VIEWPOINT

How the Pioneer ACO Model Needs to Change
Lessons From Its Best-Performing ACO

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On July 16, 2013, the Center for Medicare & Medicaid Innovation released results from the first performance year of its Pioneer Accountable Care Organization (ACO) Model. The Pioneer program is the first ACO pilot administered by the government and the first to report results. This important experiment may offer lessons for how to avoid Medicare's predicted fiscal crisis. Even short of that, however, the findings demonstrate that, for the experiment to ultimately succeed, value-based payment and patient incentives to reward clinicians and health care organizations that offer more real value to patients must spread rapidly to other payers. Otherwise, the very delivery systems that are improving cost and quality may drop out of these important experiments.

Pioneer's First-Year Results

Each of the 32 Medicare Pioneer ACOs has improved quality and patient satisfaction, and the overall Pioneer program generated a total savings of $87.6 million. However, 12 of the 32 ACOs did not achieve significant savings, and 9 will exit the Pioneer program (7 plan to join the CMS Shared Savings Program and 2 are discontinuing participation in the Pioneer program completely).[1]

The success of 1 Pioneer ACO has significant policy implications. During calendar year 2012, the Bellin ThedaCare Health Partners ACO delivered a 4.6% improvement in the year-over-year total cost of care for the approximately 20 000 Medicare beneficiaries in northeastern Wisconsin, 13 000 of whom are managed by the ThedaCare integrated health system and its physician partners. Despite high labor and rent costs, this ACO began the program with the third-lowest annual total per-capita Medicare spending. By the end of year 1, Bellin ThedaCare was the best-performing Pioneer ACO on per-capita cost and scored high (CMS has not released detailed quality rankings) on a composite of 33 Medicare ACO quality measures, including 3 (access to specialists, shared decision making, and hemoglobin A_{1c} control) in which the ACO achieved the highest score out of all the shared savings programs. Yet by achieving major first-year improvements, Bellin ThedaCare proved that a health care system that already excels on measures of real value to patients can continue to deliver sizable gains in affordability and quality.

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How the Best Baseline Performer Continues to Improve

ThedaCare and Bellin have previously been recognized for delivering high-quality care at a low cost, compared with their peers.[2] More recently, ThedaCare's physician group was ranked first in Wisconsin on a set of clinical outcome measures tracked by Wisconsin's nationally recognized clinical outcomes database. Examples of measures publicly reported include hemoglobin A_{1c} lower than 7% and breast cancer screening.[3]

This success surprised few observers. More than 10 years earlier, ThedaCare had launched a nationally recognized management system, using principles and practices from Lean Manufacturing, to improve quality and slow growth in per-capita health care spending. Key components include value-stream mapping of processes contributing to high-quality patient care such as patient flow in the emergency department or in an inpatient unit; the application of PDSA (plan, do, study, act) problem-solving cycles; and widespread use of continuous improvement teams.

Similar efforts are under way in earlier stages in dozens of North American health systems, including the University of Michigan health system; Stanford University Medical Center; St Mary's Hospital in Kitchener, Ontario; and Beth Israel Deaconess Medical Center in Boston. Indicators show that this progress is expanding geographically. The redesign of ambulatory care practices using systematic performance improvement methods has been associated with cost reductions without compromising quality. In California, a 3-way partnership among a health plan, a physician group, and an integrated health system saved $20 million with zero growth in health insurance premiums by using a package of innovations, including integrated discharge planning, evidence-based variance reduction, and patient engagement strategies.[4] Recent analysis of the CMS Physician Group Practice Demonstration revealed a $500 per-member annual reduction in costs for dual-eligible patients.[5] Such a structured management system was recently shown to be associated with reduced mortality at cardiac centers.[6]

Inadvertently Weakening the Best Performers

The bad news is that 82% of patients at Bellin ThedaCare are still cared for under a fee-for-service model operated by private insurers and Medicaid, without any shared savings or other financial rewards for high value. The same care processes that are used to more efficiently manage Medicare patients are also used to manage commercially insured patients. Thus, when Bellin

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ThedaCare achieves savings by reducing its overall volume of services, such as decreasing patient readmissions to 7.9% year-to-date in 2013, revenues still decline. So every time a hospital admission is avoided for a fee-for-service patient, it means less revenue with no chance to share savings.

ThedaCare and its primary physician partners receive 68% of the $5.2 million in shared ACO savings payments from CMS (Bellin receives the other 32%). Nonetheless, ACO participation is diminishing ThedaCare's financial strength—from a projected 3% increase in annual revenue year-over-year (according to estimates made in August 2012) to an actual 0.7% decrease through the first 6 months of 2013 (1.5 years into the Pioneer program). Part of that change is attributable to a 10% reduction in fee-for-service Medicare admissions (4617 in 2011 to 4143 in 2012), resulting in lower revenue from caring for fewer inpatients. A complicating factor in this calculation is that between 2011 and 2012 some Medicare beneficiaries moved from fee-for-service Medicare to Medicare Advantage plans, which are not included in the Pioneer shared savings program. This could result in an artificially lower fee-for-service Medicare admission result year-over-year. However, when Medicare Advantage and fee-for-service Medicare beneficiaries were added together there were 7850 admissions in 2011 and 7568 admissions in 2012, a decrease of 3.6%, and a major contributor to the reduction in health system revenue.

Unless all payers quickly move to value-based payment systems or give insurers incentives to preferentially use health care organizations that provide greater value to patients, more organizations (especially those unable to shift costs to other payers) will discontinue participation in both of Medicare's ACO programs and other related arrangements. That is why (in most markets) commercial insurers, self-funded employers, and state administrators of Medicaid must join with Medicare to discuss health system incentives that are based on value for patients, not just shared savings. The experiments may include preferential physician-hospital selection strategies such as reference pricing; value-tiered physician-hospital networks, like those implemented by the Massachusetts Group Insurance Commission, the Minnesota State Employees Group Insurance Program, and several commercial insurers; and risk-adjusted global capitation contracts with robust outcome-based bonuses.

California provides an example in which private and public sector leaders have called for rapid adoption of risk-adjusted global budgets. The state already has the ninth-lowest per-capita health care spending nationally, as well as hospital admissions at 79% and inpatient days at 74% of the national average. Nevertheless, although health maintenance organizations insure 44% of enrollees in California, 78% of state health care expenditures are paid under fee-for-service arrangements. The state has set 2 targets for 2022: (1) reducing the 78% fee-for-service figure to 50%; and (2) increasing the percentage of state residents who receive care from integrated care systems from 29% (currently) to 60%.[7] Other states need to set similar goals.

Conclusion

A systematic management system that continuously assesses and improves value for the money paid by its patients and payers is critical for improving quality of care while limiting growth in health care spending to a sustainable rate. However, this is easier said than done. The early years after implementing such a management system can prompt stressful backlash from physicians, nurses, and other health care workers. This understandably causes many health care executives, physician leaders, and physician boards to push forward. However, peer-to-peer learning networks have been shown to reduce this risk (eg, Healthcare Value Network, Ohio Children's Health Collaborative, Institute for Healthcare Improvement, and many others).

To expect health system leaders to take the necessary risks, strong federal-state and public-private partnerships will be needed to coordinate all payers in each region and, thereby, ensure that high-value care is rewarded consistently. CMS can play a key leadership role by more actively catalyzing multipayer ACOs now, but CMS cannot force private insurers to participate in the crucial payment reforms. It will take leadership from the US health insurance industry, in partnership with CMS and health systems, to achieve true reform. Today there is a unique opportunity to correct the excessive growth in health care spending. The nation should not squander that chance.

ARTICLE INFORMATION

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