STRATEGIC INNOVATIONS FOR AFFORDABLE, SUSTAINABLE HEALTH CARE:

A Model for Health System Reform

*Environmental Scan*

Accountable Care Organizations
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Accountable Care Organizations (ACO) are a set of providers and institutions, such as primary care physicians, specialists, and hospitals, which have joint responsibility for the quality and cost of care for a population. To encourage physicians and hospitals to establish these organizations requires a bonus payment structure (in addition to standard fee-for-service model) that rewards ACOs for reducing cost growth and meeting established quality of care targets. This organization model is intended to address the lack of coordinated care across delivery settings, particularly for physicians and hospitals, and for patients that would benefit from coordinated care such as those with diabetes, asthma, and congestive heart failure. Cost savings from this model would result primarily from reduced hospitalizations and readmissions.

Note: There is limited evidence, beyond the current Centers for Medicare and Medicaid Services (CMS) Physician Group Practice (PGP) demonstration, that this approach actually works to improve quality and reduce costs. In addition, there are a number of barriers that physician groups and hospitals would have to overcome for this type of arrangement to be successful, including substantial capital investment in technical infrastructure to share information across organizational settings and changing the physician and organizational culture toward a team-based approach.

Sources: 1, 2, 3, 4, 5, 6, 7

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<th>INTERVENTION AREAS AND Case Examples</th>
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<td>There is lack of coordinated care across delivery settings, particularly for physicians and hospitals. This lack of coordination may lead to increased hospitalizations and readmissions for patients with chronic conditions such as congestive heart failure, asthma, or diabetes.</td>
<td>Similar models have shown promise in quality improvement (e.g., Physician Group Practice Demo). Cost savings are less clear.</td>
<td>• The model requires strong market collaboration among providers and may depend largely on the makeup of the market. • Success likely depends on a number of factors, including the participation of large physician groups that are part of an integrated delivery system.</td>
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<td>for quality and cost metrics, ACOs would be expected to improve the coordination of care and reduce duplication of services. Because ACOs would take responsibility for resource use, Medicare could constrain health care spending by using a system of bonuses and, in some cases, withholds. This system would be designed to counterbalance the incentives under FFS payment to increase volume.”</td>
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<td>Other Comments</td>
<td>Physicians and hospitals have joint responsibility for the quality and cost of care delivered.</td>
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**Case Example 1**

**Physician Group Practice Demonstration**
(Medicare Demonstration)

Congress mandated in 2000 that CMS conduct the Physician Group Practice (PGP) demonstration to test a hybrid payment methodology that combines Medicare fee-for-service payments with new incentive payments. Though not referred to as an ACO model, the structure and aims of the demonstration are similar. The aims of the demonstration were to encourage the coordination of Part A and Part B services, promote efficiency through investment in administrative processes, and reward physicians for improving health outcomes.

- Results have been mixed. In July 2007, CMS reported that in the first performance year, two participants earned a combined bonus of approximately $7.4 million, and all 10 achieved most of the quality targets related to diabetes.
- In Performance Year 3, five physician groups received performance payments totaling $25.3 million as part of their share of $32.3 million of savings generated for the Medicare Trust Funds.
- The U.S. Government Accountability Office (GAO) concluded in its evaluation of the results from the first performance year that evidence so far indicated that the care coordination programs initiated by the participants showed promise, but the wider applicability of the payment methodology used in the demonstration may be more limited.
- Large physician groups that are part of integrated delivery systems.
- Physician groups with at least 200 physicians were eligible to apply, and 10 were selected by CMS. The 10 physician groups were Billings Clinic, Dartmouth-Hitchcock Clinic, The Evert Clinic, Geisinger Health System, Integrated Resources for the Middlesex Area, Marshfield Clinic, Novant Medical Group, and Park Nicolette Health Services. These groups, except for Marshfield Clinic, identified themselves as integrated clinics that, in addition to their physician group, included hospitals, surgical centers, or laboratories. Eight of the 10 were nonprofit, and most were in small cities or rural areas.
### Accountable Care Organizations

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| Other Comments                      | • Quality has improved in the four areas that CMS has monitored: diabetes, congestive heart failure, coronary artery disease, and preventive care.  
• Both GAO and MedPAC are less definitive in attributing cost savings from the PGP demonstration. Part of the “savings,” for example, could be better detection and coding of illness at the PGP sites relative to their comparison groups.  
• PGP design created several challenges, including lack of timely feedback and bonus payments.  
• Challenges exist on how best to set spending targets and how best to determine “savings” to Medicare. | | |
| **Case Example 2**                  | **Brookings-Dartmouth ACO Collaborative**     | The ACO Learning Network is a joint initiative of the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice with the principal goal of engaging stakeholders in piloting the ACO model and producing a successful and replicable model that can be implemented nationwide (two case studies are described below).  
The ACO learning network provides four particular service activities:  
• Pilot sites: In-depth consultation, technical assistance, and data analysis for participating health systems and payers.  
• Learning network: Offers practical guidance and a forum for interested parties to learn from one another throughout the process of planning and implementation.  
• Community initiatives: Serve as strategic support for regions interested in piloting this at the community level.  
• Washington, DC, support: Serves as a resource for legislative and executive staff on delivery system reform specifically related to the ACO model. | | |
| **Case Example 2A**                 | **Carilion Clinic, Roanoke, VA**              | Carilion is working to address the lack of coordination of care among primary care physicians and hospitals within the region.  
Organizational structure:  
• There is a tertiary academic medical center, a moderate regional community hospital, and three or four critical access hospitals.  
• There are 170 primary care providers across the region (50% in core areas). A medical home is in progress, as is the foundation of the Massachusetts’s health plan.  
• There 350 specialists, including those for an integrated care model and an | | |
|                                     | The model is still a work in progress. Activities to date include:  
• The formation of a planning workgroup, including the chief marketing officer, the chief financial officer, the chief information officer, the primary care chair, the vice president of medical affairs, and the health plan medical director;  
• Active conversation with all payers, including an overview, detailed follow-up, and a “straw man” gain share model;  
• Internal conversation with all clinical leadership, SMT, and boards with strong buy-in; and  
• Biweekly conference calls with Brookings and Dartmouth on population and methodology definitions, performance measurement, and payers. | | |
|                                     | Carilion’s model can be used in markets with a large, integrated physician practice with close hospital affiliations.  
Likely implementation challenges identified for Carilion Clinic follow:  
• Reliable, timely information provided in a quick turnaround sufficient to drive rapid-cycle improvements in care (e.g., registries, clinical outcomes, costs);  
• Balancing the need to reduce hospitalizations with managing hospitals (i.e., success means “parasitizing” yourself);  
• Managing the transition from FFS and inpatient focus to something else (i.e., the gain share may not offset the revenue loss); | | |
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<td>Approximately 50% of primary care and specialist physicians are employed by Carilion; others are not organized and are in single-specialty small groups.</td>
<td>Payer commitment: high, though a bit uneven.</td>
<td>Changing physician behavior, including being more patient centered, adopting new practice styles, and being accountable for waste and evidence-based care;</td>
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<td>No other multispecialty physician group in the area.</td>
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<td>A lack of large regional employers, making it hard to engage large groups of patients in the changes that they too need to make; and</td>
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<td>Carilion has approximately a 60% inpatient market share and a 40% outpatient market share.</td>
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<td>Communities and patients not being ready to accept changes.</td>
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Other Comments

- There is modest support for the ACO concept among business leaders and boards, but they are unsure how to get there.
- Specific issues of interest includes:
  - Performance measurement,
  - Defining success amidst moving targets, and
  - How to rationalize hospital services while reducing utilization in the current payment environment.
  - Some business leaders remain concerned about possible cost increases when hospitals, rather than physicians, provide the ACO base.
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| **Case Example 2B:** Aultman Health Foundation, Aultman Hospital, and AultCare Health Plans, Canton, OH | Aultman is working to address the lack of coordination of care among primary care physicians and hospitals within the region. This nonprofit, vertically integrated health system primarily serves a five-county market in northeastern Ohio. Aultman Hospital has a single managed care contract with AultCare, covering more than 200,000 enrollees (2,300 employers). Aultman is self-insured for health benefits, with 5,000 employees and 10,500 enrollees. Comprehensive post-acute care: residency programs, the College of Nursing, strong regional hospital partnerships, and an independent hospital network. Organizational structure: Independent physicians jointly venture to sponsor our health plan. Primary care is based mostly in private practices, and an increasing specialist base is employed by Aultman. | To be determined. The ACO team is in the due-diligence phase of the plan. The goal is to build on other strategies:  
- Implementing a patient-centered medical home pilot this fall within the Medicare Advantage Plan;  
- Utilization of current participation in performance measurement: CMS, Compare, Leapfrog, the Consumer Assessment of Healthcare Providers and Systems, the National Quality Forum, and CAQH;  
- Value-based purchasing (P4P) programs between AultCare and physicians; and  
- Adaptation of health IT implementation—computerized physician order entry, HER, the Aultman Patient Information Network (PIN), and the foundation of a Regional Health Information Organization. | The model can be used in markets with a large, integrated physician practice with close hospital affiliations. Likely implementation challenges identified follow:  
- Capital to develop a technical infrastructure;  
- Engagement of independent medical staff in the ACO process;  
- The delivery system payment model changing from fee-for-service payment;  
- Building models for ongoing sustainability; and  
- Uncertainty regarding Medicare participation. |

### Other Comments

The leadership of the foundation identified a number of reasons for their participation (beyond financial):  
- The ACO Learning Network provides an opportunity to consider how best to implement payment and delivery reforms. Specific actions can be tailored to the organization.  
- They can learn from other organizations committed to value improvement in other communities.  
- They need to adapt to emerging policies for delivery and payments reform.  
- They must identify innovative approaches.


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