Quality issues, including over- and underutilization, patient safety, disparities in care, and geographic variation, continue to compromise our health care system, despite a solid foundation of medical and scientific evidence in many areas on what constitutes best practices. Coupled with the increased cost of medical care, our current financing model pays for each service provided no matter the outcome, resulting in a system that is fragmented and inefficient, focused on discrete provider-patient encounters and variable, episodic care rather than sustained patient-provider relationships that support coordinated, evidence-based, comprehensive patient care.

In March of 2011, the Department of Health and Human Services released The National Quality Strategy, which articulates three aims for the U.S. healthcare system—better care, healthy people/healthy communities, and affordable care. Several provisions of The Affordable Care Act (ACA) have recently resulted in development and implementation of delivery and care reform initiatives to address the three aims including the Medicare Shared Savings Program, Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration project, Comprehensive Advanced Primary Care Initiative, and Bundled Payments for Care Improvement (see Exhibit A for description).

Well before these developments, models in the private sector began emerging to address issues impacting healthcare quality and unsustainable increases in healthcare costs, by strengthening care management, care coordination, and primary care through alternative approaches to health care delivery. These models—patient-centered medical homes (PCMH), accountable care organizations (ACO), and bundled/episode-based payments—contain unique elements such as incentives, the addition of a care management fee, or implantation of shared savings/risk tied to achievement of performance targets.

While these models continue to evolve as new and better methods to address quality and costs are identified, this issue brief highlights the key elements of existing patient-centered medical home, accountable care, and bundled/episode-based models operating in the commercial market today.
Key Models and Early Results: Patient-Centered Medical Home, Accountable Care Organization, and Bundled/Episode-Based Payments

Patient-Centered Medical Home

The patient-centered medical home replaces episodic care with a sustained relationship between patient and physician and involves health plan partnerships with medical groups, organized or virtual, as a “medical home” for patients. The PCMH model addresses patients’ needs (e.g., level of illness or disease and behavioral risk factors) based on sound medical evidence and patient preferences in care decisions, and promotes coordination by clinicians working in close partnership with patients to ensure that care is safe, effective, patient-centered, timely, efficient, and equitable.2

Health plans are participating in PCMH model arrangements with a variety of provider partners. There are currently over 150 medical home partnerships across the U.S. and include commercial, Medicaid, and Medicare Advantage populations. Many of these initiatives are health plan-led while others were developed by local physician groups or multi-stakeholder collaborations. Many health plans that have experienced success with the PCMH model are using this model as the basis for future accountable care arrangements.

Early Results

Under the medical home model, physicians have decreased the rate of high-tech radiology use by 6.3%3; decreased emergency room visits by 6.6%; and shown a 7.0% lower rate of adult ambulatory care sensitive ER visits over non-PCMH participating physicians.

Accountable Care Organization

Accountable care models rely on health plan partnerships with organizations of health care providers who agree to be held accountable for the quality, cost and overall care for a defined population of patients and are eligible to share cost savings if they meet certain quality and cost goals.5

Bundled/Episode-Based Payment

The use of a bundled or episode-based payment model involves reimbursing providers, or a group of providers, based on defined episodes of care, which include associated health care services under a single fee or payment. For example, a bundled or episode payment may be developed for a total knee replacement that could include physician and hospital services pre- and post-operative services, ancillary drugs and laboratory, and any associated complications and resulting treatment. Other types of bundled/episode-based payments include medical oncology care, total hip replacement, coronary artery bypass graft (CABG) surgery, bariatric surgery, and maternity care.

Several health plans have tested the bundled/episode payment model using the Prometheus Payment, a provider payment system that calculates the cost of services and potential risk for complications for a specific condition, and creates a payment for the entire episode. They have also developed bundled/episode models to address their population needs such as select medical cancer care, where projected savings across the model at full maturity could potentially reduce cancer spend by approximately 30%.7

Other types of bundled/episode payments may be structured around acute hospitalizations, post acute hospitalizations, or both. These specific models will be tested by the Centers for Medicare
and Medicaid Innovation’s Bundled Payments for Care Improvement Initiative. The Centers for Medicare and Medicaid Services previously tested the bundled payment model through the Acute Care Episode (ACE) Demonstration Project. 

**Early Results**
Most bundled/episode based payment models are in the early stages of implementation and thus results are limited. Preliminary results showed one ACE pilot achieved a 10% reduction in cost for the average hip/knee replacement episode.

**Role of Health Plans Across Models**
Research has noted that not all providers are equally ready to enter into new payment arrangements with health plans and therefore flexibility and health plan support may be critical to success and sustainability. Health plans typically offer several forms of technical assistance to providers, depending on the ability and readiness of the partnering provider groups, including population health management, disease and case management, health information exchange and data sharing support, and management of financial risk.

For example, health plan assistance with population management may include providing analytic reports to help providers identify gaps in care and opportunities for improvement while health plan support of disease and case management may include providing clinical decision support tools, such as care guidelines, and using nurse case managers. Health plans can provide access to an IT infrastructure that enables the flow of information necessary to support clinical decision-making and their experience in risk assessment and management allows plans to provide predictive modeling tools and, in some cases, stop-loss coverage or reinsurance.

Health plans and providers work together to assess the level of provider readiness to enter into accountable care agreements based on several elements: capacity to coordinate care, ability to implement delivery system changes and achieve performance measurement, health IT infrastructure promoting timely data exchange with other providers, presence of leadership and commitment to move beyond the current fragmented system. This type of assessment is necessary to identify gaps in readiness and identify areas where health plans can provide assistance or tools to physicians or practices to ensure success under the accountable care model.

Early successes under each model demonstrate the leadership and ability of health plan partnerships to move beyond the current fragmented system to a system which provides greater value for patients and shared accountability with providers.
Exhibit A: Description of Select Federal Programs

- **Medicare Shared Savings Program (Accountable Care Organization),** a program designed to improve Medicare fee-for-service beneficiary outcomes and value by offering provider groups that meet designated quality standards an opportunity to share in any savings generated.

- **Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration project,** a program designed to evaluate the effect of the patient-centered medical home in improving care, promoting health and reducing the cost of care provided to Medicare fee-for-service beneficiaries served by FQHCs.

- **Comprehensive Advanced Primary Care Initiative,** a CMS-led, multi-payer initiative to test comprehensive, accountable primary care through provision of a monthly care management fee and an opportunity for shared savings; and

- **Bundled Payments for Care Improvement,** an initiative to encourage Medicare fee-for-service providers to work together to deliver care more efficiently by testing bundled payments for different episodes of care.

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1 Berwick, The Triple Aim Care, Health and Cost. Health Affairs 27, No. 3 (2008) 759-769
2 AHIP Board of Directors Statement on Core Principles Integral to the Development of the Patient-Centered Medical Home, June 2008
3 Blue Cross Blue Shield of Michigan results from 2010. www.valuepartnerships.com
4 Ibid
5 Organizations define ACOs in different ways. For example, the Robert Wood Johnson Foundation defines an ACO as a network of doctors and hospitals who are together responsible for providing high-quality care to patients. The Urban Institute defines an ACO as a local health care organization and a related set of providers (at a minimum, primary care physicians, specialists, and hospitals) that can be held accountable for the cost and quality of care delivered to a defined population.
6 Blue Shield of California presentation at AHIP Shared Accountability Summit, October 18, 2011.
7 Horizon BCBSNJ Oncology Bundle
10 Center for Medicare and Medicaid Services: Medicare Shared Savings Program https://www.cms.gov/medicaresharedsavingsprogram/
11 Center for Medicare and Medicaid Services: Federally Qualified Health Center Advanced Primary Care Practice Demonstration https://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=zone&filterByDID=9&sortOrderByDID=3&sortOrderByDescending=1&itemID=CMS1230557&NumPerPage=10
12 Center for Medicare and Medicaid Innovations: Comprehensive Primary Care Initiative http://innovation.cms.gov/initiatives/cpci/