Introduction

The challenges facing the American health care system are clear. Tens of millions of people have difficulty paying for health care because they are uninsured or underinsured. The introduction of health insurance subsidies in 2014 under the Affordable Care Act (ACA) should substantially mitigate this issue. However, the challenge of access will remain formidable due to the choice of many states, including Florida, not to expand Medicaid eligibility. There are numerous opportunities to improve health care quality and, by extension, people’s overall health. Also, many agree that the upward trend of health care costs is unsustainable. The United States spends approximately 80 percent more per person on health care than Norway, the second country in this category. This is driven, in large part, by a fee-for-service payment structure, provider consolidation and medical technology.

Calming the storm

The Patient-Centered Medical Home (PCMH) and Accountable Care Organization (ACO) concepts have been prominently presented as potential solutions to mitigate the ills of the health care system. The ACA has brought much attention to these models; however, their genesis and the interest of the private sector pre-date the ACA. This is especially true for the PCMH. While there are overlapping elements between these two concepts, they have distinct and complementary

Braving the tempest; changing our path

While there is broad agreement regarding the problems, the hard part is identifying and implementing discrete, adequate solutions. This is difficult for two reasons. First, the challenges facing health care in this country are entangled, complex and require comprehensive solutions. For example, it is clear that more money is not the answer to better quality. Improved quality requires a combination of coordinated efforts among all providers, utilizing technology and treatment methods appropriately, and educated and involved patients and families. Many of these issues depend on people having financial and actual access to health care. This in turn is directly related to the cost of health care that manifests itself in the form of insurance premiums, out of pocket costs to consumers and additional tax dollars dedicated to health care programs.

Second, health care issues are politically sensitive and emotionally charged. Health care policy impacts public and individual finances, individual rights ranging from access to health care, to privacy, to debates over states’ versus federal realms of power. Last, but not least, health care is eventually, and literally, a life or death issue for nearly everyone.

KEY TAKEAWAYS

1. PCMHs are rooted in primary care and the chronic care model and are strongly based on evidence. The model incorporates elements that address many of the significant drivers of high health care costs and suboptimal quality.

2. ACOs serve as catalysts for the proliferation of PCMH principles throughout the health care system. The ACO model utilizes legal and financial arrangements designed to respond to incentives that encourage activities that support the PCMH concept.

3. Although there are many questions about how these models should be implemented, PCMHs and ACOs have taken hold in the public and private sectors and have shown promise.

4. We are in the learning stages of discovering the potential of PCMHs and ACOs. Public policy must encourage broad participation and a variety of approaches to these models. Robust research and evaluation is needed to identify best practices of translating evidence into practice; organizational adaptation to change; financial and legal structures; and balancing the need for providers to take on risk while protecting consumers.

5. Research and evaluation must be coordinated and build upon efforts to identify core metrics for useful comparisons to inform future implementation efforts.
roles. Essentially, the PCMH model captures the best thinking of the role of patients, providers and payers in the delivery of high quality health care. An ACO is an ecosystem that pervasively enables and catalyzes the principles of PCMHs.

Patient Centered Medical Homes: broad support and comprehensive solutions. Is it enough?

The PCMH concept has evolved over the past five decades and is firmly rooted in the culture of primary care. In 1967 the American Academy of Pediatrics (AAP) introduced the “medical home” concept to describe the coordination role of primary care pediatric practices for the chronically ill and later expanded the definition to refer to “primary care that is accessible, continuous, comprehensive, coordinated, family-centered and culturally effective.” This definition positions primary care physicians as leaders and coordinators of all of the care received by the patient. During the following three decades the World Health Organization, the Institute of Medicine, the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) embraced these elements and began to promote public policy in support of them. In 1996 Dr. Ed Wagner introduced the chronic care model which emphasized team-based care, patient self-management support and use of health information technology (HIT) to support evidence-based care. These principles were incorporated into the medical home concept.

The PCMH model contains multiple elements that are designed to address commonly identified challenges facing the health care system. Although there is some disagreement on the degree, many researchers acknowledge that there is unexplained variation in health care spending. That is, higher spending cannot be supported by medical need or evidence-based medicine. Research has shown that quality is worse in higher spending regions from the perspective of providers and patients. In 2006, a widely cited article reported that Americans receive evidence-based medicine 55 percent of the time. This means where research dictates that providers should do B if A happens, B happens slightly more than half of the time. Nationally, measurable medical errors that harm patients cost an estimated $17.1 billion annually. Finally, Americans do not demonstrate healthy behaviors. For example approximately one-third of children and two-thirds of adults in America are overweight or obese. These numbers are slightly higher in Florida. The elements of PCMH listed in the paragraph above along with an emphasis on patient participation and connection to community resources provides support for addressing these issues.

The PCMH concept has broad support. In March of 2007, the AAFP, the AAP, the ACP and the American Osteopathic Association created the Joint Principles of the Patient Centered Medical Home (Joint PCMH Principles). The Patient-Centered Primary Care Collaborative (PCPCC -- which included national employers and physician groups), health plans, consumer groups, labor unions and other stakeholders played a critical role in initiating the creation of the Joint PCMH Principles. The Joint PCMH Principles were adopted by the ACA and serve as the definition of PCMHs in the law. Furthermore, these principles led to the development of NCQA PCMH 2011 Standards. While other accreditation bodies have PCMH programs, the National Committee for Quality Assurance (NCQA) is an early leader.

For all of its qualities, the PCMH model is not a panacea for several reasons. First, implementation of the PCMH model requires funding. The acquisition and maintenance of HIT and the implementation of processes to support team-based care, population management, enhanced access and continuous quality improvement efforts requires significant financial investment. Second, the PCMH model would require significant workflow redesign and organizational culture changes. In addition to paying for the elements above, buy-in is required to effectively implement them along with establishing relationships with relevant community resources to enable effective patient-centered care. Third, there must be a high level of cooperation among practices to fully realize the intended impact of the PCMH. Thus, the culture change must be within and among practices.

Accountable Care Organizations: the “how” that delivers the “what”

ACOs serve as the legal and financial infrastructure to incentivize improved quality and a more efficient health care system. Policy experts describe ACOs as the “medical neighborhood” that facilitates the transition of accountability among providers. The model has its roots in previous concepts such as HMOs, pay-for-performance and other approaches to improve the cost-effectiveness of care. They are responsible for a defined population. However the ACO concept, formalized by Dr. Elliott Fisher in 2006, provides more flexibility regarding structure, payment and assumption of risk.

The other end of a shared continuum

PCMHs and ACOs share several elements. According to the literature, desired elements of ACOs include complete and timely information about patients; population management and care coordination among providers; patient education and self-management
The literature also reveals that the ACO model primarily focuses on organizational and systemic transformation through governance and financial arrangements. These elements include the ability to manage financial risk; a commitment by the organization’s leadership to improving value as a top priority; a system of operational accountability to drive improved performance; the ability to effectively allocate and optimize a workforce to improve quality efficiently; and the ability to effectively negotiate and align with others within the health care system supply chain. This requires a free flow of information among the providers, payers and members facilitated by a robust and highly functional HIT system. Furthermore, creating value for patients requires a holistic approach, different from incentives promoted by most fee-for-service payment models. For instance in order for a ACO to be successful a Hospital may have to provide less services, thus having less direct business.

The payment model under which an ACO operates dictates the level of risk it assumes. The Academy of Actuaries identifies five payment models: “one-sided” shared savings, “two-sided” shared savings, bundled/episode payments, partial capitation/global payments and global payments. These models are listed in order of ascending levels of risk allocated to the ACO and are explained in the appendix. The shared savings models are built on a fee-for-service platform. Thus, while there may be some potential variation in revenue, and a possibility of it having to refund money, the risk the ACO assumes is less compared to the other models. The bundled and partial capitated payment models shift more risk to the ACO, but there are limitations based on either incidence of risk or which services are paid on a fee-for-service basis versus capitation. Under the global payment model the ACO assumes full risk and is responsible for incidence and severity of their illness and how efficiently it can address that illness while meeting quality standards.

It is critical to understand how risk allocation to ACOs impacts the quality and cost of care as well as the overall health care delivery market. Transitioning payment models that allocate more risk to ACOs encourages greater focus on quality outcomes and efficiency. This transition must be purposeful and strategic. Assessing and managing risk is a highly specialized skill, and it is, expectedly, one not typically within the wheelhouse of health care providers. Although obtaining greater value for the care delivered will require providers to engage payment models that allocate more risk to them, this transition must take into account the capacity of provider organizations to manage risk and the impact to the overall market. If an ACO suffers financially, this could result in the elimination or reduction in quality of care delivered to patients. Furthermore, larger organizations are better positioned to assess and manage risk, creating a potential advantage. If not monitored properly, this transition could cause a concentration of economic power in the market that could result in higher prices for consumers without a corresponding increase in quality.

The neighbors are restless … among others

Although major stakeholders of the health care system support the general principles of ACOs, there are some differences among physicians, hospitals and payers. The AMA believes that ACOs must be physician-led. It also supports flexibility in patient referral and antitrust laws to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospital or the ACO. Hospitals have expressed concerns about overcoming physician attitudes favoring autonomy and individual accountability over coordination. Policy experts also have concerns about the horizontal and vertical integration sparked by the Medicare Shared Savings program under the ACA. The fear is that it could result in the aggregation of excessive market power, especially in smaller markets. This would lead to reduced competition and higher health care costs.

There are a number of unanswered questions regarding the implementation of ACOs. These issues are associated with payment, risk and operations. Payment and risk issues include the entrenchment of the current fee-for-service model; the ability of provider-led organizations to assess and assume risk; the ability to assess the risk of populations assigned to ACOs; and how to assign populations to ACOs. As providers bear more risk, there needs to be some consideration about how the financial health of these organizations will be monitored without overburdening them. With respect to population assignment, it is important to adjust for disease severity among populations to ensure that ACOs are not assuming risk for which they are not compensated. A complicating factor is that patients may obtain care outside of the ACO to which they are assigned, potentially limiting the impact of ACOs on the outcomes of its patients. This model also assumes significant patient engagement. Techniques must be identified to maximize the participation of patients and their families.

1 See appendix for more detailed explanation of payment models.
Operational issues include the cultural transition from patient care based on office visits to maintaining the health of a population; transitions to value-based payment models that allocate more risk to ACOs; and the lack of IT capabilities and administrative infrastructure to become a robust ACO. This is especially true among smaller practices that may have fewer resources to implement structural change.

A public and private affair
There are numerous public sector efforts regarding PCMHs and ACOs. The Federal PCMH Collaborative is a collection of seven federal agencies with initiatives related to PCMH to identify opportunities for collaboration, learn from one another and minimize duplication. According to the National Academy for State Health Policy, 43 states have adopted policies and programs to advance PCMHs. The Community Care of North Carolina, a program that links Medicaid and CHIP enrollees to community-based primary care medical homes, reportedly saved $1 billion over a four year period. Federal ACO programs, particularly the Medicare Shared Savings Program created by the ACA, have garnered a lot of attention. This program was implemented in 2012, and it includes a one-sided or two-sided shared savings reimbursement model, at the option of the ACO. Other federal ACO initiatives include the Pioneer ACO program, which includes six variations of financial incentive designs and the Advance Payment ACO program that provides upfront funding to poorly capitalized organizations to then start an ACO. As of January 2013 more than 250 ACOs cover more than four million Medicare beneficiaries. There are several private sector PCMH and ACO efforts. As of August 2012, 80 organizations were identified as having an ACO contract had only private-payer contracts or both public and private payer contracts. Blue Shield of California rolled out an ACO pilot with 40,000 members of the California Public Employee Retirement System (CalPERS), which saved an estimated $15 million and intends to expand the pilot to other markets. Blue Cross Blue Shield of Massachusetts rolled out the “Alternative Quality Contract,” which includes a global budget with annual spending growth limits; incentive payments to improve quality based on previously agreed upon measures; and technical support for participating groups and five year contracts with providers. The Brookings-Dartmouth Partnership is providing technical assistance to five pilot ACO sites and will monitor and study results of the pilots to make recommendations on further development of the ACO model. The state of Vermont, national health plans and other Blue plans have implemented or are preparing to implement ACOs.

Florida Blue has demonstrated leadership in the effort to implement PCMHs and ACOs. Approximately 30 percent of Florida Blue’s medical spend is through value based models, including PCMHs and ACOs. With over 2,200 primary care physicians and 240 participating groups, Florida Blue has one of the largest PCMH programs in the nation. Florida Blue also has eight ACO agreements with more in the pipeline. Under Florida Blue’s PCMH program, physicians have performed the same or better than non-participating peers in all of the 29 clinical quality metrics. Emergency room visits have dropped by 12 percent, and overall Florida Blue has seen a cost reduction better than four percent during the first year of implementation.

The value of evaluation
Evaluation is crucial to the ability of PCMHs and ACOs to deliver better quality care that is more efficient. These models are designed to promote and implement concepts that have been identified as solutions to the root causes of quality and cost issues. As we move forward, sound and coordinated research efforts will be essential to maximizing the potential of these concepts.

Although there are more data on PCMHs than ACOs, research conducted to-date indicates both of these models are promising and provide direction for improvement. First, the PCMH model is built on evidence-based methods to provide better primary care and chronic care. Second, several PCMH programs, including Florida Blue’s, have produced outcomes indicating improved quality, cost savings, and successful care coordination efforts among high-risk/high-need patients. Third, ACOs have been successful in engaging physicians and moving the needle in forming agreements linking payment to quality measures and efficiency. Research has also identified clear opportunities for improvement – such as engaging patients in quality improvement efforts, improving quality and reducing unnecessary utilization of care among low-risk patients, patient and provider education, and useful data sharing between payers and providers.

There is much more to learn. As we continue to utilize these models it is essential to understand systemic, organizational and stakeholder dynamics. The following list is exemplary, not exhaustive. Systemic issues include how the requirements of public programs interact with private multi-payer programs; the potential impact of these models on the quality of, and access to, care regarding vulnerable populations; and the impact of the contextual environment in which PCMHs and ACOs operate (e.g. population health status, economics, culture, politics
and health care infrastructure). Organizational issues include desired leadership characteristics needed for organizational adaptation to change; feasible financing models; allocation of financial and non-financial resources; workflow; and the flexibility needed in PCMH models to address diverse populations and settings. Stakeholder dynamics include relationship building within and among organizations and with community representatives; patient and family engagement; and continuous education among all stakeholders regarding best practices and their roles in the implementation and operation of these models. Finally, we must continue to build on current efforts to standardize evaluation measures among PCMHs and ACOs to maximize the usefulness of future research.

Informing the journey

Two things are clear. First, although some fee-for-service models allow for quality improvement and cost management, we must explore the inclusion of other payment models that provide stronger incentives for alignment among payers, providers and patients as well as better quality and more efficiency. Second, PCMHs and ACOs offer functional and, to a significant extent, politically viable solutions. These models are not silver bullets, and there are many questions to answer. However, the implementation of these concepts has begun to pervade the health care system in the public and private sectors. These efforts must continue with the purpose of continuous improvement toward the goals of consistently improving the quality of health care for all populations and making health care more affordable.

Moving forward, it is important to encourage broad participation and a broad variety of structures of PCMHs and ACOs in the public and private sectors. This will allow for the identification of best practices overall and within differing social and economic environments. The public and private sectors should also share information and learn from one another. This requires robust research and evaluation. Resources should be allocated for these purposes in the public sector and the private sector should be encouraged to participate in research efforts through financial incentives (e.g. tax credits) to dedicate resources to the collection and analysis of data with reputable research organizations. There also should be coordination between the two sectors regarding implementation, especially around performance measures and payment incentives.

Future efforts must build upon the strong foundation within the PCMH model. The primary care and chronic care models are the foundation of the PCMH concept, and they are backed by strong evidence. As the evidence-based-medicine body of work continues to evolve, PCMHs and ACOs must continue to explore the best way to translate that evidence into practice within organizations and throughout the whole system. How should resources be allocated to use people, technology and other resources to continuously integrate the latest evidence to deliver quality care? And how should organizations coordinate with one another to do it system-wide? Furthermore, research efforts should build off of current efforts to standardize performance metrics of PCMHs and ACOs to enable meaningful comparison.

Evaluation of ACOs must move beyond focus on formation to their impact on changing incentives to drive improved quality and efficiency. Specifically, it is important to understand the relationship between the risk presented by various payment models and the ability to improve the quality and efficiency of care. In addition to adapting to providing patient-centered, team-based care, providers will need to migrate towards reimbursement models that transfer risk to them to create the proper incentives. However, this must be done strategically to balance the need to move away from the entrenched fee-for-service model while not moving too fast and putting providers in peril who would otherwise survive under a more gradual, yet purposeful, migration. Also, it is essential to identify providers that are important to maintaining competition and who deliver services to vulnerable populations, but may have fewer resources than others to effectively adapt to the changing environment. These organizations may require assistance to begin their migration. The impact on vulnerable populations, such as low income or high risk/high need populations must be monitored. These incentives must be structured such that providers who address these populations are not penalized because of the needs or constraints of their patients. Finally, as more ACOs take on more risk, regulation must balance the need to protect consumers with the need to minimize burdens that would discourage experimentation and participation or would be too onerous to allow them to thrive.

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## Appendix

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<th>Payment Model</th>
<th>Characteristics</th>
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| “One-sided” shared savings           | • Fee-for-service arrangement  
• ACO receives a bonus if it meets quality of care standards at lower than projected costs.  
• ACO assumes no risk for exceeding projected costs. |
| “Two-sided” shared savings           | • Fee-for-service arrangement  
• ACO receives a bonus if it meets quality of care standards at lower than projected costs.  
• ACO assumes financial risk if projected costs are exceeded. |
| Bundled/Episode Payments             | • ACO receives a single payment for all services a patient requires for an entire episode of care.  
• ACO assumes risk for the severity risk (i.e. the amount and cost of care required to treat an illness or injury).  
• ACO does not assume risk for the incidence risk (i.e. whether an individual suffers and illness or injury) |
| Partial Capitation/Global Payments   | • ACO receives capitated payments for certain categories of services (e.g. specialty care could be paid on a capitated basis while primary care is paid on a fee-for-service basis)  
• ACO assumes risk for only the services paid on a capitated basis. |
| Global Payments                      | • The ACO receives a pre-determined payment for each patient based on a set of criteria.  
• The ACO assumes severity and incidence risk. |

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