



Quality Health Care Delivered Effectively and Efficiently

The Affordable Care Act Supports Cost-Containment Initiatives Now Across Our Country

Nicole Cafarella | April 2011

Introduction

Key provisions in the Affordable Care Act promise improvements in the quality of our nation's health care at lower costs. This promise will take time, yet actually operating right now across America, hidden in plain sight, are initiatives in the private sector and state Medicaid programs that will change the way health care is delivered. The Affordable Care Act not only builds upon these efforts but also will significantly reinforce them.

Family doctors from North Carolina to California run primary care practices that are examples of the so-called “patient-centered medical homes” that the new health law encourages doctors to establish so patients can benefit from having one health care provider responsible for coordinating their care. Many of these medical homes date back to 1967 when the American Academy of Pediatrics first laid out standards for the earliest version of pediatric medical homes.¹

Similarly, state governments alongside private insurers and health care providers are exploring new ways of paying health care providers who would hold groups of providers jointly responsible for cost and quality in exchange for the opportunity to share in potential savings—like the accountable care organizations the Affordable Care Act encourages for Medicare patients. This is the kind of experience the new health law's Center for Medicare and Medicaid Innovation will draw upon across the medical landscape to promote payment changes to encourage better quality care at lower costs.

To be sure, the new health law envisions it will take time and experimentation for these new ways for doctors and hospitals, clinics and medical specialists to coordinate care to take hold in earnest. Uncertainty about the future in large part explains why the Congressional Budget Office chose not to “score” (attribute cost savings to) these new medical practices in its analysis of the fiscal cost of the Affordable Care Act. But success-

ful replications of these initiatives, when fully implemented in Medicare and Medicaid and outside of the federal government, have the potential to double CBO’s estimated savings of the law over 10 years from \$416 billion to \$822 billion.²

In this issue brief we will examine some of the existing operations that already for some Americans improve the quality and slow the cost growth of their health care. In the pages that follow, we will detail the existing and future benefits of:

- Patient-centered medical homes—primary care medical practices that act as hubs for coordinating patient care among multiple providers and provide comprehensive and accessible care to their patients
- Accountable care organizations—groups of health care providers that are held jointly accountable for quality and that share in savings for treating their patients at a lower cost
- The Center for Medicare and Medicaid Innovation, which will test, evaluate, and expand new and existing payment and health care delivery practices that are shown to reduce costs while maintaining or improving care quality.

What may not be well understood is that the Affordable Care Act’s cost-containment strategies were set in motion long before the passage of the Affordable Care Act—through activities that extend well beyond the Medicare program and that developed absent a national health reform law. The Affordable Care Act makes Medicare a partner in innovations already underway across the U.S. health care system—in the private sector and among state governments.

By making Medicare a participant in and supporter of these efforts, the Affordable Care Act presents an opportunity to align federal programs with efforts across the private sector and state governments—advancing cost-containment initiatives that result in the improved quality of care far beyond their current scope and breadth.

Patient-centered medical homes

The concept of patient-centered medical homes has existed for decades. In 1967 the American Academy of Pediatrics defined the medical home concept as a “central location for archiving a child’s medical record.” In 2002 it expanded the definition to include “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.” Since 2002 other physician societies, including the American Academy of Family Physicians and the American College of Physicians, have developed alternative definitions of the medical home concept.³

In 2007 these physician societies and the American Osteopathic Association announced their “Joint Principles of the Patient-Centered Medical Home,” which consolidated existing sets of medical home principles adopted by each society.⁴ The physician societies defined the medical home practice as “an approach to providing comprehensive primary care for children, youth and adults [in] a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.”⁵

A year later, the National Council for Quality Assurance developed a Practice Recognition Program for patient-centered medical homes that is endorsed by all four physician societies. What’s more, the National Council for Quality Assurance’s recognition program is used by Medicare and other health care payers such as insurance companies and state Medicaid agencies.⁶

Private-sector medical homes

In many states the private sector is providing the leadership role in developing patient-centered medical homes—both with and without state involvement—since the 2007 publication of the “Joint Principles of the Patient-Centered Medical Home” by the four leading physician societies. And many private insurance companies and other health care payers are leading or participating in medical home pilots across the United States.

CareFirst BlueCross BlueShield, for example, developed a voluntary medical home program for its members in and around Washington, D.C. In this program a registered nurse care coordinator, under the guidance of the primary care physician, is responsible for ongoing care coordination and leads a care coordination team comprised of nutritionists, health educators, physical therapists, pharmacists, mental health professionals, and other medical professionals. The primary care physician participating in the program receives a 12 percent fee increase, additional payments for developing a care plan when needed, and incentive payments tied to quality and efficiency.⁷

Similarly, Capital District Physicians’ Health Plan is actively promoting medical homes in New York. Capital District Physicians’ Health Plan created a primary care pilot program designed to help primary care practices transition to medical homes. Practices participating in the pilot are also paid using a type of risk-adjusted capitation model—meaning a practice receives a fixed payment for the care delivered over a specific time period and the size of the payment is adjusted for each patient’s illness—but are made whole if a patient’s costs are higher than expected.

To help with practices’ transition to medical homes, the health plan connected primary care practices to TransforMED—a nonprofit created by the National Academy of Family Physicians. Three primary care practices participated in this New York pilot in its first year. Since then, the pilot has expanded to include 21 practices.⁸

In another example of private-sector leadership in developing medical homes, the Geisinger Health System in Pennsylvania operates a medical home initiative that provides 24-hour access to primary and specialty care services for 2.5 million patients who are, on average, poorer, older, and sicker than patients nationally.⁹ These medical homes provide nurse-care coordinators, care-management support, and home-based monitoring. Geisinger attracts physicians to the initiative by paying each physician a monthly amount of \$1,800 in addition to stipends of \$5,000 per 1,000 Medicare patients for the salaries of the additional staff needed in a medical home. Physicians are eligible to share in savings from treating patients at lower-than-expected costs, as long as certain quality metrics are met.¹⁰

And these are not the only examples of a medical home pilot with at least one private payer participant. There is an array of multistakeholder pilots initiated in the last few years, with states participating in some of these pilots while others operate solely in the private sector (see Table 1).

Public-sector medical homes

The National Academy of State Health Policy, which tracks state progress in advancing medical homes for Medicaid and state participants in the federal Children’s Health Insurance Program, recently identified 12 states participating in multipayer medical home initiatives—Colorado, Iowa, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Pennsylvania, Rhode Island, Vermont, and West Virginia—half of which are now also participating a new multipayer Medicare patient-centered medical home demonstration project.¹¹ The National Academy of State Health Policy also has identified 39 states in which:

- A state medical home program was implemented or significantly expanded or improved in 2006 or later
- A state Medicaid or Children’s Health Insurance Program agency is participating in a medical home initiative, though not necessarily in a leadership role
- A state “explicitly [intends] to advance medical homes for Medicaid or CHIP participants”
- There is “evidence of commitment, such as workgroups, legislation, executive orders, or dedicated staff”¹²

Medicare also is becoming involved in state patient-centered medical home projects. At the urging of five New England governors, for example, U.S. Secretary of Health and Human Services Kathleen Sebelius announced in September 2009 the launch of the Multi-payer Advanced Primary Care Demonstration, which will permit Medicare to partner with Medicaid and private insurers in state-based medical home initiatives.¹³

TABLE 1

Affordable, quality care already in action

Forty patient-centered medical homes now in operation around our country

Pilot	Number of physicians	State	Target start date
Alabama Health Improvement Initiative—Medical Home Pilot	70	AL	9/1/2009
UnitedHealth Group PCMH Demonstration Program	25	AZ	4/1/2009
Colorado Family Medicine Residency PCMH Project	320	CO	12/1/2008
The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot	51	CO	5/1/2009
Metcare of Florida/Humana Patient-Centered Medical Home	17	FL	11/1/2008
Savannah Primary Care Medical Home Project	184	GA	9/9/2010
WellStar Health System/Humana Patient-Centered Medical Home	12	GA	unknown
CIGNA/Piedmont Physician Group Collaborative Accountable Patient Centered Medical Home	93	GA	6/1/2010
Louisiana Health Care Quality Forum Medical Home Initiative	500	LA	9/1/2007
Greater New Orleans Primary Care Access and Stabilization Grant	324	LA	9/21/2007
Maine Patient-Centered Medical Home Pilot	221	ME	11/1/2009
CIGNA/Eastern Maine Health Systems	30	ME	1/1/2010
National Naval Medical Center Medical Home Program	25	MD	4/1/2008
CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program	84	MD	1/1/2009
Guided Care	49	MD	6/1/2006
Priority Health PCMH Grant Program	108	MI	11/1/2008
Blue Cross Blue Shield of Michigan: Patient Centered Medical Home Program	8147	MI	1/1/2008
Genesys HealthWorks Health Navigator in the Patient Centered Medical Home	unknown	MI	1/1/2008
NH Multi-Stakeholder Medical Home Pilot	63	NH	1/1/2009
CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot	253	NH	6/1/2008
NJ Academy of Family Physicians/Horizon Blue Cross Blue Shield of NJ	165	NJ	3/26/2009
NJ FQHC Medical Home Pilot	17	NJ	2/16/2010
EmblemHealth Medical Home High Value Network Project	159	NY	1/1/2008
Hudson Valley P4P-Medical Home Project	500	NY	1/1/2009
CDPHP Patient-Centered Medical Home Pilot	18	NY	5/22/2008
I-3 PCMH Academic Collaborative	753	NC	4/1/2009
Queen City Physicians/Humana Patient-Centered Medical Home	18	OH	12/1/2008
Improving access to patient-centered primary care in central Ohio	68	OH	12/1/2010
Greater Cincinnati Aligning Forces for Quality Medical Home Pilot	35	OH	9/12/2009
TriHealth Physician Practices/Humana Patient-Centered Medical Home	8	OH	5/1/2009
OU School of Community Medicine--Patient-Centered Medical Home Project	unknown	OK	9/30/2008
Dfcic PCHM pilot	1	OR	5/31/2010
Portland IPA Medical Home Project	21	OR	2/4/2010
Pennsylvania Chronic Care Initiative	780	PA	5/13/2008
Rhode Island Chronic Care Sustainability Initiative	66	RI	10/1/2008
I3 PCMH Academic Collaborative	753	SC	4/1/2009
Medical Clinic of North Texas and CIGNA North Texas Collaborative, Accountable, Coordinated Patient Centered Medical Home Pilot	160	TX	1/1/2010
Texas Medical Home Initiative	30	TX	1/1/2010
Vermont Blueprint Integrated Pilot Program	44	VT	7/1/2008
Washington Patient-Centered Medical Home Collaborative	755	WA	7/1/2009
West Virginia Medical Home Pilot	50	WV	11/1/2009

Source: "Pilots & Demonstrations," available at <http://www.pcpcc.net/pcpcc-pilot-projects> (last accessed February 10, 2011).

Medical homes in the Affordable Care Act

The Affordable Care Act supports and reinforces federal, state, and private activities to pursue patient-centered medical homes. The law creates mechanisms to encourage more widespread adoption of these practices in the public and private sectors, including a Medicaid state plan option to allow beneficiaries with at least two chronic conditions to participate in and a Medicare medical home demonstration to support federally qualified health centers operating as patient-centered medical homes. The Affordable Care Act's new Center for Medicare and Medicaid Innovation bolsters these activities while more aggressively pursuing other medical home options.

Partnering with other offices within the Centers for Medicare and Medicaid Services, or CMS, where the Center for Medicare and Medicaid Innovation resides, the federal government is moving forward with:

- The Medicaid Health Home State Plan Option
- The Federally Qualified Health Center Advanced Primary Care Practice Demonstration
- The Multi-payer Advanced Primary Care Demonstration¹⁴

Let's examine each of these programs briefly in turn.

The Medicaid Health Home State Plan Option

This state plan option will allow Medicaid beneficiaries with at least two chronic conditions, say diabetes and heart disease, or one chronic condition and the risk of developing a second chronic condition, or one chronic condition and a serious mental health condition, to name a single health care provider as his or her medical home (referred to as a "health home" under the state plan option). CMS recently released guidance to states on implementing the state plan option.¹⁵

The Federally Qualified Health Center Advanced Primary Care Practice Demonstration

This Medicare demonstration will give support to Federally Qualified Health Centers that function as patient-centered medical homes and assess their impact on access, quality, and costs. Currently, these health centers provide primary and preventive health care to medically underserved low-income groups of patients and are located in lower-income rural and inner-city communities.¹⁶ The Medicare and Medicaid Innovation Center aims to include up to 500 of these centers in this demonstration.¹⁷

The Multi-payer Advanced Primary Care Demonstration

Announced in 2009, prior to passage of the Affordable Care Act, CMS revealed in late 2010 the eight states selected to participate in the demonstration—Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. Each participating state government will be responsible for conducting and coordinating the project operating in their state. Each project will involve Medicaid and have "sub-

stantial participation” by private payers, will have primary care providers’ support, and will operate in coordination with the participating state’s health promotion and disease prevention efforts. CMS anticipates the demonstration will be completely operational by mid-2011 and will last for three years.¹⁸

Accountable care organizations

Accountable care organizations are a newer concept, going beyond primary care to encourage the full range of health care providers to take responsibility for coordinated and collaborative care of their patients. Encouraged by research supporting the potential for substantial though evolutionary reform of our health care system, CMS in 2005 initiated what became the model for these accountable care organizations—the Physician Group Practice Demonstration, which concluded in 2010. Each of the 10 group practices participating in this demonstration was permitted to share in savings generated from reducing the cost of treating their patients as long as the practice achieved certain quality benchmarks.¹⁹

Since this first Patient Group Practice Demonstration, the definition of the concept has evolved to mean “arrangements among health care providers who collectively agree to accept accountability for the cost and quality of care delivered to a specific set of patients.”²⁰ According to this definition, accountable care organizations must have the capacity to deliver services across the entire continuum of care, with a particular emphasis on primary care; be rewarded based on quality improvement and slower cost growth; and have reliable quality measures.²¹

Private-sector accountable care organizations

Prior to enactment of the Affordable Care Act, private payers began to pioneer experimentation with accountable care organizations. In January 2009 Blue Cross Blue Shield of Massachusetts introduced the Alternative Quality Contract—a new payment arrangement that pays eligible health care provider groups a so-called “global fee” (defined as a set payment to cover all the care delivered to a patient over a fixed time period) tied to quality metrics for furnishing the full range of needed care.²² Two years later, Blue Cross Blue Shield of Illinois signed an accountable care organization commercial contract with Advocate Physician Partners, a joint venture that includes 3,500 physicians and is affiliated with a not-for-profit, faith-based health care system with 10 hospitals.²³

Norton Healthcare (a not-for-profit group of physicians and hospitals) and health insurer Humana Inc. recently announced a similar arrangement in Louisville, KY.²⁴ Norton Healthcare and Humana were selected to participate in one of the five sites of a new accountable care organization pilot jointly operated by the Engelberg Center

for Health Care Reform at the Brookings Institution and The Dartmouth Institute for Health Policy and Clinical Practice. The remaining sites are located in Roanoke, VA; Tucson, AZ; Torrance, CA; and Irvine, CA.²⁵

Some health care providers are not yet ready to commit to these types of contracts with private payers but they are exploring their options. Case in point: Banner Health, a large nonprofit hospital system based in Phoenix, AZ, and operating in seven states, recently announced that it is exploring potential ACO arrangements with private insurers.²⁶ Similarly, Montefiori Medical Center, the university hospital and academic medical center for the Albert Einstein College of Medicine in New York, is engaged in discussions with its insurer EmblemHealth to develop an accountable care organization contract.²⁷ And Charlotte, NC-based Premier Healthcare Alliance, which serves more than 2,500 hospitals and 72,000 other health care sites, has formed two collaboratives for accountable care organizations—one to assist members who are able to pursue this medical practice transformation immediately and another to assist members that need to develop the capabilities necessary for operation as an accountable care organization.²⁸

Public-sector accountable care organizations

Among states, Massachusetts and Vermont stand out as developing the most ambitious set of reforms around accountable care organizations. In 2008 the Vermont legislature charged the Vermont Health Care Reform Commission to explore the feasibility of adding a pilot to their larger push to reform the state's health care system. More recently, the state has worked with public and private stakeholders to create an accountable care organization pilot, whose first site is expected to be operational in 2011.²⁹

Next door, the Massachusetts Special Commission on Health Reform recommended in 2009 that the state implement the accountable care organization model state-wide and incorporate all payers—both public and private.³⁰ Nearly two years later, Massachusetts Gov. Deval Patrick proposed legislation to transition the state's employees, Medicaid beneficiaries, and state residents receiving state-subsidized health insurance coverage to accountable care organization arrangements and encourages private payers to do the same.³¹

Accountable care organizations in the Affordable Care Act

The Affordable Care Act supports and reflects public- and private-sector activity around accountable care organizations. The law creates a voluntary program within the Medicare program where groups of health care providers can band together and share in any savings they are able to generate by reducing the costs of treating their Medicare patients while maintaining or improving quality of care.

In March 2011 CMS released a proposed rule specifying operational details of this new program. In the rule, CMS proposes to allow prospective accountable care organizations to choose one of two payment tracks, based on their capacity and willingness to take on financial risk. Those in the first track will be eligible for a share of the savings generated from treating their Medicare patients below projected spending levels (while maintaining or improving care quality) but would be required to transition to the second track after two years. Accountable care organizations in the second track will be eligible for greater financial rewards than those in the first track but would also be required to repay CMS for a portion of any expenditures above the projected spending target.³²

CMS plans to establish this program by January 2012. Health care providers ranging from an integrated public health care system in Massachusetts to a large nonprofit health system in New Jersey and a 200-physician independent physician practice operating in New York are already positioning themselves to participate in the program.³³

Beyond this new program, CMS plans to test alternative accountable care organization payment methods such as partial capitation—a payment design that would provide accountable care organizations with upfront payments to support their initial transition as well as future investments in quality improvement—through the Center for Medicare and Medicaid Innovation. These initiatives will inform and shape future refinements to CMS’s accountable care organization program. CMS intends to consider adding models tested by its innovation center in future rulemaking.³⁴

Linking public- and private-sector efforts

The Affordable Care Act provides CMS with the capacity to give our nation’s already existing movement toward quality care at lower costs a boost—aligning innovations across the public and private sectors and across federal and state governments. If successfully implemented and aligned with state and private initiatives, CMS innovations spurred by the Affordable Care Act are estimated to generate nearly half a trillion dollars in savings to the federal government alone.

CMS is pursuing this alignment primarily through a new vehicle within CMS—the Center for Medicare and Medicaid Innovation. The new center is reaching out to clinicians, health systems, community leaders, and others for new ideas that provide better care at a lower cost. Innovators can offer ideas to the center through a web submission process, open door forums, and listening sessions. The Center for Medicare and Medicaid Innovation will review each idea and select and refine the most promising models for testing and evaluation in collaboration with state and private payers.

The secretary of health and human services is explicitly authorized to scale up initiatives that prove to be successful without new legislation. Ultimately, then, innovations pioneered by the Centers for Medicare and Medicaid Services—innovations that have been in the making for decades now—have the capacity to become “programs” equivalent to the accountable care organization program established under the statute.

The mandate to experiment and the law’s commitment to pursue successful payment arrangements for the long haul—rather than simply for a relatively short “demonstration period”—boast the potential to move an active but at times slow-paced, research-oriented demonstration process into an aggressive strategy to transform our nation’s health care system so that it continues to provide the best health care available but at prices we can afford as patients and as a nation.

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