Study examines cost-savings of physician group practice program

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In an analysis of the cost-savings achieved by an earlier pilot program, the Medicare Physician Group Practice Demonstration (PGPD), researchers found modest estimates of overall savings associated with the PGPD, but larger savings among the dually eligible patients (Medicare and Medicaid), with savings achieved in large part through reductions in hospitalizations, according to a study in the September 12 issue of *JAMA*.

"To improve care and slow cost growth, payers are increasingly turning to new payment models, including accountable care organizations (ACOs). The Centers for Medicare & Medicaid Services (CMS) has launched 3 ACO programs—Pioneer, the Shared Savings Program, and the Advance Payment Model—which differ slightly in their details but share a common approach: participating organizations can share in savings if they meet quality and cost targets for their assigned beneficiaries. Accountable care organizations were included in the Affordable Care Act in part because simulations suggested that CMS could achieve savings from these models, and an earlier program, the Physician Group Practice Demonstration, appeared to be effective," according to background information in the article.

In the PGPD program, participating physician groups were eligible for up to 80 percent of any savings they generated if they were also able to demonstrate improvement on 32 quality measures, including the adequacy of preventive care and the effectiveness of chronic disease management. "Although evidence indicates the PGPD improved quality,

uncertainty remains about its effect on costs," the authors write.

Carrie H. Colla, Ph.D., of the Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, Lebanon, N.H., and colleagues conducted a study to estimate the cost savings achieved by the PGPD program for all beneficiaries and for both dually and nondually eligible beneficiaries. The analyses compared pre-intervention (2001-2004) and post-intervention (2005-2009) trends in spending of PGPD participants to local control groups. The study included 10 physician groups from across the United States. The intervention group was composed of fee-for-service Medicare beneficiaries (n = 990,177) receiving care primarily from the physicians in the participating medical groups. Controls were Medicare beneficiaries (n = 7,514,453) from the same regions who received care largely from non-PGPD physicians. Overall, 15 percent of beneficiaries were dually eligible for Medicare and Medicaid. The primary outcome measure for the study was annual spending per Medicare fee-for-service beneficiary.

For all enrollees, the reduction in growth of spending for nondually eligible beneficiaries was modest. After adjustment, annual savings estimates per beneficiary were modest ($114), with this result reflecting the average of significant annual savings in the dually eligible beneficiaries ($532) and nonsignificant savings in the nondually eligible beneficiaries ($59, $166 in savings to $47 in additional spending).

The adjusted average spending reductions were concentrated in acute care (overall, $118; dually eligible: $381; nondually eligible: $85). Further analysis revealed that in sites where savings occurred for acute care, hospitalization rates declined during the PGPD.

The PGPD was associated with lower medical 30-day readmissions on average across the 10 sites and lower readmissions for both medical and

surgical admissions in the dually eligible beneficiaries. There was significant variation in savings across practice groups, ranging from an overall mean per-capita annual saving of $866 to an increase in expenditures of $749.

"The variation both in levels and changes in risk-adjusted spending across the participating organizations was remarkable. We know little about why some succeeded and others failed to achieve savings. One hypothesis is that organizations beginning with higher spending levels have greater opportunities to achieve savings," the authors write. "Other factors may have contributed to achieving higher levels of performance in some sites, such as governance models; internal leadership; physician engagement strategies; the degree of coherence of electronic health records and other health information technological tools; and the specific approaches adopted for chronic disease management, care transitions, and quality improvement."

"Our results suggest that the ACO reforms included in the Affordable Care Act, such as the Pioneer and the Medicare Shared Savings Programs, have at least the potential to slow spending growth, particularly for costly patients. The remarkable degree of heterogeneity across participating sites underscores the importance of timely evaluation of current payment reforms and a better understanding of the institutional factors that lead to either success or failure in effecting changes in health care practices."

In an accompanying editorial, Donald M. Berwick, M.D., M.P.P., former president and CEO of the Institute for Healthcare Improvement and former Administrator of the Centers for Medicare & Medicaid Services, examines the question of what this new analysis adds to predictions about the promise of ACOs.

"First, the results for dually eligible beneficiaries are important and

encouraging. Most of the 9.2 million people in that Medicare subgroup receive poor, uncoordinated care in the status quo, and they account for over $300 billion in annual costs and 40 percent of state Medicaid expenditures. Improvements of cost and quality for them can have big payoffs. Second, the Dartmouth group documented a small overall savings for the entire beneficiary population and, were this to be multiplied over the whole of Medicare, the total would be about $5 billion per year, that is, about 1 percent of the budget. Third, the substantial variation of results among PGPD sites offers hope for continual learning about best practices, and therefore, maybe, better results in more places over time. Fourth, the evidence of what the authors gently call 'coding biases' in PGPD sites serves notice once again that surveillance by CMS and objective evaluators is necessary and prudent. Neither patients nor the nation are well served when administrative manipulations masquerade as changes in care. What is needed is better care, not better coding."

More information:

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