting best practices in clinical management. Rural communities should generate programs that motivate their populations to achieve and maintain optimum health status. Policy makers should develop rural-relevant ACO-performance measures and provide necessary technical assistance to rural providers and organizations.

Key words accountable care organizations (ACOs), Affordable Care Act (ACA), health care organizations, health care reform, rural physician practices.

Accountable care organizations (ACOs) have become one of the hottest new trends in health care. As a new Medicare payment and health care delivery alternative established by the Patient Protection and Affordable Care Act (ACA), ACOs create opportunities for rural health care providers to improve health care quality and control health care costs in their communities. However, despite new opportunities, a bright future for rural providers is

not assured. Rural providers must remain cautious of urban-based policies and large health care system programs that might disadvantage rural health care delivery. But caution has its limits. Rural stakeholders should proactively participate in ACO development discussions during rule making and implementation of the ACA. Rural providers must not be left behind. Rural providers and community leaders should take advantage of the new

public policy landscape to design and implement innovative health care delivery systems that serve rural people and places.

The purpose of this article is to analyze the potential for ACOs to either benefit or erode local health care services in rural areas. We envision the future unfolding in 1 of 3 possible scenarios:

Best. Rural health care leadership will creatively and proactively develop health care delivery innovations that serve rural people and places and concurrently ensure the long-term viability of local rural health care providers. Rural providers will develop networks with other rural providers to coordinate services that improve care and control costs. Rural networks then will initiate mutually beneficial collaborations with distant and larger health care systems. Those systems will respond as respectful and sensitive partners. The transition to innovative health care delivery systems will be supported by effective public policy recognizing the value of rural communities and the people within. As a result, current rural/urban health and disability disparities will lessen. Rural people and places will become healthier and more vital.

Intermediate. Both, rural and urban health care providers will approach innovation in a laissez-faire fashion. The priorities of the day (eg, electronic health record implementation) will preclude health care leaders from creative future planning. Collaborations will develop by chance and necessity, without significant preparation that considers the long-term needs of rural people and places and ensures local access to appropriate health care services in perpetuity. Rural/urban health and disability disparities will persist.

Worst. Urban health care systems will use their financial strength, leadership experience, market dominance, and policy clout to leverage market share from rural providers. Urban predation will shift patients (and hence payment) out of rural areas to support extensive urban infrastructure investments. An attitude will prevail that dismisses the need for all but the most basic rural health care services. Rural provider shortages will dramatically worsen. Rural hospital services will degrade, and the previously unmerited “Band-aid station” label will become a reality. Rural access to quality health care services will therefore diminish, along with the health of rural people and the vitality of rural places.

Rural providers and communities can influence which scenario unfolds, but only if they act now to influence ACO development. Rural inaction will invite urban-based providers and programs to fill the health care delivery system vacuum.

Background

The US health care delivery system is fragmented, manifest by “systemic misalignment of incentives, or lack of coordination, that spawns inefficient allocation of resources or harm to patients.”¹ In the policy arena, in which lawmakers and administrators seek to use resources wisely and optimize output (in this case, safe, effective, and accessible health care), a public policy push for health care delivery integration makes sense. Discrete and fragmented health care results in higher cost and lower quality than in more integrated systems.² An integrated delivery system is an organized, coordinated, and collaborative network of health care providers designed to provide a coordinated and comprehensive menu of services. Many examples of integrated delivery systems exist today, including Geisinger Health System, Intermountain Healthcare, Mayo Clinic, and Marshfield Clinic. These organizations will likely serve as models for the rapidly developing ACO concept.

Accountable Care Organizations

Elliot Fisher and his colleagues at Dartmouth first suggested the term *accountable care organization* in 2006 to describe a collaboration of providers who are jointly held accountable for achieving measurable quality improvements and reducing the rate of spending growth.³ Since then, others, including Devers and Berenson,⁴ Shortell and Casalino,⁵ and the Commonwealth Fund⁶ have offered ACO definitions. Despite suffering from multiple definitions by multiple experts, this much is clear: The ACO concept, at least as considered by public policy, couples provider payment and delivery system reforms.⁴ We suggest that an ACO is a health care delivery system organized to improve health care quality and control costs through care coordination and provider collaboration, and then is held accountable for its performance. We specifically note that a health care *system* can take many forms, but it generally would include hospitals, physicians, and other providers.

Patient Protection and ACA

The ACA calls for the creation of an ACO-Medicare shared savings program by January 1, 2012. The Centers for Medicare and Medicaid Services describes an ACO as “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.”⁷ The law makes contracts with ACOs a permanent option under Medicare.⁸ ACOs will continue to receive Medicare

fee-for-service payments. But in addition to the fee-for-service payments, participating ACOs would be eligible for a percentage of any savings if the per capita Medicare expenditures are less than average expenditures annualized over the past 3 years. The shared savings distribution requires that the ACO achieve savings in Part A and Part B combined, and that the ACO meet applicable quality performance standards, to be defined in Health and Human Services regulations. Meeting those requirements is referred to as *accepting performance risk* (not simply financial risk) for the health status of patients.⁹ Theoretically, the shared savings would reimburse ACO investments in service coordination, disease management, wellness programs, and other policies/programs designed to improve health and reduce expenditures. Thus, the ACO shared-savings concept begins to reverse misaligned fee-for-service incentives that provide greater payment for more services, regardless of whether or not the services improve health. In addition, the shared savings approach provides an incentive for ACOs to avoid expansions of health care capacity that do not improve health.¹⁰

Insights from Rural Managed Care

ACOs will likely share similarities with rural managed care organizations (MCOs). During the 6 years following the Balanced Budget Act of 1997, when organizations were formed and functioned as Medicare + Choice plans, we visited 8 rural plans. The purpose of the study was to understand what rural MCO characteristics seemed to be associated with success. Characteristics of a successful rural MCO of several years ago might suggest characteristics of a successful rural ACO in the near future. We found that the MCOs that remained viable in rural areas tended to be locally owned, physician driven, and non-profit. We also found that organizations that had prior experience with managed care—in particular, government-sponsored managed care (eg, Medicaid managed care)—were more likely to have success in the Medicare + Choice environment. Having a mission that prioritized the local health care system and the local community, tended to be a success factor as well. Historically, successful rural MCOs suggest that new health care organizations with proper organizational structure and local leadership will be capable of accepting financial risk.

Rural Provider Challenges and Opportunities

Regardless of whether the ACO is urban- or rural-based, several competencies will likely be essential for ACO success. The American Hospital Association has summarized

required ACO competencies from the literature. These competencies include leadership; an organizational culture of teamwork; an information technology infrastructure for population management and care coordination; an infrastructure for monitoring, managing, and reporting quality; the ability to manage financial risk; the ability to receive and distribute payments or savings; and resources for patient education and support.¹¹ We would add to the list physician engagement and leadership, non-profit local ownership, and the capacity to manage high-cost and high-risk patients effectively and with sensitivity.¹² These characteristics and competencies are common in large and well-established integrated delivery systems—but less so among disparate, independent, and autonomous rural health care providers.

Rural providers must not be left behind in public or other policies designed to improve quality and control cost.^{13,14} The same is true for rural participation in ACOs. However, significant barriers to rural ACO entry exist. We have identified 8 rural constraints to ACO participation: (1) rural provider autonomy; (2) rural practice design; (3) low rural volumes; (4) historic rural efficiency; (5) urban motivations; (6) urban provider cost structure; (7) legal and regulatory barriers; and (8) rural leadership inexperience. We will address each constraint and offer suggestions to accelerate rural preparedness for ACO participation.

Rural Provider Autonomy

Much of medical management maturation has taken place in urban integrated delivery systems, as identified by case studies from the Commonwealth Fund Commission on a high-performance health system.¹ Consequently, the ACO concept is based primarily on an urban experience. An urban model may not be as feasible with multiple independent ambulatory practices (including rural health clinics and federally qualified health centers) and several smaller hospitals. Furthermore, a unified mission and consistent approach to health care delivery is common in well-established integrated delivery systems, but not among unaligned rural providers. Many integrated delivery systems took decades to develop cost-control systems and a unified clinical care culture. The cultural authority to consistently manage organizational and provider behavior is a strong strategic asset to an integrated delivery system and is often underdeveloped or absent in autonomous and isolated rural practice situations. Rural provider practices, already frequently smaller than urban practices due to lower population density and greater geographic separation, are likely to be particularly disadvantaged in a system that requires practice redesign, care coordination, and provider collaboration.

Rural providers must begin to acknowledge that strict independence is no longer a success strategy. However, and importantly, collaboration does not imply dependence or subservience. And integration is not necessarily synonymous with ownership. Rural providers who wish to negotiate with larger or urban systems must do so from a position of financial, quality, and service strength. Negotiation strength also requires numbers. Therefore, autonomous and disparate rural providers must begin dialogues that lead to rural collaborations. Primary care physicians, specialists, and hospitals must work together not only to negotiate effectively with larger systems, but more importantly to coordinate care, improve quality, and control costs. Enthusiastic provider participation in an ACO will depend on both financial incentives and practice management requirements.¹⁵ Thus, rural leaders must learn how to effectively allocate provider payments and disseminate health management strategies among diverse providers. And finally, the collaborative mentality must extend to individual providers. Atul Gawande tells us that “we’ve celebrated cowboys, but what we need is more pit crews. There’s still a lot of silo mentality in health care—the mentality of ‘That’s not my problem; someone else will take care of it’—and that’s very dangerous. But the fact is, it’s teams and, often, great organizations that make for great care, not just great individuals.”¹⁶

Rural Practice Design

Almost one-third of all US physicians work in solo or 2-physician practices, 15% work in practices of 3 to 5 physicians, and 19% work in practices of 6 to 50 physicians.¹⁷ Independent rural practices may not have devoted resources to develop tools (such as care management, team work, and interoperable information technology) necessary to successfully coordinate care and manage population health.¹⁸ Rural providers should embrace practice redesign strategies that improve clinical quality and support care coordination; ACOs, payers, and patients will demand it. Resources for practice redesign include the patient-centered medical home,¹⁹ TransforMED,²⁰ and the Institute for Healthcare Improvement’s Office Practice topics,²¹ among many others. Lastly, shared learning must prevail over autonomy. As practices embrace new design, rural providers and networks must aggressively identify and disseminate best practices that promote efficiency, improve quality, and reduce cost.¹¹

Low Rural Volumes

Health care savings are often greater when investments in care coordination and other cost-saving strategies are

spread over a significant number of patients. Medicare will require an ACO to include 5,000 beneficiaries. Assuming Medicare beneficiaries represent 15% or more of the total population in many rural areas, the Medicare rule would require a total service area population of over 33,000—too large for many rural providers. Although a total of 5,000 enrollees is likely too low for global risk assumption (capitation), it may be high enough to preclude many rural systems (or collaborations) from program participation. In response, rural providers should consider new and innovative models. For example, noncontiguous rural areas could collaborate to develop an ACO that surpasses the 5,000-enrollee threshold. In turn, these new rural collaborations could affiliate to effectively contract with a distant tertiary care system. To jump-start these collaborations, policy help will be needed. Leaders of the Vermont Accountable Care Organization Pilot note that “rural models will require either a consolidated performance pool involving multiple payers or an expansion of the ACO to include multiple hospitals, making it possible to achieve the necessary critical mass of patients needed to support statistically meaningful measures of performance.”²²

Historic Rural Efficiency

Many rural providers already manage expenses aggressively. “Doing more with less” is a common tactic among rural providers. However, historic rural cost efficiency may be harmful if performance benchmarks are based solely on an individual provider’s cost experience. Historically cost-efficient providers will find new savings difficult to achieve. Policy makers should recall the unintended consequences for rural hospitals following implementation of the prospective payment system in 1983, when historical costs were used to develop new payment policies. Rural leaders must convince policy makers to not rely exclusively on historical cost experience when developing gain-sharing benchmarks. Alternatives to pure shared savings might include payment for improved performance compared to national benchmarks, and/or increased shared savings for providers incrementally improving from a historically efficient level.

Urban Motivations

Rural providers who are considering collaborating with larger systems should ask, “What motivates urban or distant health care systems to be rural-focused?” We suggest several potential urban motivators: (1) Scope of influence—for better or worse, new buildings and/or a large-geographic service area are tangible evidence of health care system leadership influence and accomplishment. (2) Control—physicians are an autonomous

group, yet they are required in any integrated health care system. As one doctor wryly noted, “ACOs, that sounds good, let’s graft onto that. How can I get a bigger system with more control, without all these fractious doctors to deal with?”²³ (3) Profit—although the linear thinking of “No margin – No mission” does not recognize the need to balance strategic health care delivery priorities, even nonprofit organizations cannot provide services in perpetuity if the overall organization is unprofitable. (4) Quality and patient satisfaction—although these priorities are not new to health care provider missions, pay-for-performance and public reporting of patient satisfaction will increasingly drive the business side of health care. (5) Physician satisfaction—physicians (and certain nonphysician providers) control approximately 85% of the health care dollar (the medical-loss ratio). Thus, physician allies in health care delivery system redesign are essential.²⁴ Rural providers should consider these potential urban motivators prior to collaboration (or affiliation) negotiation. And to continue the due diligence, rural providers should assess, “What factors will allow (require) an urban organization to remain mission focused during threats to profitability?” Rural providers should not only review a potential partner’s mission, but more importantly assess how the organization makes real its mission in program design, budgeting, resource allocation, and operations. If the urban organization has partnered with other rural providers, how has the larger system tangibly supported, respected, and empowered rural providers and communities?

Urban Provider Cost Structure

In the ACA, Medicare payment to ACOs is a gain-sharing relationship. However, the ACO concept will eventually demand that ACOs assume financial risk for quality outcomes and cost control. Who holds the money, who distributes the gains, and who bears the risk are all critical issues. Although savings can be realized from improved outpatient care coordination, most anticipated savings (that consequently result in gain sharing) are likely to come from reduced hospitalizations. Therefore, it may not be prudent for nonhospital providers to allow exclusive hospital control of the dollars for which they are at risk. Similar concern exists for rural hospitals in relationship with tertiary care hospitals. Like the heavy manufacturing or airline industries, tertiary care hospitals have very large fixed costs. Thus, it may be more profitable to utilize urban fixed assets (facilities, equipment, and personnel) than rural hospital services. Although rural care may appear to be “cheaper,” the cost is relative.

The important health care cost from a provider perspective is marginal cost (additional variable cost at-

tributable to that service). Thus, a large system may preferentially desire use of its infrastructure and capacity (at relatively low marginal cost) rather than refer to a rural provider, even if that rural provider’s overall costs are low. Assuming that the care is necessary and must be provided somewhere, increased volume decreases cost per unit of service, and consequently increases profit. The key factor is the location at which the marginal cost is lowest. As decision-making authority is granted (or seized), and if marginal cost is indeed higher in rural facilities, rural providers may be at a disadvantage compared to larger and more sophisticated health systems. Finally, these decisions will be complicated by decades of payment policies that have added justifiable bonus payments to rural hospitals and other providers, and that have helped compensate for low volumes and access issues. In response, rural providers must become experienced with financial risk management. They must understand the complexities of cost allocation, both in rural and urban health care organizations. Only then can wise decisions regarding site-of-service choice and gain-sharing distribution occur with equity.

Legal and Regulatory Barriers

The ACO concept requires development (if not already in place) of contractual and/or legal agreements that align incentives between different providers: primary care physicians, specialty physicians, hospitals, and others.²⁵ In situations where the health care entities are separately owned organizations (as might be the case with a rural provider collaborating with a larger urban system), ACOs require significant business relationships that could violate current antitrust laws (Medicare inurement, Stark, and anti-kickback). This situation is particularly germane to rural areas where formal provider collaborations may not be as mature. However, the ACA (Section 3022) appears to grant the Health and Human Services Secretary authority to waive at least some of these regulations.

Rural Leadership Inexperience

Overcoming the economic, relational, legal, and regulatory barriers to rural entry in the ACO milieu will require considerable leadership. As noted above, rural providers are often independent, disparate, and autonomous. Leadership development as a concerted goal is often underdeveloped among rural providers. Yet, rural ACO entry will require significant rural health care leadership and perseverance to overcome both the traditional barriers to provider collaboration and the challenges described above. Rural providers must recruit, train, and support rural leaders. Physician leaders are particularly essential

to foster physician engagement in practice redesign and collaboration building.

Rural Community Opportunities

Ideally, rural people and rural communities, rather than rural providers, will benefit most from the promise of ACOs. To effectively improve quality and control costs, ACOs must work in partnership with patients and communities. Rural communities can do a number of things to initiate population health improvements: (1) support local providers by utilizing their services; (2) assess what health care services are needed (and can be afforded) locally and what is appropriate to receive at a distance; (3) promote healthy eating options, develop safe recreation areas, build exercise facilities, and support school and workplace health education; (4) organize chronic disease education programs and support groups to complement the work of ACOs; (5) create community amenities that help make rural areas a desirable place for medical and other professionals to live and work; and (6) provide leadership, political will, and negotiation expertise when developing ACOs and other health care delivery collaborations.

Policy Maker Opportunities

At this time, only large integrated systems will likely have the scale and resources to develop and support ACOs. Despite progressive rural leadership, rural ACO development beyond these established integrated health care systems may require public policy assistance. State or nationally supported technical assistance will be critical to develop legal and other structures necessary to support new relationships between unaffiliated providers and between providers and payers.²⁶ Technical assistance with practice redesign will be needed, including, but not limited to, quality improvement, team development, advanced access, nontraditional visit planning, chronic disease management, and leadership development.²⁶ Interoperable information technology development assistance will be required for care coordination. In addition to traditional technical assistance, policy makers could facilitate programs for mentoring or “twinning” of new potential ACOs with existing organizations elsewhere in the country to learn how good models work (suggested by Stephen Shortell at the National Accountable Care Summit, June 7-9, 2010, Washington, DC). In financing policy, shared savings should be structured to not penalize historical cost efficiency. As the model matures beyond gain sharing, payers could offer various levels of financial risk. Larger and more experienced organizations will be better prepared to manage significant financial risk with

opportunity for significant reward. Alternately, organizations with less risk management experience, including many rural systems, should have an opportunity to participate in the ACO program, but with less risk for loss and less opportunity for reward.²⁶ In both financial and performance assessment, rural providers require performance metric reliability, validity, and rural relevance. Low rural volumes must also be considered during performance analysis. To improve ACO program efficacy, ACO policies should be aligned with other policy initiatives, such as value-based purchasing, payment bundling, and the patient-centered medical home. And lastly, to broaden ACO program scope, policies should encourage other payers to develop common payment models that parallel and complement the Medicare ACO program.

Summary

The march to ACOs is on, and rural providers must keep pace. ACOs are a rapidly developing health care delivery model that links provider payment to delivery design, and then holds providers accountable for both clinical quality and cost control. Different than many MCOs, ACOs will be provider-led. Rural provider participation will require collaboration among rural providers and with larger, often urban, health care systems. Although rural opportunities exist to improve care and share in cost savings, rural providers are also at risk from predatory urban systems that do not adequately value rural community health and vitality. Extensive rural preparation and careful due diligence are required. Rural providers and their communities should proactively prepare for a health care future increasingly requiring interdependence, collaboration, and accountability.

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