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Are There any Lessons to Be Learnt in France from the American Experience of Accountable Care Organizations?

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The Affordable Care Act, which is commonly referred to as 'Obamacare' and was adopted in the United States in 2010, is known primarily for its emblematic objective of making healthcare affordable to the entire population. A title of the law also focuses on the promotion of new healthcare organisations to foster better coordination between healthcare professionals and improve the quality and efficiency of healthcare delivery.

As of 2012, the Center for Medicare and Medicaid Innovation conducted various experiments with the primary goal of strengthening primary care. The Accountable Care Organization (ACO) is the most ambitious of the reform models as it also fosters improved coordination between ambulatory and hospital care organisations. Organisations of this type have spread rapidly since their introduction. In January 2016, more than 800 ACOs coordinate care for 28 million people, representing 15% of insured Americans.

This overview of the literature on this subject studies the characteristics of the ACOs, their performance, and the tools and schemes adopted, and offers valuable insight for the French health system.

The law providing for the fundamental reform of the American healthcare system, the Affordable Care Act, which is commonly referred to as 'Obamacare', was adopted in 2010 (see 'Sources and Method' inset, p. 2). The reform is based on two main principles. The first is well known: improving access to health insurance for millions of uninsured or poorly insured Americans. The second has thus far received little attention: strengthening coordination between healthcare professional and organizations, and improving the quality and efficiency of healthcare and the services provided. It is based on a simultaneous reform of the organisation and payment of healthcare services, with the ambitious goal of creating Accountable Care Organizations (ACOs). They are meso-tiers organisations that are under contract with one or several public or private financers, which coordinate and even integrate healthcare providers at various levels and in various sectors. The contracts link payment with performance and risk sharing, so that the healthcare providers in the ACO are collectively responsible for performance in terms of quality and efficiency for a given patient group.

The ACO experiment has transformed the process of integrating healthcare providers in the United States, and the ACOs have spread rapidly: there are more than 800 ACOs coordinating care for at least 28 million people, representing 15% of

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SOURCE AND METHOD

Obamacare employs three main mechanisms to improve healthcare cover (Rice et al., 2013):

Extending private insurance cover by granting public aid to help fund the cost of a private contract for low-income individuals who are not eligible for Medicaid.

Extending public coverage by raising the income eligibility thresholds for Medicaid and the payment of a tax for being uninsured. After a Supreme Court ruling in June 2012, the adoption of this measure was left to the discretion of the states and 17 have not adopted it. The new President of the United States has announced that he would like to repeal Obamacare health insurance.

Strengthening the regulatory framework of the private market with an extension of insurance cover to children who want to stay on their parents' plans until the age of 26, a ban on selection and/or exclusion on grounds of health, and a standardisation of prices for a standard contract in regions and areas with similar demographic characteristics.

The proportion of uninsured Americans has thus fallen from 16.3% in 2010, before the implementation of the reform, to 9% in 2015 (Carmen et al., 2012; Kaiser Family Fund, 2015). Nevertheless, 29 million working Americans are without insurance: eligible people without insurance (through ignorance or out of choice), eligible residents of one of the states that has not adopted the Medicaid expansion, and people who are not eligible.

See the websites The Health Systems and Policy Monitor and Obamacare Facts for regular updates on the implementation of the reform and its impact:

http://www.hspm.org/countries/unitedstatesofamerica18112013/countrypage.aspx
http://obamacarefacts.com/

insured Americans. The new President of the United States has announced that he would like to repeal Obamacare health insurance, but has not said anything about the ACOs.

This study focuses, via an overview of the literature on the subject, on the characteristics of these organisations, their performance, and the tools and schemes adopted.

Obamacare: from the extension of health insurance to the strengthening of primary care

The approach to health insurance in America differs from that which prevails in France. For two thirds of the population it is based on private health insurance coverage — they are covered by their personal insurance or that of their employer —, while the remaining third is covered by public health insurance (Table 1). There are around 30 million uninsured Americans.

The ways in which healthcare is organised, funded, as well as accessibility rules regulation, are, however, much more similar to those in France, even though they differ in two key ways. Firstly, ambulatory care is provided almost equally by self-employed and employed professionals, and by various medical and paramedical facilities, in which the healthcare professionals largely work in teams. Secondly, there is a constant tension between the insurers' desire to contain costs by creating large organisations or coordinated — even integrated — networks[1] (Managed Care Organizations), and the federal desire to promote competition by defending patients' freedom of choice of selecting their own physician.

Despite its efforts, the American health system suffers from the fragmentation of its healthcare and social protection, which often results in a compartmentalised system (Berwick, 2008). Like most of the OECD countries, the United States endeavours to foster better coordination between the actors in order to improve the quality of healthcare delivered, provide better care for complex patients, and reduce costs.

In this context, the reform of the organisation of healthcare services — the second pillar of Obamacare — is based on the strengthening of primary care, which is considered to be in decline, as a step towards more entire coverage (Starfield et al., 2005; Sandy et al., 2009).

[1] An integrated organisation is characterised by joint management and common objectives.

T1

Health insurance cover of the population in the United States in 2015

	Conditions of eligibility	Population covered
Public insurers		
Medicare	• People aged 65 or over • People with disabilities • People with End Stage Renal Disease (ESRD)	43 million (14%)
Medicaid, including Children's Health Insurance Program (CHIP)	Depends on the state, but generally: • Pregnant women • Children whose parents have low incomes • People with disabilities • Dependent senior citizens with low incomes	62 million (19%)
Other public sources	• Mainly veterans and serving soldiers, and their families	6 million (2%)
Private insurers		
Employer-based insurance	• Depends on the size of the company, the position held, and seniority • Spouse or child covered	156 million (49%)
Individual insurance	None	22 million (7%)
Uninsured	None	29 million (9%)
Total		**318 million (100%)**

Source: Kaiser Family Fund, Health Insurance Coverage of the Total Population (2015 data).

This has resulted in the enhancement of primary care and the development of payment methods that are different from the fee-for-service model (capitation, bundled payment, pay-for-performance, etc.), which will constitute around 50% of the remuneration by 2018 (Burwell, 2015). The development of the remuneration methods is considered an essential element in driving the changes in professional practices, with the aim of improving the quality and coordination of healthcare, while providing incentives for containing costs.

This also involves the promotion of new healthcare organisations, with primary care as the core element:

- The Patient Centered Medical Home (PCMH): the development of multidisciplinary practices in primary care.
- Comprehensive Primary Care (CPC): a multi-payer (public and private insurers) initiative, designed to strengthen primary care, with capitation payments, shared savings, audit and feedback mechanisms.
- The Accountable Care Organizations (ACOs): experiments with pay-for-performance and risk sharing mechanisms, to promote the coordination of healthcare between the providers of various types of care (ambulatory, hospital, medico-social, etc.), who are collectively responsible for the quality of the care and healthcare costs for a patient group (Fisher et al., 2009; McClellan et al., 2010; Barnes et al., 2014; Tu et al., 2015).

The Accountable Care Organizations in America: A new way of organising healthcare

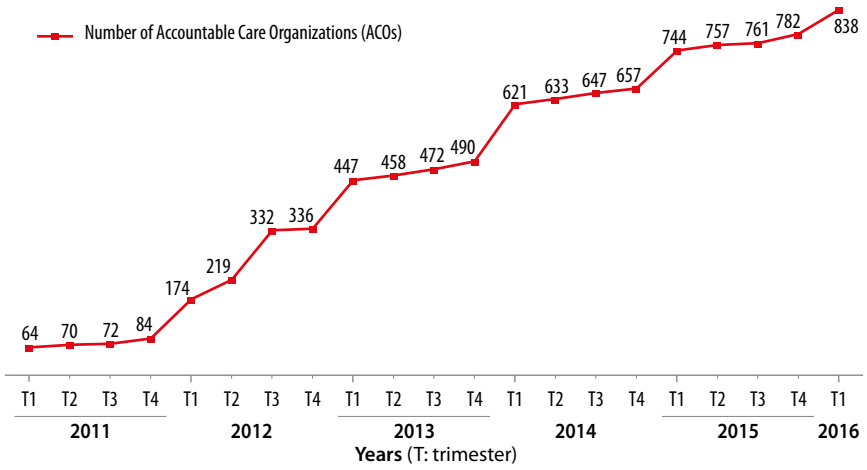
The emergence of the Accountable Care Organizations (ACOs) stems from a long tradition of innovation in the organisation of healthcare delivery in the United States. Indeed, there are already integrated systems funded by private insurers who enjoy a virtual monopoly in certain States (for example, Kaiser Permanente, Intermountain Healthcare, and Geisinger Health System) (Dafny, 2015). The characteristics of ACOs are similar to those of the Managed Care Organizations (MCOs), which were developed in America in the 1970s with the aim of encouraging a reduction in unnecessary costs and enabling shared savings. But they go further because they take into account the quality of care, and because every patient is accepted, no matter who their insurer is.

The ACO concept, which was suggested in 2006, was introduced in the 2010 Obamacare healthcare bill and the Center for Medicare and Medicaid Innovation was charged with overseeing the development of ACOs. In 2012, the first ACO-type contract was signed between Medicare and voluntary organisations, and the term was subsequently adopted by certain private insurers (Fisher et al., 2009; McClellan, 2010; Barnes et al., 2014; Muhlestein D., 2014; Tu et al., 2015; Shortell et al., 2015). Among them, Aetna, Blue Cross Blue Shield associations, Cigna, and United HealthCare are the insurers that have signed the most ACO-type contracts (Lewis et al., 2014).

Each public or private insurer contracts with provider organisations that wish to be incorporated in a single organisation and have a joint governance in order to achieve common quality and financial objectives. These ACO-type organisations may differ in size (with a minimum of 5,000 patients covered for the ACOs contracted with Medicare), coordinate different levels of care (ambulatory, hospital, medicosocial, etc.), have different payment models, and so on. However, all the ACOs have a common characteristic: they bring together several healthcare providers including at least primary care providers; their members are financially interdependent through an innovative remuneration mechanism that combines an expenditure target, risk sharing with the insurer, and a quality-based payment system. Provider organisations that have contracted with one or several insurers in the context of an ACO can, nevertheless, deliver care to all patients, regardless of their insurer.

G

Progression in the total number of ACOs between January 2011 and January 2016



Source: Muhlestein, 2016.

Download the data

The rapid development of ACOs

In 2016, there were 838 ACOs, compared with ten in 2010, covering around 28.3 millions Americans, representing 9% of the population (see Graph). Among these organisations, there are 477 Medicare ACOs, and, although they outnumber other ACOs, they serve a smaller number of patients (8.3 million) than the private insurer ACOs (17.2 million patients) (Mulhestein, 2016).

The development of ACOs has been particularly rapid in six American states: California, Florida, Illinois, Massachusetts, New York, and Texas (see Map).

However, the rapid development of ACOs does have its limits due to mixed opinion about the positive impact of the ACOs in terms of quality, particularly among healthcare professionals who do not work as part of an ACO.

The insurers employ various types of payment model

ACOs payment models vary considerably according to whether they are contracted by Medicare, Medicaid, or private insurers (see Table 2). Medicare employs, via its ACOs, a fee-for-service payment model, and Medicaid uses a capitation payment model, while a private insurer such as Blue Shield Blue Cross of Massachusetts has launched a global budget payment model. Each ACO is required to set an annual expenditure target, with a level of financial responsibility that differs according to its experience and its risk management capabilities.

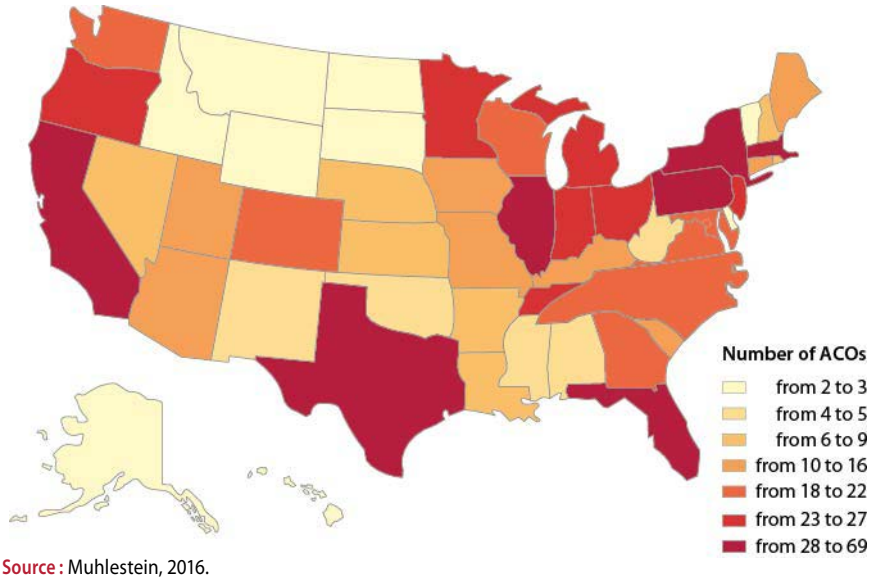
Quality-based payments differ according to the insurer contracted with the ACOs: quality scores determine the profit-sharing percentage (from 50 to 75%) in a contract signed with Medicare; good results are rewarded by the payment of a bonus with Blue Shield; and Medicaid subtracts deductions from or adds extra pay to the principal form of remuneration.

Lastly, Medicare offers ACOs two types of risk-sharing contract: either sharing in a percentage of the savings (one side models), or sharing in a greater percentage of the savings and penalty in case of spending beyond targets (two sides models), but which enables the organisation to keep a greater share of the profits, when appropriate. Medicare is currently finding it difficult to encourage its organisations to enter into the second type of contract, which entails greater risk.

The indicators used to calculate the quality scores are similar in the case of Medicare and Medicaid, but are different from those used by the private insurers (Kessell et al., 2015). They are divided into organisation indicators (10%), process indicators (70%), and outcomes indicators (20%). They are generally based on: the patient's experience; prevention, screening, and vaccination; hospital readmission and potentially avoidable hospitalisations[2], and chronic disease management. These indicators are similar to those general used in performance-based payment systems. They also reflect good coordination between hospital, primary care, skilled nursing and rehab facilities.

While, in theory, an ACO-type provider organisation can enter into contracts with different insurers, the diversity of the payment models makes it difficult in practice to enter into multiple contracts. Hence, more than half of the ACOs are, at present, only contracted with a single public or private insurer (Lewis et al., 2014; Wu et al., 2016).

Number of ACOs per state in 2016



Source : Muhlestein, 2016.

Medicare achieved net gains in 2014: A modest but significant improvement in quality, with diverse performance results

The ACO reform is relatively recent and insufficient time has elapsed to draw any firm conclusions. Several quasi-experimental studies have analysed the differences in terms of expenditure and/or care quality before and after the introduction of the ACOs, and compared to the patients who are not covered by an ACO. They conclude that, despite considerable variation in the results, the decrease in expenditure, although modest, is significant among all the ACOs and the improvement in quality varies according to the outcomes or dimensions considered (Song et al., 2014; McWilliams, 2014; McWilliams et al., 2015; Shortell et al., 2015; Nyweide et al., 2015; McWilliams, 2016a; McWilliams, 2016b).

A recent study (McWilliams, 2016b) shows that after an initial experimental deficit year in 2013, Medicare's net gains (savings less incentives) in 2014 were close to 287 million dollars, representing a reduction of $67 on average per patient or a reduction of 0.7% in health expenditure compared with 'control' patients.

The differences may largely be explained by the significant decrease in expenditure in healthcare providers in an ACO, in which it was initially higher than the regional average. It also seems that groups of primary care doctors achieve cost savings that are greater than those achieved by healthcare organisations integrated into a hospital.

In terms of healthcare quality, there has been a significant improvement with regard to the monitoring of chronic diseases; and modest and significant improvements with regard to the reduction of low-value clinical care. However, there has been no significant improve-

[2] In parallel with the ACO experiment, heavy fines were introduced, reducing hospital remuneration in the event of readmissions within 30 days.

T2

Examples of the structure of ACO contracts

	Principal payment model	Profit and/or loss sharing	Quality-based payment model
Contracts with Medicare			
Medicare Shared Savings Program (MSSP)	Fee-for-service	Profit-sharing only or profit-and-loss sharing	Quality scores that determine the profit-sharing percentage
'Pioneer ACO'	Fee-for-service + transition towards a prospective payment per patient and per month in the 3rd year in the event of savings	Profit-and-loss sharing	Quality scores that determine the profit-sharing percentage
Example of a contract with Medicaid			
'Hennepin Health ACO in Minnesota'	Capitation payment model	Profit-and-loss sharing	Quality scores that result in a deduction or increase in the amount of capitation
Example of a contract with a private insurer			
Blue Cross Blue Shield of Massachusetts: 'Alternative Quality Contract'	Global budget payment model	Profit-and-loss sharing	Quality scores that determine the amount of bonus paid

Source : Lewis et al., 2014.

ment in screening, 30-day readmission rates, and potentially avoidable hospitalisations (McWilliams et al., 2016a). Lastly, there is no clear correlation between the quality of healthcare and the savings in the use of healthcare and expenditure, nor is there any correlation between certain organisational and functional characteristics and the overall performance.

However, there is much debate on the inherent limitations of estimating the impact of the ACOs in literature on the subject. Certain authors argue that the results in terms of quality are modest but are underrated because they do not take into account the spillover effect of the good practices that benefit all the patients receiving treatment in organisations that belong to an ACO, even if they are not covered by the insurer with which the contract was concluded (McWilliams et al., 2013; Handel, 2015).

Which performance levers can be activated in the ACOs to strengthen organisational and professional practices?

Certain ongoing qualitative and exploratory studies are attempting to identify the structural factors that affect the performance of the ACOs and the levers that can be implemented to strengthen the multi-professional coordination, improve the quality of healthcare and services, and reduce healthcare expenditure. Beyond screening mechanisms for members and the use of performance- and quality-based incentives, some initial proposals have been put forward:

- The development of integrated information systems that make it possible to link information in the electronic health records with reimbursement data. It would be a necessary condition for improving team coordination and strategic reflection on the quality of clinical practices. This reflection would be conducted with representatives of the practitioners, such as mobilised data professionals in the ACOs. This would also be complemented, more conventionally, by information processing and in-housed training for all the professionals, with the primary aim of standardising the healthcare practices and protocols.
- The proactive identification of patients with major health needs and costs (using algorithms or targeting tools) and interaction with the family doctor who is treating them in order to strengthen patient support and limit hospitalisations and readmissions.
- The use of care managers (advanced practice nurses or social workers) to develop health promotion and prevention as well as adequate health care pathways.
- The establishment of transition programmes between hospitals and primary care comprising a standardisation of information/communication, joint decision-making with regard to policy, and on-the-spot patient support in the case of skilled nursing and rehabilitation therapy.
- Lastly, the associated capital expenditure and running costs, which may be conducive to the employment of additional staff within provider organisations, could be funded by the savings generated.

* * *

There has been a rapid growth in ACOs and it is estimated that the population covered by the ACOs could double by 2020. However, ACO growth is largely concentrated in six states (California, Florida, Illinois, Massachusetts, New York, and Texas). But the ACOs do not appear to be destined to spread everywhere and become a single model. Firstly, because they are dependent on health professionals' participation in the initiative, and, outside the ACO sphere, few of them are convinced of the added value for the quality of care. And also because their results are, on a global level, mixed and modest.

Nevertheless — and this is probably the main lesson to be learnt —, the ACOs have enabled a significant improvement in the monitoring of patients with chronic diseases and a reduction in expenditure among the most complex populations. Moreover, the assessments that have been conducted thus far do not make it possible to highlight all the impacts or changes in the organisational and professional practices that are essential for good coordination between care providers.

Lastly, insufficient time has elapsed to enable a proper appreciation of the ACOs performances with regard to the populations that have received healthcare (aged, multimorbid, deprived patients, etc.), the types of ACO (they vary considerably), and the practices and tools implemented.

Nevertheless, the ACO experiment and the study of the impacts of this new type of organisation and the factors associated with ACOs already provide some interesting food for thought for the French health system. Hence, the creation of intermediary organisations that operate between the care providers and the financers (public or private insurers) combined with the establishment of performance-based contracts, appears to facilitate the coordination of care, through the development of alternatives to the fee-for-service model, which encourages practitioners to make efficiency gains.

This observation raises questions about the way in which our healthcare is currently organised, while other countries such as the United Kingdom, Australia, and Germany have for several years been developing initiatives similar to the ACOs. These experiments could well open up new avenues in France in the context of continuing the policy of providing support to multidisciplinary primary care providers, on the one hand, and the new opportunities provided by the law on the modernisation of the health system with regard to greater territorial integration with the creation of territorial groups of health professionals (Communautés Professionnelles Territoriales de Santé, or CPTS) and territorial support platforms (Plateformes Territoriales d'Appui, or PTA), on the other hand. ♦

FOR FURTHER INFORMATION

- Anderson G.F., Reinhardt U.E., Hussey P.S., Petrosyan V. (2003). It's the Prices, Stupid: Why the United States is so Different from Other Countries. *Health Affairs,* 22(3): 89-105.
- Barnes A.J. *et al* (2014). Accountable Care Organizations in the USA: Types, Developments and Challenges. *Health Policy*, 118(1): 1-7.
- Berenson R. (2015). Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust. *Journal of Health Politics, Policy and Law*, 40(4): 711-744.
- Berwick D.M., Nolan T.W., Whittington J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs,* 27(3): 759-69.
- Blumenthal D., Abrams M., Nuzum R. (2015). The Affordable Care Act at 5 Years. *New England Journal of Medicine*, 372(25): 2451-8.
- Bodenheimer B., Pham H.H. (2010). Primary Care: Current Problems and Proposed Solutions. *Health Affairs*, 29(5): 799-805.
- Burwell S.M. (2015). Setting Value–Based Payment Goals—HHS Efforts to Improve U.S. Health Care. *New England Journal of Medicine*, 372(10): 897-99.
- Carmen D.W., Proctor B.D., Smith J.C. (2012). Income, Poverty, and Health Insurance Coverage in the United States: 2011, U.S. Government, U.S. Census Bureau. *Current Population Reports*, 60-243.
- Crogan C.M. (2015). Encouraging Competition and Cooperation: The Affordable Care Act's Contradiction? *Journal of Health Politics, Policy and Law,* 40(4): 633-8
- Dafny L.S. (2015). Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience. *The Commonwealth Fund*, November.
- Davis K., Stremikis K., Squires D., Schoen C. (2014). Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally. *The Commonwealth Fund*, June.
- Douven R., McGuire T.G., McWilliams J.M. (2015). Avoiding Unintended Incentives In ACO Payment Models, *Health Affairs,* 34(1): 143-9.
- Fisher E.S., McClellan M.B., Bertko J., Lieberman S.M., Lee J.J., Lewis J.L., *et al.* (2009). Fostering accountable health care: moving forward in Medicare. *Health Affairs*, 28(2).
- Handel B. (2015). Commentary — Accountable Care Organizations and Narrow Network Insurance Plans. *Journal of Health Politics, Policy and Law,* 40(4): 705-10.
- Hsu J., Price M., Spirt J., Vogeli C., Brand R., Chernew M.E., Chaguturu S.K., Mohta N., Weil E., Ferris T. (2016). Patient Population Loss at a Large Pioneer Accountable Care Organization and Implications for Refining the Program. *Health Affairs*, 35(3): 422-30.
- Kane C.K, Emmons D.W. (2015). New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment. American Medical Association, *Policy Research Perspectives*.
- Kessell E., Pegany V., Keolanui B., Fulton B.D., Scheffler R.M., Shortell S.M. (2015). Review of Medicare, Medicaid, and Commercial Quality of Care Measures: Considerations for Assessing Accountable Care Organizations. *Journal of Health Politics, Policy and Law,* 40(4): 761-796
- Kilo C.M., Wasson J.H. (2010). Practice redesign and the patient-centered medical home: history, promises, and challenges. *Health Affairs*, 29(5): 773-8.
- Lewis V.A., Colla C.H., Schpero W.L., Shortell S.M., Fisher E.S. (2014). ACO Contracting with Private and Public Payers: A Baseline Comparative Analysis. *American Journal of Management Care*. 20(12): 1008-14.
- McClellan M., McKethan A.N., Lewis J.L., Roski J., Fisher E.S. (2010). A National Strategy to Put Accountable Care into Practice. *Health Affairs*, 29(5): 982–90.
- McWilliams J.M., Chernew M.E., Zaslavsky A.M., Hamed P., Landon B.E. (2013). Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries. *JAMA International Medicine,* 173(15): 1447-56.
- McWilliams J.M., Landon B.E., Chernew M.E. (2013). Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract. *JAMA,* 310(8): 829-36.
- McWilliams J.M., Landon B.E., Chernew M.E., Zaslavsky A.M. (2014). Changes in Patients' Experiences in Medicare Accountable Care Organizations. *New England Journal of Medicine*, 371(18): 1715-24.
- McWilliams J.M., Chernew M.E., Landon B.E., Schwartz A.L. (2015). Performance Differences in Year 1 of Pioneer Accountable Care Organizations. *New England Journal of Medicine*, 372(20): 1927-36.
- McWilliams J.M., Hatfield L.A, Chernew M.E, Landon B.E, Schwartz A.L. (2016a). Early Performance of Accountable Care Organizations in Medicare. *New England Journal of Medicine*, 374(24): 2357-66.
- McWilliams J.M. (2016b). Changes in Medicare Shared-Savings Program Savings from 2013 to 2014. *JAMA*, 336(16): 1711-13.
- Mossalios E., Wenzl M., Osborn R., Sarnak D. (eds.) [2016]. International Profiles of Health Care Systems. *The Commonwealth Fund*, January.

For further information (more)

- Muhlestein D., Gardner P., Merril T., Petersen M., Tu T. (2014). A Taxonomy of Accountable Care Organizations: Different Approaches to Achieve the Triple Aim. *Leavitt Partners*.
- Muhlestein D. McClellan M. (2016). Accountable Care Organizations In 2016: Private And Public-Sector Growth And Dispersion. *Health Affairs Blog*.
- Nyweide D.J., Lee W., Cuerdon T.T., Pham H.H., Cox M., Rajkumar R., Conway P.H. (2015). Association of Pioneer Accountable Care Organizations *vs* Traditional Medicare fee for Service with Spending, Utilization, and Patient Experience. *JAMA*, 313(21): 2152-61.
- Rice T., Rosenau P., Unruh L.Y., Barnes A.J. (2013). United States of America: Health System Review. *Health Systems in Transition*, 15(3): 431 p.
- Ricketts T., Naiditch M., Bourgueil Y. (2012). Advancing Primary Care in France and the United States: Parallel Opportunities and Barriers. *Journal of Primary Care Community Health*, 3(3): 221-5.
- Sandy L.G., Bodenheimer T., Pawlson L.G., Starfield B. (2009). The political economy of U.S. primary care. *Health Affairs*, 28(4): 1136-45.
- Shortell, S. M., Wu, F. M., Lewis, V. A., Colla, C. H., Fisher E. S. (2014). A Taxonomy of Accountable Care Organizations for Policy and Practice. *Health Services Research*, 49(6): 1883–99.
- Shortell S.M., Colla C.H., Lewis V.A., Fisher E., Kessell E., Ramsay P. (2015). Accountable Care Organizations: The National Landscape. *Journal of Health Politics, Policy and Law*, 40(4): 647-68.
- Shortell S.M., Sehgal N.J., Bibi S., Ramsay P.P., Neuhauser L., Colla C.H., Lewis V.A. (2015). An Early Assessment of ccountable Care Organizations' Efforts to Engage Patients and Their Families. *Medical Care Research Review,* 72(5): 580-604.
- Smith J.C., Medalia C. (2015). Health Insurance Coverage in the United States: 2014. *U.S. Government, U.S. Census Bureau*, Current Population Reports, 60-253, Washington, DC.
- Song Z. (2014). Accountable Care Organizations in the U.S. Health Care System. *Journal of Clinical Outcomes Management*, 21(8): 364–71.
- Song Z,. Rose S., Safran D.G., Landon B.E., Day M.P., Chernew M.E. (2014). Changes in Health Care Spending and Quality 4 Years into Global Payment. *New England Journal of Medicine*, 371 (18): 1704-14.
- Starfield B., Shi L., Macinko J. (2005). Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly*, 83(3): 457-502.
- The Commonwealth Fund and The Kaiser Family Foundation (2015). Primary Care Providers' Views of Recent Trends in Health Care Delivery and Payment.
- Tu T., Muhlestein D., Kocot L., White R. (2015). The Impact of Accountable Care: Origins and Future of Accountable Care Organizations. *Leavitt Partners White Paper*.
- Wu F.M., Shortell S.M., Lewis V.A., Colla C.H., Fisher E.S. (2016). Assessing Differences Between Early and Later Adopters of Accountable Care Organizations Using Taxonomic Analysis. *Health Services Research,* 51(6): 2318-29.

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