

# THE HEALTHCARE EXECUTIVE'S GUIDE TO ACO STRATEGY



COKER GROUP

# THE HEALTHCARE EXECUTIVE'S GUIDE TO ACO STRATEGY

COKER GROUP

+HealthLeaders<sup>Media</sup>  
A Division of HCPPro

+HCPPro

*The Healthcare Executive's Guide to ACO Strategy* is published by HealthLeaders Media.

Copyright © 2012 HealthLeaders Media

All rights reserved. Printed in the United States of America. 5 4 3 2 1

ISBN: 978-1-60146-836-9

No part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center (978/750-8400). Please notify us immediately if you have received an unauthorized copy.

HCPro, Inc., provides information resources for the healthcare industry. HCPro, Inc., is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

Coker Group, Author

Carrie Vaughan, Editor

Bob Wertz, Managing Editor

Matt Cann, Group Publisher

Doug Ponte, Cover Designer

Mike Mirabello, Graphic Artist

Matt Sharpe, Production Manager

Shane Katz, Art Director

Jean St. Pierre, Senior Director of Operations

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions. Arrangements can be made for quantity discounts. For more information, contact:

HCPro, Inc.

75 Sylvan Street, Suite A-101

Danvers, MA 01923

Telephone: 800/650-6787 or 781/639-1872

Fax: 800/639-8511

E-mail: [customerservice@hcpro.com](mailto:customerservice@hcpro.com)

HCPro, Inc., is the parent company of HealthLeaders Media.

**Visit HealthLeaders Media online at [www.healthleadersmedia.com](http://www.healthleadersmedia.com)**

03/2012  
21964

# Contents

- About the Authors..... vii**
  
- Acknowledgments .....xiii**
  
- Preface ..... xv**
  
- Chapter 1: Accountable Care Organization—An Overview ..... 1**
  - What Is an ACO?.....2
  - The Logic of ACOs .....3
  - Basic ACO Tenets .....6
  - The Key Characteristics of Accountable Care .....12
  - Summary .....16
  
- Chapter 2: How We Got Here.....17**
  - A Look Back at the 1980s and '90s .....17
  - The Alternatives to HMOs .....20
  - Medicare Prospective Payment System.....22
  - Physician-Hospital Organizations .....24
  - Summary .....25

**Chapter 3: What We Anticipate About the Accountable Care Concept .....27**

Accountable Care Organizations .....27  
Why ACOs?.....28  
What Will an ACO Look Like?.....31  
Structural Change.....38  
Challenges of Collaboration .....42  
Summary .....52

**Chapter 4: Physician-Hospital Integration .....55**

ACOs as a Driver of Alignment .....55  
Different Alignment Models .....61  
Continuum of Care and Physician-Hospital Integration.....81  
Summary .....88

**Chapter 5: Compensation and Anticipated Changes .....91**

Historical and Current Reimbursement Structures.....92  
Proposed Reimbursement Structures.....98  
Medical Home Payment Models .....106  
Summary .....110

**Chapter 6: Are You Ready for an ACO Environment? .....113**

Organizational Assessment .....113  
Financing—Startup and Ongoing Expenses .....118  
Market Assessment .....120  
Summary .....121

**Chapter 7: Legal Considerations.....123**

    Requirements.....126

    Governance .....128

    Antitrust Issues .....131

    Stark Law and Anti-Kickback Statute .....136

    Summary .....137

**Chapter 8: The CMS Shared Savings Program.....139**

    Program Overview.....140

    Shared Savings Program Tracks .....141

    Interim Payment Option .....144

    Summary .....146

**Chapter 9: Benchmarks for CMS Shared Savings Program .....149**

    Assignment of Beneficiaries.....150

    Cost Benchmarks .....151

    Summary .....154

**Chapter 10: Quality Measures .....157**

    Benchmarks, Standardization, and Protocols .....158

    Use of Evidence-Based Medicine .....167

    Measuring Outcomes.....169

    Patient Compliance.....171

    Summary .....176

**Chapter 11: The Role of Information Technology.....179**

    Technology Considerations.....180

    Current State of the Health Information Technology Market  
    as It Relates to ACOs.....183

    Harmonizing the ACO through Connectivity.....192

    Summary .....194

**Chapter 12: Patient-Centered Medical Homes .....197**

    How Consolidation Has Shaped the Future .....197

    Positioning for an Evolving Healthcare System .....200

    What is the Patient-Centered Medical Home?.....202

    Comparing ACOs and Medical Homes.....210

    Summary .....212

**Conclusion: Where Do We Go From Here?.....215**

    Physicians and Hospitals Need to Form Alliances.....215

    Attitude Adjustment: Partnering in the Delivery of Quality  
    and Cost-Effective Medical Care.....218

    Review Current Compensation and Reimbursement Models and Plans .....219

    Recap of the ACO Programs.....222

**Appendix A: Pilot Programs .....229**

**Appendix B: Glossary of Acronyms .....243**

# About the Authors

## Max Reiboldt, CPA

---

Max Reiboldt provides sound financial and strategic solutions to hospitals, medical practices, health systems, and other healthcare entities through keen analysis and problem solving. Working with organizations of all sizes, Reiboldt engages in consulting projects with organizations nationwide. His expertise encompasses employee and physician employment and compensation, physician-hospital affiliation initiatives, business and strategic planning, mergers and acquisitions, practice operational assessments, ancillary services development, physician-hospital organization, independent practice association and management services organization development, practice appraisals, and negotiations for acquisitions and sales. He also performs financial analyses for healthcare entities as well as buy/sell agreements and planning arrangements for medical practices.

Reiboldt is president and CEO of Coker Group and has led the firm's growth since the late 1990s to its position today as one of the leading healthcare consulting firms in the United States and abroad. He is a prolific author and accomplished public speaker on healthcare management topics.

Reiboldt has authored or contributed to many of Coker Group's 50-plus books. Recent titles include *Financial Management of the Medical Practice*, Third Edition (© 2011, AMA Press); *Reimbursement Management: Improving the*

## About the Authors

*Success and Profitability of Your Practice* (© 2011, AMA Press); *RVUs at Work: Relative Value Units in the Medical Practice* (© 2010, Greenbranch Publishing); and *Physician Entrepreneurs: Strength in Numbers—Consolidation and Collaboration Strategies to Grow Your Practice* (© 2008, HealthLeaders Media).

A graduate of Harding University, Reiboldt is a licensed certified public accountant (CPA) in Georgia and Louisiana and a member of the American Institute of Certified Public Accountants, Healthcare Financial Management Association, and American Society of Appraisers.

## Sue Hertlein

---

Sue Hertlein is a manager at Coker Group, and she works with physicians and hospitals across the country on numerous technology, strategic planning, and assessment projects. Hertlein's experience includes operational and workflow analysis, practice management and electronic health record (EHR) assessments, and readiness evaluations, vendor analysis/recommendation, vendor contact negotiations, systems testing, implementation, project management, and community needs assessments. In addition to her client work, Hertlein also manages Coker's research and assists in obtaining information on new situations that affect the healthcare industry, such as healthcare reform, meaningful use/EHR incentives, accountable care organizations (ACO), and physician-hospital alignment.

Hertlein has been a contributing author to several of Coker Group's 50-plus books. Recent titles include: *The Complete EMR Selection Guide* (© 2011 HIMSS); *Financial Management of the Medical Practice*, Third Edition (© 2011,

AMA Press); *Starting, Buying, and Owning the Medical Practice* (© 2012, AMA Press). Hertlein has also authored numerous published articles and white papers. She has also been a featured speaker on subjects such as EHRs, healthcare automation, ACOs, return on investment for EHRs, and employee-based topics, such as improving productivity, employee embezzlement, and staff training.

## Contributors

---

### ***Justin Chamblee, MAcc, CPA, senior manager***

Justin Chamblee works with clients in a variety of strategic and financial areas, mainly dealing with physician compensation and hospital-physician transactions. He holds a Bachelor of Business Administration degree in accounting and a Master of Accounting from Abilene Christian University. He is licensed as a CPA in the state of Texas and is a member of the American Institute of Certified Public Accountants.

### ***Jeffrey Daigrepoint, senior vice president***

Jeffery Daigrepoint specializes in healthcare automation, strategic planning, operations, and deployment of fully integrated information systems for medical practices and hospitals. For fiscal year 2009, he chaired the ambulatory information steering committee (AISC) of the Healthcare Information and Management Systems Society (HIMSS). In addition, as the ambulatory committee liaison for fiscal year 2009 to the Annual Conference Education Committee, he represented the HIMSS ambulatory and AISC members.

***Aimee Greeter, MPH, manager***

As an integral part of Coker's financial services service line, Aimee Greeter works on a variety of consulting projects, including financial consulting, hospital accounts, and practice management initiatives, as well as research and writing for various client projects. She holds a Master of Public Health in health policy and management from the Rollins School of Public Health at Emory University. She is an honors graduate of Michigan State University, where she attained a Bachelor of Science in human biology.

***Craig Hunter, senior vice president***

Craig Hunter serves as Coker's business development leader, and he works with health systems, hospital-based networks, multi- and single-specialty groups, and independent physician practices facilitating phases of integration and practice development, including mergers, strategic planning, management reviews, and negotiations. He speaks frequently to health system and physician executives, administrators, and other healthcare personnel, and is a published author on practice management topics such as compensation, integration, and physician recruitment and employment.

***Greg Mertz, FACMPE***

Greg Mertz has more than 30 years of healthcare industry experience. His expertise is in performance improvement of complex physician organizations in both hospital-affiliated and private settings. He has also advised clients on the business impact of industry trends, the beneficial impact of technology adoption, and the various models available for physician compensation. Mertz holds

bachelor degrees in business and psychology from Gettysburg College, a Master of Business Administration/HMSA from Widener University, and is a member of the Medical Group Management Association.

***Mark Reiboldt, MSc, senior vice president***

Mark Reiboldt works in Coker's financial services group where he advises health-care facilities through the transaction process, including due diligence, valuation and fairness opinion, as well as general strategic financial advisory. He received a Bachelor of Arts in political science from Georgia State University and a Master of Science in financial economics from the University of London. He is a Financial Industry Regulatory Authority-registered securities dealer with Series 7, 63, 65, and 79 licenses.

## **About Coker Group**

---

Coker Group, a national healthcare consulting firm, helps providers achieve improved financial and operational results through sound business principles ([www.cokergroup.com](http://www.cokergroup.com)). Coker's team members are proficient, trustworthy professionals with expertise and strengths in various areas, including healthcare, technology, finance, and business knowledge. Coker represents three service lines: Coker Consulting, Coker Capital Advisors, and Coker Technology. Through these service areas, Coker consultants enable providers to concentrate on patient care.

Service areas include, but are not limited to: hospital-physician alignment, ACO readiness, capital advisory, strategic financial advisory and analysis, practice management, mergers/acquisitions and due diligence, compensation, pre- and

## About the Authors

post-merger integration, strategic IT planning and review, vendor vetting, managed IT services, hospital operations, medical staff development and executive search.

Coker Group's nationwide client base includes major health systems, hospitals, physician and specialty groups, and solo practitioners in a full spectrum of engagements. Coker has gained a reputation since 1987 for thorough, efficient, and cost-conscious work to benefit its clients both financially and operationally. The members of the firm pride themselves on their client profile of recognized and respected healthcare professionals throughout the industry. Coker Group is dedicated to helping healthcare providers face today's challenges for tomorrow's successes.

# Acknowledgments

Books written by employees of Coker Group are always touched by the many people both inside and outside our organization. This work is no exception. First, we would like to give special thanks to the contributions made by our fellow Coker family members for their dedication to researching the content offered in this publication: Justin Chamblee, Jeffery Daigrepoint, Aimee Greeter, Craig Hunter, Greg Mertz, and Mark Reiboldt. In addition to our primary authors, Max Reiboldt and Sue Hertlein, we thank these contributors for extending their knowledge from their many years of work in medical practices and physician networks.

Kay Stanley, who has contributed to Coker's 50-plus books since Coker's publishing initiative began in the early 1990s, has served as editor and project manager. Sue Hertlein spent hours researching the accountable care organization proposed regulations to ensure that readers have the most up-to-date information. Trish Hutcherson ably managed the team of contributors.

Special thanks and recognition goes to key players in the Norton Healthcare and Dartmouth-Hitchcock organizations, including Kevin Stone, director of accountable care development, Dartmouth-Hitchcock; George Y. Hersch, system vice president, material management, Norton Healthcare; Ben Yandell, PhD, CQE, vice president, material management, Norton Healthcare; and Ken Wilson, MD,

## Acknowledgments

system vice president, clinical effectiveness and quality, Norton Healthcare. Their input and willingness to share information proved invaluable.

Finally, we appreciate the confidence placed in Coker Group by HealthLeaders Media to relay accurate and pertinent market information.

# Preface

With the passing of the Patient Protection and Affordable Care Act (PPACA), signed into law by President Barack Obama in 2010, the healthcare industry has been in preparation mode for the changes that will ensue as the law goes into effect. One of the principles of the Act is the concept of accountable care and, more specifically, the establishment of accountable care organizations (ACO) for Medicare beneficiaries under the fee-for-service program. Although ACOs take up only seven pages of the massive new health law, they have become one of the most talked-about provisions.

This latest model for delivering services offers physicians and hospitals financial incentives to provide good quality care to Medicare beneficiaries while keeping down costs. ACOs would make providers jointly accountable for the health of their patients, giving them strong incentives to cooperate and save money by avoiding unnecessary tests and procedures. For ACOs to work, they have to seamlessly share information. Those that save money while also meeting quality targets would keep a portion of the savings. But some providers could also be at risk of losing money under Track 2 of the Centers for Medicare & Medicaid Services (CMS) program.

In March 2011, the CMS released its proposed guidelines, which provided a draft of what an ACO would look like. This was an exploratory time used to iron out

some of the details. Late in 2011, CMS released the final rule for Medicare ACOs; however, some items are not fully finalized. (**Note:** CMS is still finalizing some items that will be released at a later date, and CMS and the Office of Inspector General [OIG] have released an “interim final rule with comment period” [60 days] regarding anti-kickback laws and some suggested waivers.)

With the CMS ACO initiative scheduled to launch in April 1, 2012 (followed by the second wave of ACO entities on July 1, 2012), the formation of ACOs has already begun. Hospitals, physician practices, and insurers across the country are announcing their plans to form private ACOs. Many healthcare providers have formed these private ACOs prior to the release of even the proposed CMS regulations so they could be one of the first groups to move forward with this new, innovative model in patient care. They believe that being patient-centered, improving the quality of care, working in tandem with their peers (and competitors in some cases), and reducing costs are the right things to do. Some of them also chose the private model to avoid more in-depth government regulations. Other providers are taking a wait-and-see perspective to evaluate the success (or failure) of the private ACOs and also to gain a further understanding of the financial implications of forming and/or joining a CMS ACO entity. There is no doubt that this new generation of healthcare models is under careful review from all types of providers because there are many questions to be answered and results to analyze.

The purpose of this book is to focus on what we know about ACOs at this early stage. The subject matter addresses ACOs in general and discusses various aspects of private and CMS entities. With the release of the final regulations in late 2011, there is a greater emphasis on the CMS Shared Savings Program.

# Are You Ready for an ACO Environment?

You have read about the ACO requirements and anticipated changes. Now, for the difficult decision—do you want to join an ACO? Hospital administrators, physicians, practice managers, and other healthcare professionals can face this question. One of the first steps is to conduct a self-analysis to determine if you and/or your organization support the ACO philosophies. Would this be a good fit for you? What is the level of your current information technology (IT) infrastructure, technology adoption levels, and data collection capability? What is your current alignment of integration with a hospital; and if you are a hospital, with physicians?

## Organizational Assessment

---

An organizational assessment can be determined by evaluating six key areas:

1. The organizational and accountability level and culture
2. Clinical results
3. Infrastructure

## Chapter 6

4. Leadership: ability to embrace the ACO philosophy and lead a team into a patient-centered environment
5. Coordination and information-sharing abilities
6. Costs: what are actual costs at the diagnosis-related group (DRG) and current procedural terminology (CPT) level?

These categories must be assessed, and some level of competency is required before an organization should begin forming an ACO on its own. While an organization is assessing its capabilities, it should pay particular attention to:

- The operating data of the hospital
- The information regarding healthcare services in its area
- The availability for information sharing and coordination of care
- The relative acceptance level on the part of physicians and providers to participate in an ACO
- Current cost containment program

Physicians and physician groups need to assess the following:

- Current physician/hospital alignment
- IT infrastructure
- Cost at a CPT level

- Culture and philosophy
- Market (Medicare population, primary care physicians [PCP], and specialists in the area)

While conducting an assessment, an organization may choose to use surveys, focus groups, workshops, and one-on-one interviews as well as third-party objective groups who can come in to an organization and provide experience and a second opinion of the capabilities of an organization. As part of this assessment, organizations may find areas they can make improvements on right away, with or without the formation of an ACO.

As an organization begins to prepare for the ACO model to be launched by the Centers for Medicare & Medicaid Services (CMS), many executives are struggling with how to provide their administrative team, board members, and medical staff with accurate and relevant information that will help guide strategic decision-making, as well as information to evaluate the gaps as they relate to ACO development and implementation.

What is most notable here is that there is a shared recognition between hospitals and groups that they need to partner together to form ACOs and deliver accountable care. At the same time, however, a sorting out is underway that is very much geography-specific, differing from locality to locality.

The first key to a successful ACO is a strong alignment model with a hospital and other providers. If you currently have a well-established alignment with matching objectives and coordinated cultures, you may be a good candidate to participate

in an ACO entity. Teamwork is essential in an ACO, and collaboration is mentioned throughout the ACO regulations. If you are not currently aligned, then perhaps you need to review that as a strategy.

Technology is another critical factor. The exchange of patient information between ACO participants is essential to meet the requirements of an ACO. Additionally, CMS has indicated that electronic connections with patients and their caregivers will be important as part of the delivery of care and customer service to the beneficiaries. Are you currently using an electronic health records (EHR) system that has been approved under Meaningful Use? If not, do you plan to implement one in 2012? Automation of data for patient records is significant and the ability to share the data within the ACO is a requirement.

### ***Who are the appropriate players and leaders?***

When forming an ACO, start by assessing the appropriate players:

- Your leadership
  - What is his or her vision?
  - Does he or she have the ability to successfully grasp all aspects of the ACO requirements and lead the group in this endeavor?
  - Does your leadership have the ability to create a team environment of full collaboration?

- Does the participating hospital have the ability to:
  - Deliver high-quality patient care?
  - Contain costs?
  - Be patient centered?
  - Collaborate with physicians and other healthcare providers?
- For physicians
  - Do they have the ability to work with competitors and become team members?
  - Do they have a reputation for delivering high-quality patient care?
  - Do they have the ability to control costs?
  - Can they be patient focused?
- Other providers
  - Do they have the ability to control costs?
  - Do they have a reputation for high-quality patient care?
  - Can they work together to be patient centered?

## Financing—Startup and Ongoing Expenses

---

ACOs will require up-front costs. Among the most obvious is IT that will report and store data. Because all providers in an ACO will be jointly accountable for quality and cost measures, IT will have to be compatible for multiple providers to allow them to share information. Due to the high costs of IT, potential participants, such as small physician groups and solo practitioners, should assess whether joining an ACO is realistic. An ACO must have an IT infrastructure that enables it to collect, analyze, and share data among providers/suppliers in the ACO organization to support clinical decisions, as well as support CMS reporting. And the up-front costs may be greater than expected. Most early clinically integrated networks, which are precursors to ACOs, took longer than was anticipated to put in place and had greater than expected startup cost and staff requirements. Original ACO pilots were somewhat amazed at the high costs and extensive time required to build their IT infrastructure. Recently organized physician groups may also lack the history needed for benchmarking costs that would be required for a private ACO.

In addition to up-front costs, ACOs will require continuing expenses relating to reporting. These expenses will involve personnel, IT maintenance, governance, and continual coordination among the different members in an ACO. In an effort to assist providers with the upfront costs of creating a CMS ACO, the government has created a program called the Advance Payment Model. This model allows for three different payment options:

1. Upfront single fixed payment
2. Upfront, variable payment based on number of historically assigned beneficiaries

3. Monthly varying amount depending on number of historically assigned beneficiaries

These advance payments will be recovered from future savings distributed to the ACO—this is a loan, not a grant. Only two types of organizations will be eligible for the Advance Payment program. An ACO cannot include any inpatient facility and also must have less than \$50 million in total annual revenue. The second type of ACO entity that could apply for financial assistance is one that does include inpatient facilities that are critical access hospitals and/or Medicare low-volume rural hospitals and has less than \$80 million in total annual revenue. This program specifically excludes ACOs that are co-owned by a health plan, even if they fall into either of the above-mentioned categories. Also, only those ACOs that begin the ACO program in 2012 will be eligible to participate in the Advance Payment Model.

Organizations must make every effort to perform a detailed financial plan to establish capital requirements, milestones, and timing to include the following:

- Financial performance
  - Cash flow analysis and coverage
  - Cost analysis
- Future cash flow sustainability
- Projections: level of growth, improvements, staffing, costs, cash flow, etc.

- Market characteristics/fundamentals
- Capital requirements (Significant capital will be required to successfully transform any organization into a medical home or ACO. Organizations must have a detailed financial plan to secure sufficient capital at the most favorable terms.)
- Project panel size insurance coverage (The organization must ensure that it has appropriate levels of malpractice insurance because it will be treating chronically ill Medicare patients.)

### **Market Assessment**

---

The current market for ACOs is undergirded by lots of energy and buildup, and some pilot efforts are currently underway. CMS will limit the number of ACOs approved in a geographic location. The rapid growth of physician-hospital alignment over the last decade as reimbursements shrunk have forced physicians to look at other alternatives to protect their income. Also, managed care has created a payment system that rewards high technology procedures and providers who either own their own facilities or have increased their volume of services. Physicians are hiring consultants to help them create their own business models and are investing heavily in ancillary services and technology that will provide them with an annuitized income for years to come. The result is an increase in the direct competition between physicians and hospitals. For this reason, physicians are apt to resist ACOs.

Another market change is that physicians are starting to see that employment within a hospital is a viable model; therefore, the environment is increasingly collegial and collaborative. For years, physicians have competed against each other and would resist any acceptance of responsibility for care of all patients in a local delivery system such as an ACO where they do not control all of the factors.

## Summary

---

In conclusion, ACOs offer physicians and hospitals a model to collaborate, innovate, and improve the quality of healthcare delivery in America, and share in the financial savings from those efforts. The ACO is intended to be a physician-based model as the PCP is the basis for assignment of beneficiaries to a CMS entity, and the PCP, as in most managed care programs, is responsible for directing and coordinating patient care. However, just like physician hospital organizations of the past, the model is only as good as the leaders and those in control of governance and decision-making. It is critical that physicians and hospitals take their time, investigate, and conduct proper due diligence before joining an ACO. Now is the time for physicians and hospitals to examine who they would like to integrate and collaborate with, and to approach and discuss these issues with colleagues. There will be many ACO options, and physicians need to understand how each option will affect their day-to-day practice of medicine, as well as the legal and financial implications. Each provider must also understand that the real focus of an ACO is “accountable care” and that means to the patient and the community. The patient must always come first for quality and customer service in any type of ACO model.

ACOs hold great promise as the healthcare delivery and payment system of the future. If the various demonstration projects prove the model to be successful, ACOs could be a groundbreaking change in the healthcare industry. Understandably, some healthcare providers are eager to be at the forefront of this movement and proceed quickly to participate in an ACO. However, despite the overwhelming amount of industry discussion and publication on this topic, there is still much concern by healthcare providers regarding the cost of participation and the ability to succeed in a CMS ACO environment. Therefore, we urge providers to take caution and carefully review the current statute and future regulatory guidelines before leaping into any new arrangements or making any changes to existing relationships.

# THE HEALTHCARE EXECUTIVE'S GUIDE TO ACO STRATEGY

**Coker Group**

*The Healthcare Executive's Guide to ACO Strategy* is the first comprehensive book dissecting the integral components of ACOs from physician, provider, and payer views, including analysis of the CMS final regulations.

In the wake of healthcare reform, ACOs continue to emerge as the care delivery and reimbursement model of the future. Get the book that provides specifics on incorporating accountable care structure and strategy into your organization so you can enter the ACO era prepared and positioned to succeed.

Get expert advice on ACOs and the elements for success, including how to:

- Participate in the CMS Shared Savings program
- Distinguish the various characteristics of an ACO and its operations
- Understand how ACO reimbursement structure will work
- Evaluate the process of forming an ACO—including the legal, financial, IT, and governance requirements
- Fulfill important quality measures for an ACO
- Reshape and refine hospital-physician alignment strategies

For more on HealthLeaders Media's complete line of healthcare leadership resources, visit [www.healthleadersmedia.com](http://www.healthleadersmedia.com).

**HealthLeaders**<sup>Media</sup>  
A Division of HCPro

**HCPro**

75 Sylvan Street | Suite A-101 | Danvers, MA 01923  
[www.hcmarketplace.com](http://www.hcmarketplace.com)

ACOAG

ISBN: 978-1-60146-836-9



9 781601 468369