



OCTOBER 2014

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Douglas McCarthy, M.B.A.  
Senior Research Director  
The Commonwealth Fund  
DM@cmwf.org

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1768  
Vol. 21

## The Road to Accountable Care: Building Systems for Population Health Management

Douglas McCarthy, Sarah Klein, and Alexander Cohen

**Abstract** This case study series describes how three diverse organizations are developing accountable care systems to improve the quality and reduce the costs of care, and ultimately improve the health of populations of patients insured by Medicare, Medicaid, and commercial health plans. They employ a constellation of strategies to identify and address unmet medical needs, improve care transitions, and reduce inefficiencies and unnecessary variation in care. Care managers, outreach workers, or virtual care teams help improve outcomes for patients with complex needs that are costly to treat. Data integration and analytics are key to their efforts, although the sophistication of these capabilities varies. Two study sites have established a record of savings, while the third is still proving the potential of its approach. Their progress to date suggests that payment reforms can foster the will and accountability necessary to transform care.

### BACKGROUND

Creating a health care system that rewards providers for achieving optimal care outcomes at a sustainable cost is a key reform goal of the Affordable Care Act. Provisions in the law have allowed the federal government to test and implement several new payment models designed to achieve this goal for the Medicare program, many of them built on academic blueprints<sup>1</sup> and prior demonstrations.<sup>2</sup> Likewise, several states are redesigning their Medicaid programs in pursuit of accountable care,<sup>3</sup> while commercial insurers are partnering with health care providers in various arrangements that similarly seek to reward value rather than volume of services.<sup>4</sup>

These efforts stem from a common recognition that payment reform is necessary to achieve the triple aim of improved care and healthier populations at reduced cost. The early experiences of organizations participating in public and private payment reform programs may offer insight for policymakers to gauge whether the programs are likely to achieve policy goals as well as how the programs may need to evolve to do so. Lessons learned also may help health care leaders decide whether to enter into such arrangements and, if so, how to increase the likelihood of success.

This report synthesizes the findings of three case studies that describe how diverse delivery systems have responded to accountable care initiatives (Exhibit 1).<sup>5</sup>

These organizations (or their founders) were the subject of prior research by The Commonwealth Fund, which investigated the attributes of high-performing organized delivery systems.<sup>6</sup> They were selected to illustrate a range of mature efforts, early successes, and ambitious aims for the accountable care model under different payment and local contexts.

## IMPETUS FOR ACO FORMATION AND DEVELOPMENT

The study sites shared the same main motivation for forming accountable care organizations (ACOs): they all saw the model as a natural progression of long-standing efforts to enhance primary care services and a means for extending quality improvement and care management initiatives. Other motives were unique to each site.

- The creation of [Health Share of Oregon](#), a regional Medicaid coordinated care organization, was prompted by Oregon Governor John Kitzhaber’s vision for transforming health care in the midst of a Medicaid budget shortfall, which led the state to consolidate contracting regionally in pursuit of greater efficiency and community service integration.
- The [Hill Physicians Medical Group](#) was motivated by market forces to partner with hospital and health plan partners to regain market share lost to Kaiser Permanente, an integrated delivery system that was underpricing its competitors. Meeting this challenge required the ACO partners to jointly reduce spending to bring Blue Shield’s premiums below Kaiser’s.
- For the [Marshfield Clinic](#), the Medicare Shared Savings Program offered a source of potential incremental revenue to support the continued evolution of mission-driven population health management for all its patients. These physician-led efforts had begun seven years earlier through the clinic’s participation in Medicare’s Physician Group Practice (PGP) demonstration, which tested the ACO concept.

**Exhibit 1. Case Study Sites**

Organization	Location	Type of organization	ACO participation	ACO population
<a href="#">Health Share of Oregon</a> *	Greater Portland, Oregon	Nonprofit collaboration of medical and dental health plans, county mental health agencies, and community and social service agencies	Medicaid coordinated care organization	227,000 Medicaid beneficiaries residing in three Oregon counties
<a href="#">Hill Physicians Medical Group</a> <sup>7</sup>	Northern California	Independent practice association (IPA) of 3,800 private-practice physicians serving 300,000 patients	Several commercial ACOs, including a partnership with Dignity Health and Blue Shield of California in the Sacramento market	41,000 members of the California Public Employees’ Retirement System (CalPERS) in the Sacramento market
<a href="#">Marshfield Clinic</a> <sup>8</sup>	Central Wisconsin	Nonprofit multispecialty medical group practice of 700 employed physicians serving 383,380 patients across 41 clinical sites	Medicare Shared Savings Program (following participation in Medicare’s Physician Group Practice demonstration)	30,000 traditional (fee-for-service) Medicare beneficiaries

Note: ACO = accountable care organization.

\* CareOregon, a health plan that is one of Health Share’s founders, was the subject of a previous Commonwealth Fund case study.<sup>9</sup>

Source: Authors’ analysis.

## BUILDING A SYSTEM FOR POPULATION HEALTH MANAGEMENT

The study sites adopted a variety of approaches and interventions to optimize care and identify opportunities to achieve performance and savings targets and goals. Exhibit 2 summarizes select examples from the study sites.<sup>10</sup>

***Care redesign to improve the delivery and coordination of care.*** All three organizations are building on past efforts to redesign and strengthen primary care, which typically involved establishing the infrastructure and supports needed for physician practices to function as patient-centered medical homes. Another common area of focus was improving transitions in care from hospitals to postacute or community settings, and in one case from skilled nursing facilities to in-home care. For example, Hill Physicians Medical Group and its ACO partners aligned incentives to promote coordination across settings and worked collaboratively as a cross-continuum team to successfully reduce hospital readmissions. Health Share sought to ensure that all members seeking behavioral health services received the same level of care from mental health agencies in three different counties. It created a single provider network and streamlined the process for authorizing services and determining service levels to meet patient needs. This integration enhanced the ACO's ability to measure and monitor the performance of the network.

***Care management of patients with costly, complex needs.*** All study sites have invested resources in deploying care managers, outreach workers, or virtual care teams to engage with and help improve outcomes for patients with complex needs or at risk of incurring high costs. All stress an individualized approach to identify and address unmet needs through in-person or telephone visits. For example, care teams that may include social workers as well as pharmacists and case managers have been deployed by urban safety-net clinics affiliated with Health Share and by Hill Physicians Medical Group to help address the psychosocial and clinical factors that play a role in improving patients' health and treatment adherence. Marshfield Clinic embedded nurse care coordinators in all its primary care clinics to help patients avoid unnecessary hospital use, with the expectation that shared savings would help fund this infrastructure. It subsequently discontinued the program because it was partially duplicating a service offered by its health plan and because the program's cost was not sustainable without support from other payers. The clinic retains a care management program serving heart failure patients, and is reconfiguring primary care teams to take over the care coordination responsibilities.

***Patient and family engagement and patient activation initiatives.*** All the study sites recognized the value of engaging patients in care management to identify personal goals for lifestyle change or treatment and educating them about their treatment options, though all felt they could do more in this regard. Health Share has had a unique opportunity to partner with community-based organizations and social service agencies to address nonmedical determinants of health within the practical constraints of its budget. However, Medicare ACOs face particular challenges in engaging patients because Medicare beneficiaries are not formally enrolled in an ACO and cannot be offered incentives to change their behavior. Therefore, Medicare ACOs must rely on their physicians' rapport with patients to encourage voluntary compliance with referrals within the ACO network and other recommendations.

## Exhibit 2. Key Capabilities for Population Health Management: Examples from Study Sites<sup>11</sup>

Care redesign to improve the delivery and coordination of care	Behavioral health service delivery is being integrated across three counties and enhanced through colocation of services, improved transitions from psychiatric inpatient units to community mental health programs, and streamlining of administrative processes (Health Share)
	A standard hospital discharge practice was established to connect inpatient and outpatient care managers, arrange follow-up primary care appointments, enhance patient education, and create stronger links between skilled nursing facilities and in-home management services (Hill-Dignity-Blue Shield)
	Midlevel practitioners were employed to increase timely access to care, medical assistants were assigned to help physicians meet patients' care needs, and nurses staffing a 24-hour call line were provided with access to electronic records and care protocols to help route patients to appropriate sites of care (Marshfield)
Care management of patients with complex, costly needs	Health resilience specialists engage, mentor, and help meet medical and nonmedical needs of at-risk patients in a grant-funded, proof-of-concept program (Health Share)
	An integrated referral process is used to ensure that patients in need of case management services (e.g., for heart failure, diabetes, cancer) receive them from the most appropriate partner in the ACO, thus avoiding duplication of services (Hill-Dignity-Blue Shield)
	Virtual care teams made up of pharmacists, social workers, and case managers help primary care physicians manage the clinical and psychosocial needs of primary care patients with chronic conditions; physicians are deployed to Sacramento-area skilled nursing facilities to monitor patients and intervene when necessary to avoid admissions (Hill-Dignity-Blue Shield)
	Nurses embedded in primary care sites coordinate care and provide individualized care management to patients at risk of hospitalization; nurses receive electronic alerts when patients visit an ED or are hospitalized or discharged; patients with some chronic conditions are referred to specialized care management programs (Marshfield)
Patient/family engagement and activation	A community advisory council is tasked with performing a community health assessment and developing a health improvement plan to guide care transformation (Health Share)
	A patient activation measure is used to assess patients' self-management capacities and determine appropriate support levels to achieve treatment goals (Marshfield)
Integrated data and analytics	Medical group monitors physician performance and provides coaching when there are signs of unnecessary use of services or inappropriate specialty referral patterns; high-cost patients in need of care management are identified using professional, pharmacy, and hospital claims data (Hill Physicians Medical Group)
	Risk stratification data from Medicare are combined with in-house data (on billed charges, numbers of specialists seen, medications prescribed, gender, and age) to predict patients in need of care management (Marshfield)

Note: ACO = accountable care organization; ED = emergency department.  
Source: Authors' analysis.

***Integrated data and analytics.*** Every site had developed capabilities to identify patients who could benefit from more intensive care management, and several had systems to alert physicians or care managers when patients use or transition from the hospital. For example, through its partnership with Dignity Health in the Sacramento ACO, the Hill Physicians Medical Group has been able to combine professional and hospital claims data to more accurately identify and intervene with patients at risk of hospital admission. Marshfield Clinic has developed customized systems to study outcomes, identify variations and best practices in care, and report performance to physicians—a capability its leaders consider key to its success. All stressed the importance of achieving what is possible with available data and resources and noted that even when data are not yet electronically integrated, sharing timely information (e.g., daily hospital census) across ACO partners can provide insights to improve care coordination.

**Supportive payment models and financial incentives.** Capitation provides the greatest flexibility for creating a global budget to make strategic investments or to engage providers in novel ways. Yet, it is perhaps easier and more feasible to layer a shared-savings or shared-risk model on top of existing reimbursement arrangements, at least initially (Exhibit 3).

**Exhibit 3. ACO Payment Models and Results**

Payment model	Results
<p>Health Share receives a global per-capita budget from the Oregon Health Authority (i.e., the state’s Medicaid agency), which it apportions to risk-accepting entities (RAEs) that in turn pay contracted providers on a capitated or fee-for-service basis. The state withholds 2 percent of Health Share’s overall budget, with payment contingent on the organization and its RAEs meeting cost and quality targets. Future increases in per-capita payments to Health Share will be reduced by 1 percentage point in the first year and a cumulative 2 percentage points the second year.</p>	<p>Health Share has mapped an ambitious plan to improve care and outcomes for Medicaid beneficiaries through the alignment of physical, capital, and human resources, with the expectation that its efforts will reduce avoidable hospitalizations and emergency department (ED) use and produce savings of \$32.5 million in the first three years. In 2013, its first full year of operations, Health Share earned 100 percent of its performance incentive pool for meeting benchmark or improvement targets set by the state on 12 of 16 measures, such as an 18 percent reduction in ED visits, and for enrolling more than 80 percent of its members in primary care medical homes.</p>
<p>Hill Physicians Medical Group and its partners in the Sacramento ACO–Dignity Health and Blue Shield of California–set a target of reducing spending by \$15.5 million in the ACO’s first year to bring premiums for Blue Shield’s HMO product in line with or below those of its competitor Kaiser Permanente. Risk and savings are shared among the medical group, hospital system, and the health plan, proportional to each partner’s ability to bear risk and influence spending.</p>	<p>The Sacramento ACO reduced spending by \$20 million its first year, of which nearly \$5 million in savings was shared among the three partners. Cost savings reflected reduced unit cost of services as well as reduced use of services, including a 15-percent reduction in 30-day readmissions; a 15-percent reduction in inpatient days per 1,000 members; and a 13 percent decline in the average length of a hospital stay for ACO patients. In total, the three-year pilot ACO reduced Blue Shield premiums for CalPERS beneficiaries by \$59 million, or \$480 per member per year.</p>
<p>Marshfield Clinic opted to participate in the Medicare Shared Savings Program’s one-sided risk model,* which permits the organization to share in up to 50 percent of the savings it produces for Medicare, provided it meets or exceeds a minimum savings rate and prescribed quality performance standards. Savings payments are capped at 10 percent of total benchmark expenditures each year.</p>	<p>During the five-year Medicare Physician Group Practice Demonstration, a forerunner of the Medicare Shared Savings Program, the clinic saved Medicare \$118 million, of which it earned \$56 million in shared savings for meeting quality and financial targets. (Results for the first year of the clinic’s participation in the Medicare Shared Savings Program are not yet available.) The clinic reports reductions in hospitalization and readmission rates among patients engaged in its heart failure management program.</p>

Note: ACO = accountable care organization; CalPERS = California Public Employees’ Retirement System; HMO = health maintenance organization.  
 \* Under one-sided risk-sharing, an ACO receives bonus payments for achieving quality and cost targets but no direct penalty for not doing so. Under two-sided (upside and downside) risk-sharing, an ACO earns savings for achieving cost and quality targets and faces a financial penalty for failing to do so.  
 Source: Authors’ analysis.

## RESULTS

While it is too early to tell whether Health Share's bold experiment will prove successful in the Portland area, the Hill–Dignity–Blue Shield ACO and the Marshfield Clinic have established a record of savings (Exhibit 3) that suggests the potential of the accountable care approach in two different contexts. Results for the Hill–Dignity–Blue Shield commercial ACO may be indicative of the kinds of savings that can be achieved when purchasers and marketplaces give consumers incentives to choose among competing value-based networks of providers.

In the Medicare arena, Marshfield Clinic was much more successful in reaping savings than other participants in the PGP demonstration, the forerunner to the Medicare Shared Savings Program. Many contemporary ACOs are expanding strategies for cost containment to include making better use of postacute care, which was not a significant source of savings in the PGP demonstration.<sup>12</sup> Such efforts take time to bear fruit. Hence, early results from the Medicare Shared Savings Program may not be indicative of the full potential of the model.<sup>13</sup>

## INSIGHTS AND LESSONS LEARNED

Across the three study sites, gaining buy-in from providers and building systems for performance reporting and feedback appear essential for fostering an environment of accountability. Each of these organizations also had prior experience with managed care or shared-savings arrangements and, as a result, had developed internally managed reporting systems and feedback mechanisms that have been accepted by providers as a credible way of identifying opportunities for improvement. The organizations also were working toward explicit cost-reduction targets, whether set by federal or state governments or self-imposed based on market conditions. These targets helped them identify and prioritize programs that could lead to reductions in costs or improvements in quality.

Marshfield Clinic benefitted from its dominant position and existing close working relationships with hospitals in its local, rural markets. As the sole sponsor of its ACO, the clinic did not share savings with hospitals, nor was it at risk for lost revenue from reductions in inpatient stays. This obviated the need for the trust-building exercises that were essential to Health Share and the Hill–Dignity–Blue Shield ACO, which sought to transform competitive relationships among partners. Doing so required time, patience, and perseverance. Moreover, the commercial ACO partners found that joint success required a shared willingness to reveal not only how each partner makes and loses money, but also how they underperform. The ACO's success also occurred in a mature managed care market with a dominant purchaser (CalPERS) that structured its benefit offerings to encourage cost-consciousness in its beneficiaries when they chose among competing health plan offerings. In effect, price-sensitive consumers and the market competition they fostered led the ACO partners to realize mutual benefit by acting together like a virtually integrated delivery system.

The ACOs also faced challenges. Chief among these was the difficulty of changing patient and provider behavior. The sites that have produced early results had an infrastructure for robust data analytics to monitor performance and identify opportunities for improvement. The Marshfield Clinic had an enterprise-level integrated health information system—including telehealth capability—that connected its geographically dispersed ambulatory care sites and physicians. None of the sites had access to a functional regional health information exchange. This capability would likely have accelerated ACO development efforts among partners in Health Share and the Hill–Dignity–Blue Shield ACOs, which improvised in sharing information.



The method Medicare uses to determine whether ACOs qualify for shared savings presents another challenge for ACOs that need to invest in staff and technology to manage care. Some of the ACO's expenses (e.g., for case managers who oversee the care of patients with chronic and complex conditions) may recur each year, while Medicare's savings expectations will increase over time to ensure total spending for ACO patients continues to decrease relative to fee-for-service spending. In Marshfield Clinic's case, the benchmark savings target for its ACO reflected in part the reduced spending levels the clinic had previously achieved in the Physician Group Practice Demonstration, which made it more challenging for the clinic to finance intensified care management programs that could benefit all its patients. The clinic's experience offers a cautionary lesson about the challenges Medicare ACOs may face when Medicare resets their shared savings benchmarks at the end of their initial participation in the program.<sup>14</sup> From a policy perspective, the Shared Savings Model may be only a halfway point on the road to more durable and comprehensive risk-sharing arrangements.

The leaders of the ACOs stress the importance of the following:

- Developing a portfolio of initiatives that take aim at several challenging problems (e.g., care coordination, patient engagement) because discrete quality improvement programs will not achieve the returns needed to qualify for shared savings or other payment incentives.
- Creating a system to ensure decisions made by the leaders of partner organizations and their staff are operating in lockstep. For Health Share, this meant establishing a medical directors' group that met regularly to discuss how they were carrying out the organization's mission.
- Carefully considering each organization's willingness, readiness, and competency (including physician leadership capability) before engaging in an ACO or partnering with other organizations in an ACO relationship.

To promote successful engagement in accountable care arrangements among provider organizations that are less experienced than these case study sites, it will be important to continue to research how ACOs of many kinds are performing under a variety of circumstances. As these case studies suggest, some approaches are likely to require refinement and adaptation to address the challenges facing organizations and providers in diverse geographic markets that differ in spending levels, savings potential, and capacity for the partnerships necessary to achieve savings and quality goals. However, the progress that the case study sites have made to date suggests that payment and delivery system reforms are producing the will and accountability necessary to transform care and that these efforts are worthy of continued investment.

## Appendix. Summaries of the Case Studies

**Health Share of Oregon** is a nonprofit founded in 2012 by four competing health plans, three county-run mental health agencies, and several health care provider organizations to improve the care of Medicaid beneficiaries in a tricity region encompassing Portland. As one of 16 coordinated care organizations designated by the state to oversee and integrate the delivery of medical, dental, and mental health care for a geographically defined population, Health Share receives a global budget, which it distributes in per-capita payments to risk-accepting entities (RAEs). Each RAE determines how it will meet collective cost and quality goals. Through their participation in the governance of Health Share, the RAEs collaborate in adopting common practices for improving care for high-need, high-cost patients; achieving efficiencies by centralizing certain administrative functions; and creating accountability for performance. Health Share also facilitates partnerships of providers, community-based organizations, and social service agencies working to help high-needs patients achieve better health.

**Hill Physicians Medical Group**—Northern California's largest independent practice association (IPA)—joined local hospitals and commercial health plans in forming four separate accountable care organizations (ACOs) aimed at improving quality, reducing fragmentation, and lowering the cost of care as a means of retaining business. This profile focuses on the first and largest ACO, which was established in January 2010 to reduce premiums for 41,000 public sector employees and retirees covered by the California Public Employees' Retirement System (CalPERS). The ACO has decreased hospital use and per-member per-month spending in its first three years, resulting in \$59 million in savings to CalPERS or \$480 per member per year. Leaders credit success to developing a mutual understanding of one another's strengths and challenges, which was a prerequisite for improving care coordination, increasing patient education, and reducing unwarranted variations in care.

**Marshfield Clinic**, a nonprofit multispecialty group practice in central Wisconsin, joined Medicare's Shared Savings Program in 2013, following its success in Medicare's Physician Group Practice demonstration—the program's forerunner. The clinic's Medicare ACO benefits from the organization's past investment in advanced primary care infrastructure and disease-specific care management capabilities, which have yielded reductions in hospitalization and readmission rates. The clinic has an advanced, internally developed electronic health record system and enterprise data warehouse, which allow internal performance reporting and identification of best practices that have galvanized physician support for quality improvement efforts. Marshfield Clinic's track record of achieving cost savings and quality targets set by Medicare suggests the importance of combining mission-driven performance improvement initiatives with a commitment to mutual accountability among providers in group practice.



## NOTES

- <sup>1</sup> E. S. Fisher, D. O. Staiger, J. P. Bynum et al., “Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” *Health Affairs*, Jan./Feb. 2007 26(1):w44–w57.
- <sup>2</sup> C. H. Colla, D. E. Wennberg, E. Meara et al., “Spending Differences Associated with the Medicare Physician Group Practice Demonstration,” *Journal of American Medical Association*, Sept. 12, 2012, 308(10):1015–23.
- <sup>3</sup> S. Silow-Carroll, J. N. Edwards, and D. Rodin, *Aligning Incentives in Medicaid: How Colorado, Minnesota, and Colorado Are Reforming Care Delivery and Payment to Improve Health and Lower Costs* (New York: The Commonwealth Fund, March 2013); and S. L. Kocot, C. Dang-Vu, R. White et al., “Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities,” *Population Health Management*, 2013 16(Suppl. 1):S4–S11.
- <sup>4</sup> A. D. Van Citters, B. K. Larson, K. L. Carluzzo et al., *Four Health Care Organizations’ Efforts to Improve Patient Care and Reduce Costs* (New York: The Commonwealth Fund, Jan. 2012); S. Silow-Carroll, and J. N. Edwards, *Early Adopters of the Accountable Care Model: A Field Report on Improvements in Health Care Delivery* (New York: The Commonwealth Fund, March 2013); and J. F. Damore, S. D. DeVore, R. W. Champion et al., *The Many Journeys to Accountable Care: 4 Case Studies* (Charlotte, N.C.: Premier Research Institute, Aug. 2013).
- <sup>5</sup> The research team conducted a qualitative cross-case analysis of interview transcripts and secondary documents using case-ordered displays to identify commonalities and differences between study sites; see: M. B. Miles and A. M. Huberman, “Cross-Case Displays: Exploring and Describing,” Chapter 7 in: *Qualitative Data Analysis*, 2nd Ed. (Thousand Oaks, Calif.: Sage Publications, 1994).
- <sup>6</sup> A. Shih, K. Davis, S. C. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (New York: The Commonwealth Fund, Aug. 2008).
- <sup>7</sup> T. Emswiler and L. Nichols, *Hill Physicians Medical Group: Independent Physicians Working to Improve Quality and Reduce Costs* (New York: The Commonwealth Fund, March 2009).
- <sup>8</sup> D. McCarthy, K. Mueller, and S. Klein, *Marshfield Clinic: Health Information Technology Paves the Way for Population Health Management* (New York: The Commonwealth Fund, Aug. 2009).
- <sup>9</sup> S. Klein and D. McCarthy, *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner* (New York: The Commonwealth Fund, July 2010).
- <sup>10</sup> Findings are organized in accordance with an evolving framework for population health management developed by John W. Whittington, M.D., and the Institute for Healthcare Improvement in collaboration with health care organizations working toward the Triple Aim; see: Institute for Healthcare Improvement, Triple Aim for Populations, <http://www.ihl.org/explore/tripleaim/pages/default.aspx>.
- <sup>11</sup> Institute for Healthcare Improvement, Triple Aim for Populations, <http://www.ihl.org/explore/tripleaim/pages/default.aspx>.
- <sup>12</sup> RTI International, *Evaluation of the Medicare Physician Group Practice Demonstration: Final Report* (Baltimore, Md.: U.S. Centers for Medicare and Medicaid Services, Sept. 2012), <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/PhysicianGroupPracticeFinalReport.pdf>.
- <sup>13</sup> Centers for Medicare and Medicaid Services, “Press release: Medicare’s delivery system reform initiatives achieve significant savings and quality improvements,” Jan. 30, 2014.
- <sup>14</sup> The Medicare Shared Savings Program (MSSP) uses a complex method to set a benchmark for determining whether an ACO has achieved savings. In general, the benchmark is what Medicare would have paid assuming historical spending for patients that would have been attributed to the ACO over the prior three years before joining the MSSP increased at the national rate of growth in Medicare spending. If an ACO continues in the MSSP beyond the initial contract period, its savings benchmark will be reset to reflect the level of spending at the end of the contract period. Hence, savings will not automatically recur, even though care management expenses to sustain those savings may continue. See: Centers for Medicare and Medicaid Services, *Medicare Shared Savings Program Shared Savings and Losses and Assignment Methodology Specifications*, Version 2, April 2013.

## ABOUT THE AUTHORS

**Douglas McCarthy, M.B.A.**, directed this project as senior research adviser at the Institute for Healthcare Improvement from 2011 to 2013. He currently serves as senior research director for The Commonwealth Fund, where he oversees the Fund's Scorecard project, conducts case-study research on delivery system reforms and breakthrough opportunities, and serves as a contributing editor to the Fund's bimonthly newsletter *Quality Matters*. His 30-year career has spanned research, policy, operations, and consulting roles for government, corporate, academic, nonprofit, and philanthropic organizations. He has authored and coauthored reports and peer-reviewed articles on a range of health care-related topics, including more than 50 case studies of high-performing organizations and initiatives. Mr. McCarthy received his bachelor's degree with honors from Yale College and a master's degree in health care management from the University of Connecticut. During 1996–1997, he was a public policy fellow at the Hubert H. Humphrey School of Public Affairs at the University of Minnesota.

**Sarah Klein** is an independent journalist in Chicago. She has written about health care for more than 10 years as a reporter for publications including *Crain's Chicago Business* and *American Medical News*. She serves as editor of *Quality Matters*, a bimonthly newsletter published by The Commonwealth Fund. Ms. Klein received a B.A. from Washington University and attended the Graduate School of Journalism at the University of California, Berkeley.

**Alexander (Sandy) Cohen, M.P.H., M.S.W.**, a research associate at the Institute for Healthcare Improvement (IHI), supports qualitative research of high-performing local and regional health systems, as well as the design and rollout of a formative evaluation system applied to a range of IHI quality improvement projects. For more than five years he has engaged in a diverse spectrum of health services research and practice across academic, nonprofit, and community-based settings, specializing in mental and behavioral health services, care management systems, and health care reform. Mr. Cohen received master's degrees in clinical social work and public health, concentrating in health policy and management, from Boston University.

## ACKNOWLEDGMENTS

The case studies were developed as part of a grant from The Commonwealth Fund to the Institute for Healthcare Improvement (IHI). The authors gratefully acknowledge the following individuals who kindly provided information for the case studies:

**Health Share of Oregon:** Janet L. Meyer, chief executive officer; David Labby, M.D., chief medical officer; Alyssa Craigie, M.P.A., associate director, Health Commons. At CareOregon: Patrick Curran, chief executive officer; and Rebecca Ramsay, B.S.N., M.P.H., director of community care. At Legacy Medical Group, Primary Care Division: Melinda Muller, M.D., clinical vice president; Jon Hersen, vice president of care transformation; Prasanna Krishnasamy, M.D., medical home medical director; and Jackie Ross, medical home program manager.

**Hill Physicians Medical Group:** Darryl Cardoza, chief executive officer; Rosaleen Derington, chief medical services officer; David Joyner, chief operating officer; and Dan Robinson, chief administrative officer, Hill Physicians. At Blue Shield of California: Kristen Miranda, vice president of strategic partnerships and innovation.

**Marshfield Clinic:** Kori Krueger, M.D., medical director, Institute of Quality, Innovation, and Patient Safety; and Marilyn A. Follen, R.N., M.S.N., administrator, Institute for Quality, Innovation, and Patient Safety.

The authors also thank staff at The Commonwealth Fund and the Institute for Healthcare Improvement for advice on and assistance with case study preparation, in particular John W. Whittington, M.D., lead faculty for the Triple Aim initiative at IHI; Trissa Torres, M.D., senior vice president at IHI; and Anne-Marie Audet, M.D., vice president, Health Care Delivery System Reform and Breakthrough Opportunities at The Commonwealth Fund. We also thank The Commonwealth Fund communications team for support in reviewing and publishing the report.

*The views presented here are those of the authors and not necessarily those of the Institute for Healthcare Improvement or The Commonwealth Fund or their directors, officers, or staff. The case studies were based on publicly available information and self-reported data provided by the case study institutions. The Commonwealth Fund is not an accreditor of health care organizations or systems, and the inclusion of an institution in the Fund's case study series is not an endorsement by the Fund for receipt of health care from the institution.*

---

*Editorial support was provided by Deborah Lorber.*

The aim of Commonwealth Fund-sponsored case studies of this type is to identify institutions that have achieved results indicating high performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance. The studies are intended to enable other institutions to draw lessons from the studied institutions' experience that will be helpful in their own efforts to become high performers. It is important to note, however, that even the best-performing organizations may fall short in some areas; doing well in one dimension of quality does not necessarily mean that the same level of quality will be achieved in other dimensions. Similarly, performance may vary from one year to the next. Thus, it is critical to adopt systematic approaches for improving quality and preventing harm to patients and staff.



The  
COMMONWEALTH  
FUND

[www.commonwealthfund.org](http://www.commonwealthfund.org)