Accountable Care Organizations
Testing Their Impact

SUMMARY

Accountable Care Organizations: Testing Their Impact is a national effort funded by the Robert Wood Johnson Foundation (RWJF) to study the impact of accountable care organizations (ACOs) on the delivery of health care services.

An ACO is an organized network of health care providers—that can include primary care physicians, specialists, hospitals, and other providers—that coordinates care for a group of patients (defined by geography or insurance coverage, such as Medicaid, Medicare, or private insurance) and is paid based on how well it meets cost and quality goals. The organizational structures and payment mechanisms developed to hold providers accountable for the care they provide as part of an ACO differ significantly. But they share a common goal: “The outcomes of ACOs are meant to address quality and disparities in the health care system,” says Claire Gibbons, PhD, an RWJF senior program officer in Research-Evaluation-and-Learning who managed the program at its inception.

RWJF selected four research teams via competitive solicitation to produce case studies on ACOs serving either the private health insurance market or Medicaid. Two research teams studied ACOs nationally, one research team focused on Medicaid ACOs [or coordinated care organizations (CCOs)] in Oregon, and one research team focused on ACO-like arrangements in California. Several ACOs that also serve Medicare beneficiaries plus one of the other markets were included in the research.

In 2015, RWJF program officers expect to commission additional papers on predefined ACO topics from subject matter experts. (See The Work Continues section of this report for details.)

Funding

RWJF is providing $3 million in funding for Accountable Care Organizations: Testing Their Impact. The national program started December 1, 2011 and it is scheduled to run through May 31, 2016. RWJF is managing this program internally.


**CONTEXT**

The idea of ACOs “is to couple changes in payment—which is critical, moving away from fee-for-service payments and creating incentives for keeping people well—with organizations that can respond to those kinds of payment incentives. I always talk about the co-evolution. It is the co-evolution in payment reform and delivery-system reform,” says Stephen M. Shortell, PhD, MPH, MBA, a member of the technical advisory committee for the program.¹

While ACOs share many characteristics with health maintenance organizations (HMOs), there are two distinct differences:

- Patients in ACOs are not required to stay within the defined provider network—they can seek care from anyone they wish.
- ACOs must specify measures of quality to document that they are not achieving cost savings at the expense of patient care; to do so ACOs need to be real-time data driven organizations.

When RWJF launched the program, ACOs were just beginning to come into widespread use, with about 100 in operation in late 2011. In the years since, growth has exploded, with the figure climbing to 626 as of May 2014.²

Through its dominant position in the health care sector, the federal Centers for Medicare & Medicaid Services (CMS) has fueled much of this growth through three programs:

- Medicare Shared Savings Program, launched in 2012, allows providers to share in any savings they generate from managing the health care needs of a population of Medicare fee-for-service beneficiaries.
- Advance Payment ACO Model gives physician-owned and rural ACOs access to anticipated savings up front, so they can invest in the infrastructure—such as additional staff and electronic medical records—necessary to improve patient-care coordination.
- Pioneer ACO Model was designed for organizations with previous experience managing the care of a population of patients in an ACO or similar model. Pioneer ACOs share both upside and downside financial risk.³

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¹ Shortell is the Blue Cross of California distinguished professor of health policy and management, director of the Center for Healthcare Organizational and Innovation Research (CHOIR), and dean emeritus of the School of Public Health at University of California, Berkeley, where he is also a professor in the Haas School of Business. He was one of the originators of the ACO concept and a supporter of including funding for demonstration programs in the Affordable Care Act.

With federal programs, explains Gibbons, “there are a lot of rules and those rules are public, so you know what they are doing.”

That is not the case in the private health insurance market. “There isn’t a general overseer,” Gibbons says. In early 2012, when RWJF was developing this ACO research program, “There was a lot going on in the private market, but we really didn’t know what it was. There wasn’t a lot of scholarship around what was happening,” she says.

Adds Andrea Ducas, MPH, RWJF program officer in charge of managing the program since 2013, “CMS was in the middle of trying to bid out contracts to evaluate their ACO programs, so we thought our money could best be leveraged to study ACOs that were developing outside of the Shared Savings and Pioneer programs. Rather than duplicate efforts, we decided to focus our research on ACOs developing in the private sector and in Medicaid.”

**RWJF’s Other Work on ACOs**

One of the grantees in RWJF’s program, *Developing Payment-Reform Strategies for High-Value Care*, the Vermont Green Mountain Care Board, is facilitating the formation of ACOs, including a federally qualified health center (FQHC) ACO. Another of the grantees in that program, UPMC for You, is piloting a purchasing innovation for medically-complex children under Medicaid managed care in Pittsburgh, which they are using to understand the viability of a pediatric ACO. In addition, RWJF is supporting a multimillion dollar grant to the Center for Health Care Strategies Supporting Organization for promoting awareness and understanding of and best practices for implementing trauma-informed approaches to care; it includes pilot sites and one of them is a Medicaid ACO in Newark, N.J.

In addition, a number of grantees in RWJF’s program *Aligning Forces for Quality* (AF4Q) are in markets with substantial ACO activities.

**RWJF’s Pursuit of a Culture of Health**

Funding qualitative research on ACOs fits with RWJF’s goal of building a Culture of Health in the United States, which RWJF President and Chief Executive Officer Risa

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3 Upside risk focuses on uncertain positive returns rather than negative returns. For this reason, upside risk is not a “risk” at all in the sense of a possibility of adverse outcomes. Downside risk is the financial risk associated with losses. That is, it is the risk of the actual return being below the expected return, or the uncertainty about the magnitude of that difference. Shared Savings ACOs require a migration from upside-only financial risk to upside and downside risk over time.

4 ID# 69912 ($417,600, May 15, 2012 to May 14, 2015)

5 ID# 69913 ($440,567, May 15, 2012 to May 14, 2015)

6 ID# 72319 ($4,098,131, December 15, 2014 to June 14, 2018)
Lavizzo-Mourey, MD, MBA, describes as, “enabling all of our diverse society to lead healthy lives, now and for generations to come.”

ACOs have the potential to contribute to “moving us toward that Culture of Health vision” because they are “designed to reduce waste, reduce duplication, increase care coordination, and align incentives within health care systems—in turn making care better and more affordable” says Ducas.

If ACOs provide high quality and efficient health care services, they will certainly improve the overall health of large groups of patients. But ideally, the benefits would extend to the entire community—if ACOs reach outside their patient caseloads and collaborate with local nonprofit and government entities to address social issues that influence health, such as housing, poverty, or living in unsafe neighborhoods—they have the potential to improve their bottom lines while addressing health in a more holistic way Ducas says.

“We view the ability to be able to do research and learning in this area as a way to spur progress, or at the very least, promote our understanding of where some of the most innovative examples and opportunities are and shine a light on them,” she adds.

For more information on the Culture of Health, read the RWJF president’s 2014 message on the topic.

**THE PROGRAM**

Four research teams conducted case studies to learn more about how ACOs were evolving in the private insurance and Medicaid markets, the challenges they were facing, and the strategies they used to address them. (See Appendix 1 for project list.)

"This program was pulled together to understand the impact of ACOs on the general insurance marketplace—on costs, on patient access to care, and to make sure that ACOs were also considering the needs of vulnerable populations.”—Barbara Leonard, MPH, Technical Advisory Committee member

Initially, RWJF had expected to fund quantitative studies of ACOs to measure their early impact. An 11-member technical advisory committee—including researchers, federal government officials, and representatives from other health care foundations and

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Leonard is also vice president for programs at the Maine Health Access Foundation in Augusta.
consumer groups—met in the spring of 2012 to discuss the parameters of the program and craft a call for proposals. (For a list of committee members, see Appendix 2.)

Committee members were unanimous in their opinion that a quantitative research approach would not work. “They said, ‘The field is way too young for that. These ACOs are just trying to figure out how they are going to get off the ground. They don’t have the data you are looking for. What we need is a really good understanding of how they are developing, what their market contexts are like, and what their decisions have been,’” recalls Ducas. “We really took that to heart and adapted our approach.”

Based on the committee’s recommendations, RWJF shifted mostly to a qualitative approach, funding the four, two-year projects. Each research group plans to conduct two rounds of site visits, including key-informant and provider interviews, to develop in-depth case studies. Some of them also plan to host focus groups with patients and caregivers. They completed the first round of site visits between March 2013 and March 2014; the second round of visits are scheduled to occur between March 2014 and March 2015.

### Four Research Teams

The projects, and their research teams, are as follows:

- **Accountable Care Organizations: Measuring Their Impact.** The study is looking at four ACOs to understand how they were developed, implemented, and structured, and how their performance is evaluated. The sample includes ACOs that vary by area of specialty (such as a pediatric population); whether they involve a hospital system or a primary care group practice; and population served (e.g., vulnerable populations or the broader community).

  The research has been conducted primarily at the Ohio State University College of Medicine, and the first round of information gathering included 82 interviews and five focus groups with 52 patients and caregivers.8

- **Learning from Emerging Safety-Net Accountable Care Organizations.** The study goal is to learn from three early leaders who adapted the ACO model to Medicaid/safety-net populations in California, Massachusetts, and Minnesota. JSI Research & Training Institute, based in Boston, and Bailit Health Purchasing, in Needham, Mass., conducted 40 interviews with internal stakeholders and state health policy officials during the first round of information gathering.9

- **Community-Based Payment Reform: Can Oregon’s Medicaid ACOs Deliver?** This study is looking at coordinated care organizations, which assume full risk for

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8 Grant ID #70677 ($400,000, March 15, 2013 through March 14, 2015). One of the researchers moved to the University of North Carolina and continues to work on the project.

9 Grant ID #70676 ($399,996, March 15, 2013 through March 14, 2013)
physical, behavioral, and dental health services for a group of Medicaid patients through a global budget. CMS granted Oregon’s Medicaid program a demonstration waiver to develop the coordinated care organizations. In exchange for a $1.9 million federal investment over five years, the state pledged to save the federal government $11 billion over 10 years. If it fails to do so, it will return the funds.

The study, which looked at two coordinated care organizations and included some 150 interviews in the first round of information gathering, is being conducted by the Center for Outcomes Research and Education (CORE), part of Providence Health & Services in Portland, Ore. The team has interviewed state policymakers, health care delivery system leaders, providers, community leaders, and consumers.

Accountable Care Organizations: Testing Their Impact—Preliminary Results. Because California has a highly developed managed care market, this study combined a case-study approach with quantitative research. Conducted by Integrated Healthcare Association, based in Oakland, Calif., researchers tapped into data on 35,000 physicians in nearly 200 group practices that were part of five major provider networks in the state. Researchers are measuring structure and strategy, payment arrangements, and performance over time.

See Appendix 3 for a list of the ACOs studied by the four research teams.

FINDINGS TO DATE

The four research teams presented preliminary findings from their projects, based on the first round of site visits, at AcademyHealth’s Annual Research Meeting in San Diego in June 2014. More information on these presentations is available online.

The grantees gave similar presentations on November 12, 2014 at the National Accountable Care Congress meeting in Los Angeles. They will continue their research through mid-March 2015.

Preliminary Findings From the Four Teams

As summarized in the presentation abstracts and other research material, the major findings from each team’s first round of interviews and site visits, related to the ACOs under study, are as follows:

Accountable Care Organizations: Measuring Their Impact. Ohio State University College of Medicine:

10 Grant ID# 70678 ($390,691, March 15, 2013 through March 14, 2015)
11 Grant ID# 70681 ($389,132, March 15, 2013 through March 14, 2015)
— There is considerable variability across ACOs with respect to size, provider composition, patient population, and contracting arrangements.

— As with the managed care arrangements of the 1990s, ACOs are concerned about managing risk and shortening hospital stays. In contrast to those models, however, they are also focused on engaging physicians and patients. Strategies to do so include:

• Involving physicians in decision-making, providing them with financial incentives, tracking and sharing physicians’ individual performance data, and investing in performance-improvement training programs for physicians. The first step, however, is securing physicians’ support of the ACO model. “The providers have to actually buy into it,” as one study participant told Ohio State researchers. “You can provide reports and have meetings and do everything you want to, but if providers haven’t actually bought into it, it’s an uphill battle.”

• Educating patients about how to manage their health, usually through a care-coordination program, and providing an online portal where patients can access their medical records.

— Although patients are generally unfamiliar with the term “accountable care organization,” they value providers having access to their health records and having a more integrated health care experience.

— Better access to data helps ACOs build confidence in their abilities to manage population health. As one study participant told Ohio State researchers, “We were able to confidently say, ‘Yes, we can accept this rate’ because we knew what the population was going to do over time.”

• Learning from Emerging Safety-Net Accountable Care Organizations. JSI Research & Training Institute and Bailit Health Purchasing:

— While there is considerable diversity in the payment models, key components include flexibility to make strategic investments using capitated payments or shared savings, and limited financial risk.

— There is also diversity in the delivery systems, but all three ACOs studied are building a care-management program to oversee both the medical and behavioral health needs of high-cost patients.

— Safety-net ACOs are developing strategies to address social needs that have an impact on health, such as safe housing, access to transportation and healthy food, and employment opportunities. Two strategies have emerged so far: Use of a screening tool to assess patients’ social and economic needs and coordination with a diverse group of social service agencies, such as housing providers.
Several common implementation challenges have emerged, including:

- Having adequate capital to make the necessary investments to improve delivery systems
- Determining the appropriate staffing model to manage high-cost patients
- Addressing the cultural and ethical challenges of moving from a volume-driven approach to a population-oriented approach that provides additional services to select high-risk patients
- Building data systems for risk stratification and care coordination. This includes coordination within the health system, but also across the medical, behavioral health, and social services sectors.

Community-Based Payment Reform: Can Oregon’s Medicaid ACOs Deliver?

- The health systems, providers, payers, health departments and others that choose to participate in a coordinated care organization do so both for financial reasons and the desire to better serve vulnerable populations. The financial incentive to succeed is based in part on the assumption that Oregon would lower reimbursement rates for providers if the coordinated-care program failed to rein in costs.
- Coordinated care organizations (CCOs), which is what ACOs are called in Oregon, are more likely to implement payment innovation and new models of care in communities where partner organizations have a history of collaborating to serve the Medicaid population.
- While multiple delivery organizations may join forces as a CCO on paper, they may then divvy up global payments from Medicaid and continue to operate as separate organizations. Coordinated care organizations that maintain their existing, independent relationships are less likely to share accountability for services and outcomes.
- Strategies to manage the complex medical, social, and behavioral needs of Medicaid beneficiaries are necessary if an ACO hopes to earn incentive payments. As a result, Oregon’s coordinated care organizations are doing the following:
  - Addressing the social determinants of health, such as the level of education and income, nutrition, neighborhood safety, and access to transportation. “For the safety net population, all of those come into play, and you really need a lot more collaboration between the health care sector and the social services sector,” says Shortell.
  - Integrating, or coordinating, physical and behavioral health care for patients who suffer from both types of illnesses.
• Implementing case management, or care coordination, for patients with complex medical needs—often by hiring community health workers. The ACOs closely track patients to make sure they are following their treatment plans, such as taking all prescribed medications regularly. The goal is to “keep them out of the hospital and out of the emergency room,” Shortell says.

• **Accountable Care Organizations: Testing Their Impact—Preliminary Results.** Integrated Healthcare Association:
  
  — California’s long history in managed care has fueled high interest in ACOs across the state, although contractual arrangements, metrics, and outcomes vary significantly.
  
  — Purchasers, payers, and providers are collaborating on ACO arrangements, with an emphasis on global budgets for specific patient populations and risk sharing.
  
  — The development of ACO arrangements for the safety net and Medicaid populations lags behind those for commercial and Medicare payer populations in California.
  
  — Hospital involvement in ACO arrangements lags behind that of purchasers, payers, and physician organizations. In fact, some California physician-led ACOs included in the case study were not able to develop partnerships with hospitals.
  
  — Physician-led communication with ACO patients is generally more successful than outreach initiated by health plan staff, especially when the primary care provider is the lead. In response, insurers have delegated patient care management to their physician partners.
  
  — Physicians have found it difficult to find the right approach to communicate with patients and engage them in care management, particularly patients in Medicare’s fee-for-service program or commercial preferred provider organizations (PPOs).
  
  — It is difficult to find cost savings in the commercial health insurance arena because the patient population tends to be relatively healthy, so ACOs tightly manage the referrals of their patients to specialists.
  
  — Both HMOs and preferred provider organizations involved in ACO arrangements have implemented bonus programs that emphasize cost savings.

**Common Challenges**

RWJF program officers, technical advisory committee members and principal investigators from the four project teams identified some of the common challenges that ACOs faced in launching and managing their operations:

• **There is no common definition of an ACO.** “ACOs look very different and there is not a clear and unified sense of what an ACO is among different stakeholder groups,”
says Ducas. For example, there can be variations in structure (e.g., one ACO may be a network of disparate providers, and another a single health system); in the cost and quality metrics under scrutiny; or in the amount and type of risk providers undertake.

In addition, “any single health care organization may be in multiple ACO arrangements, which is somewhat confusing, I suspect,” says technical advisory committee member Leonard.

- **Not all ACOs have commitment from top leadership.** Some hospital or health system chief executive officers say, “Okay, we are going to dabble in this ACO stuff. We will have an ACO,”” explains Shortell, but “they don’t give the ACO all of the resources needed to really get it off the ground. They are not sufficiently committed, given other priorities in the larger organization,” Shortell says.

- **Payers may not provide timely feedback.** Feedback from payers tends to come from claims data, which is not available soon enough to be useful in tracking an ACO’s performance on quality and cost metrics.

- **Information technology (IT) is costly.** Electronic medical records are costly to implement, but crucial to an ACO’s ability to monitor the health status of patients in a timely, ongoing manner and to track progress in reaching contractual cost and quality goals. Managing populations, as ACOs are designed to do, requires finding ways to generate and use real-time clinical data. The National Association of ACOs conducted a survey in November 2014 that found the startup costs for ACOs to be about $4 million—with almost 25 percent of that spent on IT tools and vendors. Only one-third of new ACOs who responded to the survey expected to break even after their first year.\(^\text{13}\)

- **Patients are not fully engaged.** “From what we are seeing, most patients don’t know they are in an ACO. If they do know, they don’t really understand what it means,” Ducas says.

In addition to engaging ACO patients as a means of encouraging them to actively manage their health, Leonard says there is a broader advocacy issue as well:

> “How do we ensure that some patients are informed and engaged in the planning of this approach to ensure that patient needs and desires and issues are being appropriately considered? There needs to be a patient voice at the table when plans and decisions are made.”—Barbara Leonard, Technical Advisory Committee member

- **Managing change is difficult.** “This is terribly disruptive [in terms of] how physicians have practiced medicine for centuries. It just takes time to do this,” says

\(^{\text{13}}\) This might be part of the reason why CMS developed the ACO investment model.
Shortell. For example, he says, physicians may be asked to use electronic health-records systems, prepare for patient visits ahead of time, and collaborate with numerous health care professionals, all things they are not used to doing.

- **Learning to work collaboratively takes time and effort.** One example is Health Share of Oregon—a coordinated care organization that includes four payers, three hospital systems, three county health departments, and many community-based organizations. As researchers from the Center for Outcomes Research and Education wrote in a *Health Affairs* blog post, “Describing the early days, one leader said, ‘The first six months was group therapy … there was no way they could even agree on who would get to vote.’”

- **Squeezing out cost-savings requires a defined strategy.** One pediatric ACO, for example, focused on team-based care and enhancing primary care through patient-centered medical homes while another tried to rein in specialist costs by tightening referrals to essentially create a narrow network, Ducas says.

- **It is tricky to track the patients for which an ACO is responsible.** Because their patients do not have to stay within a narrow network for care, it is difficult for ACOs to track their patients’ encounters with out-of-network health care providers.

- **There is a lack of focus on health care disparities.** The providers in safety net ACOs “often view themselves as folks who address disparities by working with safety-net patients every day, but there are not necessarily discussions we’ve seen about trying to identify disparate care within their own systems,” Ducas says. For example, Oregon’s coordinated care organizations have not focused on promoting health equity because it’s not an explicit goal, and they have other priorities, according to researchers from the Center for Outcomes Research and Education.

- **ACOs are generally not delving deeply into public health.** While there are some notable exceptions, particularly among Medicaid ACOs, most ACOs do not appear to be working with other organizations, such as social service agencies or local public health departments, to tackle community-wide problems, such as high rates of hunger or violence.

- **Fee-for-service patients do not get the same intensive care coordination available to patients enrolled in ACOs.** ACOs “have a specific set of patients that get these enhanced services,” Ducas says, and notes that what services are provided are a function of how big a percentage of a provider’s population is in the ACO.

An example comes from Paula Song, PhD: an ACO built a fence around a house of an enrolled family whose members were high utilizers of the emergency department to keep the children safe. The ACO suggested that the capitated payment arrangement

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for this population enabled them to justify this investment, something that would not be feasible under a free-for-service arrangement.

LESSONS LEARNED TO DATE

1. **Recruit people from myriad professional backgrounds to serve on a technical advisory committee—even for a research project.** “Typically, for research-focused projects, you look for people who are researchers,” explains RWJF’s Gibbons. But for its ACO program, RWJF also included providers and consumer advocates. Gibbons believes that input from a variety of perspectives led to a stronger call for proposals and better funded projects.

   “Not everybody has to have a PhD to bring value,” Gibbons says.

2. **To encourage research teams to stick to the project timeline and share information, schedule status calls with all grantees together.** “We touch base together as a group via videoconference every three months—instead of relying on individual funder/grantee conversations,” says Ducas. During the calls, Ducas asks team members to update everyone on their insights and also publication plans.

3. **Write blog posts to link multiple journal articles from a research program.** Using a blog post to discuss common themes can bring “more visibility and a cogent narrative” to a research program in which there are multiple journal articles published over a span of time, says Ducas, who says she plans to ask technical advisory committee members to author such blog posts toward the end of the program.

4. **Use common questions to compare findings across numerous case studies on a single topic.** After the research teams presented their initial findings at a technical advisory committee meeting in the spring of 2014, “One of the things we did is suggest that across the grantees, why not ask some standardized questions, so you can make some comparisons across your studies?” says technical advisory committee member Shortell. “That was not done from the beginning; everybody went their own way.” That was not an initial requirement of the funding opportunity.

THE WORK CONTINUES

The four research groups plan to complete a second round of site visits and interviews before their grants end in March 2015, drawing on a common set of core questions. The researchers collaborated on developing the common question set through a series of conference calls and email exchanges. (See Appendix 4 for a list of these questions.) Findings from the research on these questions will be shared with the technical advisory committee before the study comes to a close.

The researchers also plan to publish their findings in a variety of outlets. The teams “feel accountable for further dissemination, and have made plans to highlight learnings from their specific organizations under study,” explains K. Bruce Bayley, PhD, regional
director of the Center for Outcomes Research and Education at the Providence Health & Services in Portland, Ore., one of the grantees.

In the next phase of ACOs: Testing Their Impact, which begins in the spring of 2015, RWJF has decided not to fund a second round of competitive awards, but instead to commission papers on predefined topics from subject matter experts. “That was an intentional decision because of how much is changing in the market,” Ducas says. “We are trying to be flexible about our grantmaking in this area, so that we are putting out quality information and quality products that are as relevant and attuned to needs of the field as possible. But we are also balancing that with the need to get information out quickly and for that reason we are not necessarily relying on the fund-study-publish model.”

Among the papers RWJF expects to commission:

- The continuum of ACO contractual arrangements and how those impact various stakeholders, such as consumers, hospitals, physicians, and purchasers
- Barriers and facilitators to innovative consumer engagement strategies
- Strategies to address public health in the larger community—rather than only among patients in a given ACO—through collaborations with social service and other community-based agencies

Ultimately, Shortell suggested, ACOs could evolve into mechanisms for improving population outcomes, what he refers to as “accountable communities for health.” But this is not likely to happen, he says, without financial incentives tied to improvements in health outcomes for an entire community. For this model to work, he says, a community coalition, or integrator, would need to coordinate the efforts of not only the health care organizations but also the transportation, education, housing, and business sectors.

“There would be a global budget for doing that,” Shortell says. “The medical system ACO gets some of those savings, but only if they work with the other sectors.”
**APPENDIX 1**

**Project List**

**Integrated Healthcare Association (Oakland, Calif.)**
Accountable care organizations: testing their impact—preliminary results
ID# 70681 (March 15, 2013–March 14, 2015) $389,132

  **Project Director**
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**JSI Research & Training Institute (Boston, Mass.)**
Learning from emerging safety-net accountable care organizations
ID# 70676 (March 15, 2013–March 14, 2015) $399,996

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**Ohio State University College of Medicine (Columbus, Ohio)**
Accountable care organizations: measuring their impact
ID# 70676 (March 15, 2013–March 14, 2015) $400,000

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Center for Outcomes Research and Education (CORE), part of Providence Portland Medical Center (Portland, Ore.)

Community-based payment reform: can Oregon’s Medicaid ACOs deliver?

ID# 70677 (March 15, 2013–March 14, 2015) $390,691

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**APPENDIX 2**

**Members of the Technical Advisory Committee**

*(Current as of the end date of the program; provided by the program’s management; not verified by RWJF.)*

**Timothy Cuerdon, PhD**  
Director  
Division of Research on Payment and Accountability  
Center for Medicare & Medicaid Innovation  
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**Irene Fraser, PhD**  
Director  
Center for Delivery, Organization, and Markets  
Agency for Healthcare Research and Quality  
Rockville, Md.

**Suzanne Frances Delbanco, PhD**  
Executive Director  
Catalyst for Payment Reform  
Berkeley, Calif.

**Paul B. Ginsburg, PhD**  
Founder  
Center for Studying Health System Change  
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**Elliott S. Fisher, MD, MPH**  
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**Steven T. Hester, MD, MBA**  
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Chief Medical Officer  
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**Barbara A. Leonard, MPH**  
Vice President  
Programs  
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Augusta, Maine

**Michael Miller, MPP**  
Director  
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Community Catalyst  
Boston, Mass.

**Hoangmai Huu Pham, MD**  
Director  
Seamless Care Models Group  
Center for Medicare & Medicaid Innovation  
Centers for Medicare & Medicaid Services  
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**Brian Rosman, JD**  
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Health Care for All  
Boston, Mass.

**Stephen M. Shortell, PhD, MPH, MBA**  
Professor  
Health Policy and Management  
Dean Emeritus  
School of Public Health  
University of California, Berkeley  
Berkeley, Calif.

**APPENDIX 3**

**ACOs Studied by the Four Research Teams**

Thirteen ACOs were included in the analyses conducted by the four research teams:

- **Accountable Care Organizations: Managed Care with a New Name?** Ohio State University College of Medicine, Columbus, Ohio:
  
  — New West Physicians, a physician-owned primary care practice based in Denver, Colo., with 91 physicians and 17 locations
  
  — Advocate Health Care, a health system based in Downers Grove, Ill., with 12 hospitals and a multispecialty physician group practice
  
  — Partners for Kids, a physician-hospital organization in Columbus, Ohio, which manages patient care through contracts with health plans and is sponsored by Nationwide Children’s Hospital
  
  — Children’s Mercy Pediatric Care Network, a network of hospitals and physicians in Kansas City, Mo., that coordinates care for patients in managed care organizations and is owned by Children’s Mercy Hospital

- **Learning from Emerging Safety-Net Accountable Care Organizations.** JSI Research & Training Institute (Boston) and Bailit Health Purchasing, Needham, Mass.:
  
  — Hennepin Health, Minneapolis, Minn. The county-run ACO includes: Hennepin County Medical Center, Hennepin County Human Services and Public Health, the
county-owned Metropolitan Health Plan, and NorthPoint Health and Wellness Center, a federally qualified health center.

— AltaMed, which operates in Los Angeles and Orange Counties, is California’s largest federally qualified health center and also operates a large independent practice association of physicians. Partners in AltaMed’s ACO include: Citrus Valley Health Partners, Hollywood Presbyterian Medical Center, LAC +USC Healthcare Network, and White Memorial Medical Center.

— Baystate Health, Springfield, Mass., a health system that includes hospitals, physician practices, laboratories, and other services, as well as a teaching relationship with Tufts University School of Medicine.

• Community-Based Payment Reform: Can Oregon’s Medicaid ACOs Deliver? Center for Outcomes Research and Education (Portland, Ore.):

— Health Share of Oregon, Portland, Ore., which is a community-based coordinated care organization. The partners—including multiple health systems, Medicaid health plans, and county health departments—created Health Share to contract with the state and manage the budget.

— PacificSource Community Solutions, a nonprofit Medicaid health plan, which operates a coordinated care organization in central Oregon. While PacificSource is the entity accepting financial risk, it has only one vote on the Central Oregon Health Council, a multistakeholder body that governs the coordinated care organization and includes a health system, physicians, consumers, county health departments and community health clinics.

• Accountable Care Organizations: Testing Their Impact—Preliminary Results. Integrated Healthcare Association (Oakland, Calif.):

— AltaMed, California’s largest federally qualified health center, as noted above

— Brown & Toland Physicians, a network of more than 1,500 physicians in the San Francisco Bay Area

— HealthCare Partners, a physician group and network of independent physicians that oversees the care of patients in managed care organizations, or HMOs

— Monarch HealthCare, a network of more than 2,500 private-practice physicians in Orange County

— St. Joseph Heritage Medical Group, a multispecialty physician group in Orange County
APPENDIX 4

Common Questions for Second Round of Interviews

The four research teams participated in a conference call to develop a list of common questions. Based on their comments, K. Bruce Bayley, PhD, regional director of Providence Health & Services in Portland, Ore., developed and circulated a list of questions for review and revision. The researchers ultimately agreed on the following list:

1. What are the three to five key outcome or performance metrics that the ACO is tracking?

2. What do you consider to be the core components of your accountable-care strategy, such as medical homes, narrow networks, or care coordination? Probe or follow-up question: What is your ACO doing to reduce the total per capita costs of care?

3. What are the three top implementation challenges that your ACO has experienced (in the areas of care delivery implementation & payment)?

4. What key actions (about three) are you taking for patient engagement?

5. What is your ACO doing to address disparities?
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