Nurs Admin Q
Vol. 41, No. 1, pp. 39–47

New Hampshire Nurse Practitioners Take the Lead in Forming an Accountable Care Organization

Wendy L. Wright, MSN, APRN, ANP-BC, FNP-BC, FAANP, FAAN

In 2012, New Hampshire nurse practitioners (NPs), along with Anthem Blue Cross/Blue Shield, formed the first Patient Centered Shared Savings Program in the nation, composed of patients managed by nurse practitioners employed within NP-owned and operated clinics. In this accountable care organization (ACO), NP-attributed patients were grouped into one risk pool. Data from the ACO and the NP risk pool, now in its third year, have produced compelling statistics. Nurse practitioners participating in this program have met or exceeded the minimum scores for 29 quality metrics along with a demonstrated cost-savings in the first 2 years of the program. Hospitalization rates for NP-managed patients are among the lowest in the state. Cost of care for NP-managed patients is $66.85 less per member per month than the participating physician-managed patients. Data from this ACO provide evidence that NPs provide cost-effective, quality health care and are integral to the formation and sustainability of any ACO. **Key words:** *accountable care organization, cost-effective care, nurse practitioner, patient-centered shared savings program, quality metrics*

ACCOUNTABLE CARE ORGANIZATIONS: THE HISTORY

To curtail rising health care costs, improve coordination of care between providers, and reward health care professionals providing cost-effective care, the concept of accountable care organizations (ACOs) was first introduced in late 2006 at a public Medicare Payment Advisory Commission (MedPac) meeting.[1] The concept of an ACO gained enough momentum that by 2009, it was formally mentioned in all 3 drafts of the Affordable Care Act (ACA).[2] Officially signed into law by President Barack Obama, ACO official regulations were present in the final legislation known as the Patient Protection and Affordable Care Act.[2] These provisions authorized the Center for Medicare & Medicaid Services to create Medicare Shared Savings Programs intended to encourage the formation of ACOs with a start date of no later than January 1, 2012.[2] Shared Savings Programs were believed to be key to encouraging networks to form ACOs aimed at improving the health of participants along with the overall health of the nation. They were also planned for positioning Medicare financially for the influx of baby boomers entering into an already financially strapped governmental managed health care program. According to Medicare ACO regulations, patients managed by nurse practitioners (NPs) are unable to participate in an ACO as qualified patients unless the patient is first seen by a "qualified" physician, thus essentially excluding patients managed in

Author Affiliation: *Wright & Associates Family Healthcare @ Amherst and @ Concord, Bedford, New Hampshire.*

Correspondence: *Wendy L. Wright, MSN, APRN, ANP-BC, FNP-BC, FAANP, FAAN, Wright & Associates Family Healthcare @ Amherst and @ Concord, New Hampshire, 2 Rolling Woods Dr, Bedford, NH 03110 (WendyARNP@aol.com).*

DOI: 10.1097/NAQ.0000000000000205

NP–owned offices from participation in these programs.

Although the original concept of Shared Savings Programs was designed for Medicare and Medicaid recipients, similar programs and their subsequent ACOs have expanded into the private sector as well. Since the passage of the Patient Protection and Affordable Care Act, more than 744 private sector ACO programs exist today.[3] Major insurers such as Cigna, United, Blue Cross/Blue Shield, and Aetna, along with hospitals such as Dartmouth-Hitchcock and Partners HealthCare in Boston, Massachusetts, have jumped into the ACO arena.[4] While there is debate as to the successfulness and sustainability of these organizational structures (given the costs associated with their formation and maintenance), it appears that they are not disappearing anytime soon. Insurers continue to encourage the formation of ACOs, operating under the premise that providers and institutions will participate in ACOs, meet quality metrics, and reduce overall cost of care if financial incentives are provided. Institutions, physicians, NPs, and physician assistants (PAs) must find ways to optimize participation in these evolving ACOs.

DEFINING ACOs

Multiple definitions have been proposed to explain the concept of an ACO. For this article, an ACO is a group of health care providers (physicians, NPs, and PAs) who come together voluntarily with patients, hospitals, and payers to provide coordinated, cost-effective, and evidence-based quality health care to a defined population. Hospitals and providers participating in an ACO are charged with accepting full responsibility for the management (including minimizing cost while meeting health care needs) of a defined patient population.[5] Shared savings programs and ACOs are based on the premise that by incentivizing systems and providers to manage the health of a population, the costs of health care will decrease. It is postulated that providers with vested financial interest will be more likely to avoid ordering unnecessary tests, inappropriately sending patients to the emergency department (ED), or admitting patients to a higher level of care than needed. Accountable care organization and their participating providers who meet predefined quality criteria and metrics while demonstrating cost-savings will receive a percentage of the cost-savings.[5] In many cases, the shared cost savings could be significant. Conversely, financial risks to ACOs not meeting metrics can also be substantial. Depending upon the type of ACO and the contract negotiated, some ACOs could be responsible for reimbursing the insurer when quality and cost-savings are not realized. While it is beyond the scope of this article to define all prerequisites to form an ACO, in general ACOs must have a separate legal structure, a governance board composed of providers and administrative staff, and at least 5000 eligible or attributed patients in a given performance year. They must also agree to at least a 3-year participation period.[6]

NEW HAMPSHIRE CHAMBER OF ENTREPRENEURIAL NURSE PRACTITIONERS

In February 2007, shortly after opening Wright & Associates Family Healthcare PLLC in Amherst, New Hampshire, this author conceived of the need to form a group composed of entrepreneurial NPs operating clinics within New Hampshire. More than 10 practices, owned and operated by NPs, were already in existence within the state. The mission of this new organization was identified along with the plan for NP business owners to serve as resources for others currently in practice as well as NPs interested in future clinic ownership. In June 2007, the NH Chamber of Entrepreneurial Nurse Practitioners (NHCENP) was formed and held its inaugural meeting. The goals of this organization were to problem-solve any local and national advanced practice issues that arose, serve as a support/consultative group to other NPs within the state choosing to open their own practices, and negotiate contracts;

formation of an ACO was not even envisioned. Today, NHCENP continues to meet approximately every 8 weeks and has an attendance of approximately 15 NPs and practice managers at each meeting. Agendas are developed from member submissions. Over the past 8 years, numerous local and national businesses have presented to, and proposed ideas to, the NHCENP to gain feedback or encourage members to utilize their services. Members include NP owners of primary care offices and specialty clinics, including diabetes and lipid disorders, psychiatry, palliative care, and alternative/complementary services. There are no fees and members generally meet at a local restaurant that donates meeting space to the group. Guidance in the formation of the NHCENP was received from Lisah Carpenter, JD, then-acting Executive Director of the NH Nurse Practitioner Association. Since inception, this organization has become the "go-to" group when issues arise at the state or on the federal level that may impact NP business owners.

ANTHEM PATIENT-CENTERED SHARED SAVINGS PROGRAM

In January 2012, Anthem Blue Cross/Blue Shield of New Hampshire, a division of Wellpoint, introduced its first Patient-Centered Shared Savings Program (PCSSP) to the NH medical community. Using principles of the Medicare and Medicaid Shared Savings program, Anthem's program is designed to provide financial incentives for participating providers and practices to meet 29 quality metrics while demonstrating cost-savings (B. Manter, e-mail communication, September 2, 2015). Program quality metrics are divided into 4 major categories: acute and chronic care management, preventive care, improvement, and utilization (B. Manter, e-mail communication, September 2, 2015). Providers are evaluated on attainment of a number of metrics from these domains. Examples of Acute and Chronic Care Management metrics include diabetes care (such as annual eye examination), A1C testing, and urine protein screening. Adherence to medications used for hyperlipidemia (statins), diabetes, and hypertension (angiotensin-converting enzyme [ACE] inhibitors/angiotensin receptor blockers [ARBs]) are also assessed. Preventive care metrics include performance of annual mammography, cervical cancer screening per American College of Obstetricians and Gynecologists guidelines, and annual well-visits for select adults and children. Providers are evaluated on improvement of the quality metrics from the initial score card to closing scores at the end of the year-long reporting period. Utilization of EDs, hospital admission rates, and use of branded versus generic medications are also included in the metrics (B. Manter, e-mail communication, September 2, 2015). Table 1 provides a comprehensive list of the programs quality metrics.

Individual practices receive a percentage of the cost-savings only if their entire participating panel or risk pool demonstrates quality care while maintaining cost-effectiveness and overall savings. Even if an individual NP provider or NP-owned clinic demonstrates excellent quality metrics and savings, financial rewards will not be realized if the participating panel does not meet the minimum metrics. Panel composition is determined by Anthem representatives and is based upon the size of various practices as well as location within the state. Each panel must have a minimum of 5000 eligible or attributed patients to form.

Governing rules for the PCSSP state that each participating provider or practice will be paid a per-member-per-month fee based on the collective severity of illness of his or her patients (B. Manter, e-mail communication, September 2, 2015). On the basis of documented medical diagnoses, each patient is assigned a health risk score, and providers receive between $3.00 and $7.00 per member per month, based on the potential risks associated with a patient's documented medical conditions. For instance, patients with coronary artery disease (CAD) or cerebrovascular disease (CVD) are rated higher than patients with gout. Therefore, they

Table 1. Quality Metrics in Anthem Patient-Centered Shared Savings Program[a]

Categories	Quality Metrics	Total Score, %
Acute and chronic care management	1. Diabetes care: eye, A1C, urine protein	16%
	2. Persistent monitoring: ACE inhibitor/ARB, digoxin, diuretics	
	3. Medication adherence: ACE inhibitor/ARB, oral diabetes, cholesterol (Statins)	
	4. Appropriate testing for children with pharyngitis	
	5. Appropriate treatment for children with URI	
	6. DMARD therapy for RA	
	7. Acute phase treatment: depression	
	8. Continuation phase: depression	
	9. Osteoporosis management in women with fracture	
	10. Beta-blocker therapy after MI	
	11. Use of appropriate asthma medications	
Preventive care	1. Breast cancer screening	32%
	2. Cervical cancer screening	
	3. MMR—children	
	4. Varicella vaccine—children	
	5. Well-child visits: 0-15 mo, 3-6 y, and 12-21 y	
Improvement	1. Appropriate testing for children with pharyngitis	12%
	2. Days covered with statins	
	3. A1C testing	
	4. Breast cancer screening	
	5. Well-child visits: 3-6 y	12%
Utilization	1. Generic dispensing rate	40%
	2. Ambulatory sensitive admits	
	3. Potentially avoidable ED visits	

Abbreviations: ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker; DMARD, disease-modifying antirheumatic drugs; ED, emergency department; MI, myocardial infarction; MMR, measles, mumps, and rubella; RA, rheumatoid arthritis; URI, upper respiratory infection.

[a]From B. Manter (e-mail communication, September 2, 2015).

warrant a higher monthly payment to the participating provider. High-risk diagnoses, such as cancer, CAD, CVD, diabetes, asthma, and hypertension are a few of the diagnoses that command higher monthly reimbursement. In addition, patients who are frequent ED utilizers are also assigned a higher score. The money received by each clinic is to be used at the discretion of each participating provider or practice but is paid monthly to provide income to practices for care planning, care coordination, and establishment of systems to decrease ED utilization and improve medication adherence, all of which are costly to implement and maintain. Since the inception of the PCSSP, Wright & Associates Family Healthcare, PLLC @ Amherst, has received approximately $2500.00 per month, while the Concord facility, with fewer patients, receives $800.00 to $1000.00 per month, resulting in a total cash infusion of approximately $40 000.00 annually to these 2 clinics. The monthly payments can vary, as they are dependent upon the number of attributed patients within each practice multiplied by the risk score of each patient member.

In addition to this monthly, per-member-per-month fee, there is an annual incentive-based payout calculated as a percentage of the shared savings, attainment of quality metrics, achievement of NCQA Patient Centered Medical Home certification, and the number of attributed patients for each provider (B. Manter, e-mail communication, September 2,

2015). This incentive is calculated by combining the quality metric scores and cost-savings from all practitioners working in a particular risk pool (or panel) (B. Manter, e-mail communication, September 2, 2015). The larger the risk pool with patients having multiple comorbidities, the greater potential payout if savings are realized. Reporting periods close every March 31 and payouts occur approximately 6 months later, in September to October (B. Manter, e-mail communication, September 2, 2015). While it is hoped that all participating practices within the state will receive this payout, it is possible that practices failing to meet metrics and save cost will not be included.

Before launching the PCSSP, Anthem representatives convened an advisory board comprising primary care physicians, an NP, and administrators to obtain feedback regarding the program and its overall functionality. Sean Lyon, APRN, FNP, of the Lifelong Care in New London, NH, served as the NP representative to the Anthem PCSSP advisory board prior to inception and remained on for the first 2 years of the program. He was instrumental, along with Kathleen Kidder, APRN, FNP, FAANP, in helping Lifelong Care become the first NP-owned clinic in the nation to achieve Level 3 NCQA Medical Home certification. He was also a member of the NH Chamber and recognized a unique opportunity this PCSSP presented for the NHCENPs. Sean reached out, via e-mail, to all members of NHCENP working in primary care. He requested a meeting to discuss the feasibility of an APRN (only) Risk Pool as a part of the New Hampshire Patient Centered Shared Savings Program (APRN Risk Pool, e-mail communication, November 9, 2012). As a result of that meeting, the idea of an NP-only managed panel was conceived. He then presented this NP-only risk pool (panel) to the Anthem representatives who agreed to structure the program by grouping all NP-owned practices within one risk pool, contingent on achieving at least 5000 attributed NP patients. The idea for the panel was simple: All participating NP business owners recognized that data obtained from the ACO would be invaluable to the body of literature surrounding NP practice. Both data on attainment of 29 quality metrics by NP-only managed patients and the cost of their care would be obtained. Since current regulations prohibit Medicare beneficiaries managed by NPs working in NP-owned and operated clinics from participating in a Medicare ACOs unless seen by a qualified physician, it was hypothesized that the information obtained from this ACO would provide actual data for rule makers on the federal level to modify the Medicare ACO regulations for the benefit of patients and communities.[5]

DATA FROM NURSE PRACTITIONER RISK POOL

During the first year of the PCSSP, the number of patients attributed to NP-owned clinics did not equal to or exceed the 5000 patients needed to form an ACO. Therefore, in order for the NPs to participate, physician's patients needed to be included within the NP-risk pool. During the first year, attributed NP patients made up approximately 51% of the panel. By year 2, the number jumped to 71%. Today (year 3 of the program), the panel is almost completely composed of patients managed exclusively by NPs (W. Wright, unpublished raw data, November 23, 2015). Despite the fact that not all patients within the ACO are managed by NPs working within an NP-owned clinic, significant information specific to NP practices such as quality metric attainment and cost of care has been extracted. That information is presented in this article.

Data from this program have been provided to NP owners. The data are proprietary to each individual practice and are not readily available for publication. Data from Wright & Associates Family Healthcare @ Amherst (WAFHC @ Amherst) and Wright & Associates Family Healthcare @ Concord (WAFHC @ Concord) are available and are presented to provide examples of reporting metrics. At the end of year 2, WAFHC @ Amherst received the following scores: Acute and chronic management received 8% of a possible 24%, preventive care 24% of a possible 24%, improvement

12% of a possible 12%, and utilization 21.79% of a possible 40% for a total of 65.79% (Table 2) (B. Manter, e-mail communication, September 2, 2015). WAFHC @ Concord received 16% of a possible 16%, 32% of a possible 32%, 0% of a possible 12%, and 21.79% of a possible 40%, respectively, for a total of 69.79% (Table 3) (B. Manter, e-mail communication, September 2, 2015). Both clinics were shown to excel in preventive care. WAFHC @ Amherst improved significantly over the reporting period while WAFHC @ Concord did not demonstrate significant improvement (there were too few attributed patients to score) (B. Manter, e-mail communication, September 2, 2015). WAFHC @ Concord achieved maximum points on Acute and Preventive Care. While these scores may appear low at first glance, the all provider scores in the state are reported to range from a low of 30% and the high of approximately 75%. These NP-owned practices exceeded the minimum score required for the annual payout (W. Wright, unpublished raw data, November 23, 2015).

During the second year of the program, the NP panel had no hospital admissions for adults and children (B. Manter, e-mail communication, September 2, 2015). Population health data suggest that, given the number of patients attributed to NPs over the course of the year, it should be predicted that there would be at least 7 to 8 hospitalizations (B. Manter, e-mail communication, September 2, 2015). Cost of hospital care is significant and could negatively impact the overall cost of care of the panel, particularly if 1 or 2 of those hospitalized patients had a catastrophic event. The hospital admission scores for the referenced NP-managed patients were some of the lowest in the state of NH. Data showed that the NP-managed patients were up to 2 times more complex, based upon documented diagnoses (such as CAD, CVD, diabetes, and chronic kidney disease) in comparison to the average of MD-managed patients.

Table 2. Scorecard for Wright & Associates Family Healthcare @ Amherst[a]

Categories	Score Received, %	Possible Score, %
Acute and chronic care management	8	24
Preventive care	24	24
Improvement	12	12
Utilization	21.79	40
Total	**65.79**	

[a]From B. Manter (e-mail communication, September 2, 2015).

Table 3. Scorecard for Wright & Associates Family Healthcare @ Concord[a]

Categories	Score Received, %	Possible Score, %
Acute and chronic care management	16	16
Preventive care	32	32
Improvement	0	12
Utilization	21.79	40
Total	**69.79**	

[a]From B. Manter (e-mail communication, September 2, 2015).

In both years of the program, the NP risk panel met and exceeded minimum quality metrics while demonstrating cost-savings. All NP clinics received end-of-year payouts for both years of the program. In year 1, payouts to the NP-owned practices ranged from a low of $15 000.00 to a high of $125 000.00. WAFHC @ Amherst received approximately $90 000.00 and the Concord facility received approximately $35 000.00. Clinic owners reported that other NP-owned clinics within the state received $80 000, $50 000, and $35 000. A total of $300 000.00+ was earned by NP-owned clinics in first year of reporting (W. Wright, unpublished raw data, November 2015). Nurse practitioner business owners shared that the money earned was used to hire additional employees, upgrade outdated equipment, payoff business loans, and provide raises and bonuses to employees

(W. Wright, unpublished raw data, November 2015).

The second year of the PCSSP payout was reduced but was still substantial to the NP business owners and their practices. Payouts ranged from $10 000.00 to a high of $65 000.00. WAFHC @ Amherst received approximately $45 000.00, while the Concord facility received $20 000.00 (W. Wright, unpublished raw data, November 2015). When payouts came in lower than expected in the second year of the program, all NP business owners were quick to discuss the results of the scorecard and to identify quality improvement programs that could improve the entire panel's metrics. Each NP business owner assumed responsibility for examining their own numbers and implementing programs to improve care.

Nine NP practices and 9 physician practices make up the current NP risk pool. Four of the 5 practices, which provided the lowest cost of care per member per month, are NP-owned and operated (W. Wright, unpublished raw data, November 23, 2015). The lowest cost of care on a per-member-per-month basis was provided by an NP-managed group. That group's cost of care to the insurer was $234.84 per member per month, for 5.25% of the 5000 member risk pool. The highest cost of care was provided by a physician-managed group comprising 7.03% of the panel, which cost $658.70 per member per month to the insurer. Only 1 physician-managed panel ranked in the top 5 for lowest cost of care per member per month (W. Wright, unpublished raw data, November 23, 2015). When the overall cost of the program was calculated across all participating providers within the NP-risk pool, the average NP-managed patients cost the insurer $476.07 per member per month. The average physician–managed patients cost per member per month was $552.92 (W. Wright, unpublished raw data, November 23, 2015). In summary, NP-managed patients cost the system an average of $66.85 less per member per month than the physician-managed patients (Table 4) (W. Wright, unpublished raw data, November 23, 2015).

IMPROVEMENTS TO CARE FROM PARTICIPATION

As a result of the NP participation in this ACO, all NP-owned practices have initiated quality improvement programs to further enhance patient care. One NP-owned practice sent messages to all patients within the practice via the patient portal to explain the difference between ED and urgent care visits (W. Wright, unpublished raw data, November 23, 2015). This education was designed to educate patients about the differences in cost and care received in the ED care versus urgent care. The overall goal was to improve consumers' understanding so they can make better informed choices about their care.

Another practice sent a letter to all patients taking statins, ACE inhibitors/ARBs, and diabetes medications stressing the importance of medication adherence. Information was provided about the impact of poor medication adherence on increased risks of complications (W. Wright, unpublished raw data, November 23, 2015). WAFHC @ Amherst and @ Concord partnered with Patricia White, PhD, and her students in the MSN Family Nurse Practitioner program at Simmons College in Boston. Through this partnership, students collected data regarding the care of patients with diabetes, asthma, and depression, and the attainment of quality metrics pertaining to these disease states. These students proposed quality improvement techniques to enhance evidence-based care while improving quality metrics. While these may seem like simple practices to adopt, they may not be widespread practices among providers.

THE FUTURE OF THE PCSSP

Nurse practitioner involvement in governance activities is crucial to ensure that all providers have an equal voice, to raise concerns about measurability or feasibility of proposed metrics, and to suggest continued enhancements to the program. The continually evolving Anthem PCSSP is dynamic and makes changes based upon the work of its advisory

Table 4. Top 5 Cost Savers: Medical Cost Performance Drilldown; November 2015[a]

Panel Member	Sum of Count, %	Sum of PMPM Total	Sum of PMPM Inpatient Care	Sum of PMPM Outpatient Care
NP-7	5.25	$234.84	$23.05	$72.87
NP-6	1.09	$336.52	$46.38	$88.61
MD-9	0.43	$423.36	$21.14	$173.21
WAFHC-C	4.41	$439.92	$48.90	$113.19
WAFHC-A	10.06	$467.64	$50.65	$135.33

Abbreviation: PMPM, per-member-per-month.
[a]From W. Wright (e-mail communication, November 23, 2015).

board, as well as suggestions from participating providers. Anthem remains committed to the program and is slated to continue the PCSSP for the foreseeable future. In July 2015, representatives from Anthem Blue Cross/Blue Shield of NH presented results of the first year of the PCSSP.[7] Reported cost savings included a $9.51 reduction in per-member-per-month cost, with a total 1-year savings of $6.62 million.[7] In addition, there was a 3.5% reduction in ED costs, and a 1.6% reduction in ED utilization.[7] The cost savings were double what had been initially projected at the outset of the program.[7] In addition, participating providers of the PCSSP outperformed their peers in quality metrics by 4.3% in diabetes care, 4.3% in adult preventive care, 4.8% in monitoring of annual medications, 3.9% adherence to medications, and 9.6% in pediatric preventive care.[7]

The advisory board members and Anthem representatives continue to explore ways of improving health care for beneficiaries while saving cost. Nurse practitioner business owners are doing the same by exploring new techniques for delivering evidence-based, cost-effective care. For example, WAFHC @ Amherst and @ Concord have launched a telehealth division to deliver cost-effective care and to help patients avoid ED/urgent care visits, when appropriate. Diabetes education (including diet, exercise, and weight loss sessions) are being provided through telehealth visits for $49.00. Depression follow-up visits are being conducted in the same manner. Many of the NP practices are open up to 12 hours per day and operate on Saturdays. One practice has expanded hours to include Sunday. The increase in availability is designed to reduce the need for patients to seek care in more expensive venues. The NHCENPs continue to meet regularly to discuss best practices and exchange ideas. As of this writing, the scorecard has closed for the third year of the Anthem PCSSP, and NP owners are looking forward to their quality metric and cost data.

SUMMARY

In 2012, the primary care NPs of NH came together with Anthem (BC/BS) to form this country's first PCSSP (ACO) composed of patients managed in NP-owned and operated clinics. Data from the first 2 years have provided compelling, positive results. Nurse practitioners enrolled in the program have demonstrated attainment of 29 quality metrics, while maintaining a low cost of care delivery. During the second reporting year of the program, no NP-managed patients were hospitalized. As a result, hospital admission rates have been among the lowest in New Hampshire. Patients managed by NPs working in NP-owned clinics cost Anthem an average $66.85 less per member per month than the physician-managed patients. Data obtained from the Anthem ACO provide evidence that NPs provide quality, cost-effective health care. Our conclusion is that including NPs in Medicare, ACOs will decrease costs to Medicare through the provision of high-quality, cost-effective care provided by NPs.

REFERENCES

1. Cohen NA. Medicare accountable care organization practice management 2012. From ACO Practice Management 2012.pdf. Published August 2011. Accessed May 29, 2016.
2. Sullivan K. The history and definition of the accountable care organization? http://pnhpcalifornia.org/pnhp-california/. Published 2010. Accessed May 29, 2016.
3. Gold J. Accountable care organizations, explained. *Kaiser Health News*. September 14, 2015. http://khn.org/news/aco-accountable-care-organization-faq/. Accessed May 5, 2016.
4. Rosenfeld M. Poised for growth, commercial ACOs also face considerable challenges. *Calif Healthline*. http://californiahealthline.org/news/poised-for-growth-commercial-acos-also-face-considerable-challenges/. Accessed May 1, 2016.
5. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule, 76 *et seq*. https://www.gpo.gov/fdsys/pkg/FR-2011-11-02/html/2011-27461.htm. Published 2011.
6. Bithoney W. 6 necessary guidelines to create and manage a successful ACO. *Becker's Hosp Rev*. 2014. http://www.beckershospitalreview.com/accountable-care-organizations/6-necessary-guidelines-to-create-and-manage-a-successful-aco.html.
7. Manning C. Making your health care dollar work smarter for you and your employees. Lecture presented at Business & Industry Association Conference in Radisson Hotel; October 23, 2015; Manchester.