education for nurses and laid the groundwork for the development of APRNs. We need an equivalent effort now. The approximately $160 million per year in Medicare funding for nursing education should be used to support clinical training of graduate-level APRNs rather than diploma nursing programs.

It will be extremely difficult, if not impossible, to generate enough nursing faculty, APRNs, and nurses to fill leadership and executive roles requiring graduate-level education if entry-level nursing education does not shift entirely to the baccalaureate level. The stakeholders (educational institutions and students) will respond to financial incentives—which are, after all, the tried-and-true American way of bringing about change.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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See also related letters to the Editor (10.1056/NEJMc1013895).

Assessing an ACO Prototype — Medicare’s Physician Group Practice Demonstration

John K. Iglehart

One of the few major provisions of the Affordable Care Act (ACA) with solid bipartisan support establishes a new delivery model: the accountable care organization (ACO). Congress directed the Department of Health and Human Services (DHHS) to develop an ACO program to improve the quality of care provided to Medicare beneficiaries and reduce its costs while retaining fee-for-service payment. Under this program, medical groups would have to take responsibility for achieving these goals and would share in any savings derived by Medicare.

Despite the burst of interest in ACOs, little attention has been paid to the results of a demonstration project sponsored by the Centers for Medicare and Medicaid Services (CMS) that was the model for the reform law’s ACO provisions. In the Medicare Physician Group Practice (PGP) demonstration, the CMS contracted with 10 large multispecialty groups with diverse organizational structures, including free-standing physician groups, academic faculty practices, integrated delivery systems, and a network of small physician practices.

As a share of total Medicare spending, fee-for-service expenditures for physician services have been relatively stable (13% of $491 billion in 2009). However, this payment model has been under attack because of its inherent incentive for increasing the quantity, but not necessarily the quality, of physician-delivered care. But policymakers vividly remember the backlash against managed care, whose capitation payments were seen as an incentive to stint on care, so with no new alternative to fee for service in the offering, Medicare’s physician-payment policy has remained essentially static.

In 2000, Congress tasked the DHHS with testing incentive-based payment methods for physicians, directing Medicare to encourage care coordination and investment in processes for more efficient service delivery and to reward physicians for improving health care outcomes. In response, the CMS designed the PGP project to examine whether care management initiatives could generate cost savings by reducing avoidable hospital admissions, readmissions, and emergency department visits, while improving quality.

The demonstration began in April 2005, with 10 large group practices (ranging from 232 to 1291 physicians) operating in various regions of the country. Participating doctors received their regular Medicare fee-for-service payments, but the groups were also eligible for an 80% share of Medicare’s savings (“performance payments”) if the...
practitioners collectively achieved specified quality and cost targets for the beneficiaries “attributed” to their group. To qualify for performance payments, groups had to generate savings for Medicare Parts A and B amounting to more than 2% of their target expenditures to rule out the possibility that savings merely represented random fluctuations. The CMS established the spending targets by creating a comparison group of Medicare beneficiaries in the same geographic area and comparing the PGP’s per capita expenditures in its base year with those for the comparison group, adjusting for case mix.

On December 9, 2010, the DHHS reported results from the project’s fourth year (ending March 31, 2009), when all 10 PGPs met at least 29 of the 32 quality goals, most of which were process measures related to coronary artery disease, diabetes, heart failure, hypertension, and preventive care. By also beating their expenditure targets, five PGPs generated Medicare savings of $38.7 million, earning performance payments of $31.7 million. According to RTI International, a research institute that evaluated the demonstration for the CMS, PGPs attributed their savings to many factors, including organizational structure, investments in care management programs and redesigned care processes, more intensive diagnostic coding, and changes in market conditions. One group, the Marshfield Clinic in Wisconsin, earned more than half the total savings ($16.2 million), as it had in most previous years (see table). Dr. Theodore Praxel, who directed Marshfield’s PGP activities, ascribes the clinic’s success to an aggressive acceleration of “multiple initiatives . . . including health information technology (point-of-care reminders, being completely chartless), care management programs, [and] education and feedback to providers regarding populations of patients with a given condition.” Participating groups were not penalized financially for missing their expenditure targets.

In announcing the results, CMS Administrator Donald Berwick characterized the 10 groups as leaders in organizing care delivery, but he added: “Now we want to raise the bar. We want to support these practices to demonstrate just how much American medicine can achieve if we put the right incentives in place. CMS is currently working to transition these physician groups into the ACO program established under the reform law.”

The CMS is drafting regulations that will guide implementation of the ACO program,

<table>
<thead>
<tr>
<th>Physician Group Practice</th>
<th>Percentage of Quality Goals Attained</th>
<th>Shared Savings Payments ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Year 1</td>
<td>Year 2</td>
</tr>
<tr>
<td>Billings Clinic, Billings, MT</td>
<td>90.91</td>
<td>97.78</td>
</tr>
<tr>
<td>Dartmouth–Hitchcock Clinic, Lebanon, NH</td>
<td>95.45</td>
<td>97.78</td>
</tr>
<tr>
<td>Everett Clinic, Everett, WA</td>
<td>86.36</td>
<td>95.56</td>
</tr>
<tr>
<td>Forsyth Medical Group, Winston-Salem, NC</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Geisinger Clinic, Danville, PA</td>
<td>72.73</td>
<td>100.00</td>
</tr>
<tr>
<td>Marshfield Clinic, Marshfield, WI</td>
<td>81.82</td>
<td>100.00</td>
</tr>
<tr>
<td>Middlesex Health System, Middletown, CT</td>
<td>86.36</td>
<td>95.56</td>
</tr>
<tr>
<td>Park Nicollet Clinic, St. Louis Park, MN</td>
<td>95.45</td>
<td>97.78</td>
</tr>
<tr>
<td>St. John’s Clinic, Springfield, MO</td>
<td>100.00</td>
<td>100.00</td>
</tr>
<tr>
<td>University of Michigan Faculty Group Practice, Ann Arbor</td>
<td>95.45</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.
scheduled to begin January 1, 2012. Although this exercise is highly confidential, the relevant lessons of the PGP demonstration have no doubt been analyzed by the CMS. And issues raised by the project were covered in an evaluation that Secretary of Health and Human Services Kathleen Sebelius sent to Congress in March 2009. Although its conclusions were based on the program’s second year, there’s no reason to believe that the fourth-year results would yield substantially different findings.

One of the questions probed by RTI was whether the financial results that were achieved might have been obtained by the participating organizations even without the project. Four of the PGPs achieved savings in the second year of the program, with average actual expenditures of $334 per person below their spending targets, but RTI noted that “this performance was almost matched in the predemonstration period” and suggested that the previously “favorable cost trends” at these PGPs “might have continued had the demonstration not occurred.”

The four PGPs earning performance payments in the second year either were affiliated with an academic medical center (Dartmouth–Hitchcock and University of Michigan) or were free-standing physician groups (Everett and Marshfield). No performance payments were earned by the five PGPs that are part of integrated delivery systems (systems that include hospital ownership but are not affiliated with academic medical centers) or by the physician network (Middlesex) that is sponsored by a hospital affiliate. The majority of the savings at all sites occurred in outpatient, not inpatient, services. RTI hypothesized that the presence of a hospital was “a potential deterrent to achieving savings . . . since these systems may be unable to reduce avoidable admissions or use lower cost care substitutes without affecting their inpatient revenue.” The two participating academic medical centers “may be able to replace reductions in Medicare inpatient revenue with private pay admissions,” RTI reasoned.

Because the PGP demonstration retained the fee-for-service structure, there was no enrollment process or lock-in feature preventing beneficiaries from seeking care elsewhere. If they did so, the PGP to which they had been attributed remained responsible for the cost of the care they received — which made it more difficult for a group to control its expenditures. Patients were attributed retrospectively to a PGP if they received more of their primary care from the group’s physicians than from anyone else. These details of attribution — whether, when, and how beneficiaries are informed that they’re part of an ACO and what data on the patient population will be provided to the ACO by the CMS — have provoked intense debate.

The ACO model is a work in progress, and the CMS must address many questions in crafting the new program’s regulations. One challenge, as a skeptic described it, is that “proponents of the shared savings model have designed an approach that attempts to upset or dislocate no one.” Since the PGPs in the demonstration faced no financial risk if they missed their targets, it’s hard to say whether the incentives for ACOs will be strong enough to change physicians’ behavior. If beneficiaries are unaware that they’ve been assigned to a medical group that operates on incentives for improving care and reducing costs, they may not be able to become full partners in managing their care. Under the fee-for-service model, patients have not had to worry that financial considerations might lead to stinting on care. And medical groups won’t know how they’re performing if, as in the PGP demonstration, they aren’t provided timely feedback on their patients’ utilization trends. Meanwhile, as it attempts to reduce the vast budget deficit, Congress may need to take more sweeping steps to slow the growth in Medicare spending long before the ACO model can prove whether it is up to meeting these challenges.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1013896) was published on December 22, 2010, at NEJM.org.


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