Innovative Approaches to Care:
Accountable Care Organizations and Medical Homes
Gary Scott Davis, P.A. and Julie Brillman[1]

I. ACCOUNTABLE CARE ORGANIZATIONS ("ACOS")

A. Introduction

Similar to the medical home model, ACOs are not rigidly defined. Developed by Dartmouth College scholars and researchers at The Brookings Institute and Engelberg Center for Health Care Reform,[2] accountable care organizations often involve "one or more hospitals and the physicians who work within and around them who are formally organized to manage quality and costs for the populations they serve."[3] Generally, ACOs are groups of providers across a defined care setting (a hospital) that agree to be jointly accountable for patient's care; quality and efficiency are measured across the patient's entire episode of care and each provider's compensation depends on the quality and efficiency of care delivered by all providers in the ACO.

Many view the ACO and the Patient-Centered Medical Home (the "PCMH") as interlocking components. The PCMH is reflective of coordination of care; the ACO is reflective of the continuum of care. The PCMH is the 'home' and the ACO is the 'house.' The PCMH serves as the epicenter of the patient's care (i.e. where their care is coordinated and integrated[4]), the ACO is the platform upon which providers and payers collaborate and cooperate with the goal of "lower[ing] costs and improve[ing] care."[5] The Dartmouth Institute for Health Policy & Clinical Practice articulates three essential

---

[1] The contributions of Julie Brillman are gratefully acknowledge. Julie, Class of 2010 University of Miami School of Law, was a 2009 Summer Associate and is a Class of 2010 incoming Associate with McDermott Will & Emery, Health Industry Advisory Practice Group.
[2] Jeff Goldsmith, The Accountable Care Organization: Not Ready for Prime Time, (17 Aug. 2009), available at: http://healthaffairs.org/blog/2009/08/17/the-accountable-care-organization-not-ready-for-prime-time/.
[3] Elliott S. Fisher et al., Creating Accountable Care Organizations: The Extended Hospital Medical Staff, 5 HEALTH AFFAIRS w44, w45 (5 Dec. 2006) (Web exclusive available at www.healthaffairs.com).
[4] Paul Grundy, The Patient Centered Medical Home & The Accountable Care Organization: Two Sides of the Same Coin, DISEASE MANAGEMENT CARE BLOG, (11 Aug. 2009), available at: http://diseasemanagementcareblog.blogspot.com/2009/08/patient-centered-medical-home.html.
[5] Phil Galewitz, ACOs: A Quick Primer, KAISER HEALTH NEWS, (17 Jul. 2009), available at: http://www.kaiserhealthnews.org/Stories/2009/July/17/ACO.aspx.

elements differentiating the ACO from the medical home, requiring that ACOs: 1) can provide or manage continuum of care as a real or virtually integrated delivery system; 2) are of a sufficient size to support comprehensive performance measurement; and 3) are capable of prospectively planning budgets and resource needs.

1. Integrated Delivery System

Similar to the medical home model, the underlying goal of ACOs "is to improve the quality and lower the cost of care by fostering greater accountability on the part of providers for their performance."[6] The ACO model is intended to realign the interests of the participating providers with the goal of decreasing costs while increasing performance across the continuum of care. Physicians and hospitals receive shared-savings bonuses by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients. Proponents of both models agree, "the provision of high quality care for any serious illness requires coordination, longitudinal care and the engagement of multiple professionals across different institutional settings."[7]

2. Sufficient Size

The accountable care organization model, however, extends further than the medical home concept of a physician-run medical team; ACOs aim to coordinate the extended hospital medical staff as a "team." Although the primary care team functions as the nucleus of the medical home model, the hospital will most likely serve this function in the ACO being "the locus of both performance assessment and accountability."[8] Many existing groups, such as physician-hospital organizations and integrated delivery systems already exist, and ACOs strategists foresee adapting these organizations to implement the ACO model.

3. Budget and Resources

---

[6] Fisher et al. at 44.
[7] Fisher et al. at w45.
[8] Id.

Hospitals, with their existing resources, potentially are in the best position to function as a focal point of accountability by performing the administrative functions required to evaluate quality and outcomes. Through greater accountability and facilitated coordination, hospitals, patients and physicians are expected to enjoy higher performance at lower costs. Because ACO members are held jointly accountable for care, they will share in any cost savings stemming from the quality gains. Additionally, the interests of the hospital and the physicians are aligned, and "savings generated by teamwork would be shared by [the payors] and the doctors and hospitals involved in the organization."[9]

B. Support for the ACO Model

According to the Congressional Budget Office, ACOs can produce savings for Medicare.[10] The Centers for Medicare and Medicaid Services (CMS) are currently implementing ACO-type payment reforms. These initiatives, which are "voluntary for providers, [build] on current referral patterns, [require] no change in benefits or lock-in for beneficiaries, and [offer] the possibility of sustained provider incomes even as total costs are constrained."[11] Virtually all physicians already associate with hospital systems, whether through their own inpatient work or through the care patterns of the patients they serve.[12] Thus, the foundation for the creation of the organization exists today, facilitating the progression towards the ACO. "Because it is feasible to define the extended hospital medical staff and the patients they serve using readily available administrative databases, the implementation of performance measurement at this level could begin nationwide in relatively short order, especially when compared with the challenges of measurement within physicians' offices."[13] Significantly, "higher spending across U.S. health systems is largely attributable to greater use of discretionary 'supply-sensitive' services and the

---

[9] John Reichard, Accountable Health Organizations Enter Policy Spotlight, THE COMMONWEALTH FUND NEWSLETTER, (2009), available at: http://www.commonwealthfund.org/Content/Newsletters/Washington-Health-Policy-in-Review/2009/Mar/Washington-Health-Policy-Week-in-Review-March-16-2009/Accountable-Health-Organizations-Enter-Policy-Spotlight.aspx.
[10] James Arvantes, MedPAC Considers Accountable Care Organizations as Possible Path to Health Care Reform, AMERICAN ACADEMY OF FAMILY PHYSICIANS NEWS NOW, (20 Apr. 2009), available at: http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20090420acc-care-orgs.html.
[11] Reichard at 2.
[12] Fisher et al. at w45.
[13] Id. at w55.

use of institutional settings (rather than outpatient settings) for care . . . [but] decisions to invest in care management, reduce acute care capacity, forgo unnecessary specialist recruitments, or more effectively manage post-acute care resources could result in improved quality and lower costs."[14] Proponents admit "they will have to develop ways of managing high-cost and high-risk patients aggressively -- and effectively -- without triggering the same kind of backlash we saw against HMOs . . . This is, after all, about *accountable* care."[15]

C. Opposition to the ACO Model

Similar to the medical home model, the need for payment reform is a core component for implementation.[16] Even where hospitals and their doctors are highly integrated, systemic administrative changes will require resources and time. Fully recognizing the benefits of integrated care may take decades.[17] Recent market trends and payment systems "that effectively encourages entrepreneurial physicians to compete with hospitals – work against the integration of physicians and hospitals. Culturally, physicians have long operated with a high degree of professional autonomy, and many will resist the notion of accepting some responsibility for the care of all patients within their local delivery system."[18] Physicians are skeptical of hospital administrative oversight, often viewing it as intrusive and obstructive.[19] Even if payment incentives become aligned, prior attempts to simultaneously reform health care delivery and financing have evidenced increased administrative complexity without equivalent

---

[14] Fisher et al. at w53.

[15] THE NEW AMERICA FOUNDATION, Health Reform: Accountable Care Organizations – The Real Thing This Time?, HEALTH POLICY, (Jul. 2009), available at: http://www.newamerica.net/blog/new-health-dialogue/2009/health-reform-accountable-care-organizations-real-thing-time-13385.

[16] James Arvantes, MedPAC Considers Accountable Care Organizations as Possible Path to Health Care Reform, AMERICAN ACADEMY OF FAMILY PHYSICIANS NEWS NOW, (20 Apr. 2009), available at: http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20090420acc-care-orgs.html.

[17] Phil Galewitz, ACOs: A Quick Primer, KAISER HEALTH NEWS, (17 Jul. 2009), available at: http://www.kaiserhealthnews.org/Stories/2009/July/17/ACO.aspx.

[18] Fisher et al. at w54.

[19] Dennis Erwin, Changing Organizational Performance: Examining the Change Process, 87 HOSPITAL TOPICS 28, (2009).

improvements in cost and quality.[20] At worst, critics warn that the ACO model is nothing more than a new acronym for past failures. Some opponents also warn of Stark law prohibitions and antitrust issues that may prevent wholly integrated systems, specifically where, "almost by definition an ACO implies a degree of collusion between providers."[21]

D. Conclusion

Unquestionably, "many of the deficiencies in U.S. heath care are reflections of the disjointed and poorly coordinated care that patients receive as they move across settings and among providers."[22] The ACO model professes to offer a solution to such problems and "because most patients receive their care within the context of a local delivery system comprising physicians and the hospital where they work, the hospital and its extended medical staff provide a natural organizational setting within which to improve the overall experience of care."[23] Despite existing infrastructure, physician culture remains relatively autonomous and the medical community often frowns upon bureaucratic micro-management. Additionally, "many physicians will resist the notion of accepting a degree of responsibility for the care of all patients within their local delivery system."[24]

Introduced to Congress on July 14, 2009, America's Affordable Health Choices Act of 2009,[25] mandates the establishment of a pilot program to test different payment incentive models and evaluate accountability to effectively reward high quality, cost efficient health care services. Reduction of legal barriers to physician-hospital collaboration will facilitate the development of ACOs, but the successful establishment of data collection and metrics devices remains indeterminate. Organizations aiming for

---

[20] Paul M. Elwood & Lynn M. Estheredge, The 21st Century American Health Care System, 11 HEALTH CARE STRATEGIC MANAGEMENT 1, 1 (1993).
[21] Austin Frakt, Antitrust After Health Reform: Are Economists Ready?, THE INCIDENTAL ECONOMIST, (7 Jul. 2009), available at: http://theincidentaleconomist.com/accountable-care-organizations-health-insurer-market-power-and-antitrust/. "Legal obstacles to physician-hospital collaboration are substantial, especially with regard to sharing the potential financial gains of more efficient care. The recent exemption granted to allow hospitals to purchase health information systems for physicians in affiliated practices is a notable exception." Fisher et al. at w54.
[22] Fisher et al. at w55.
[23] Id. at w55-56.
[24] Fisher et al. at w54.
[25] H.R. 3200, 111th Cong. § 1301 (2009).

ACO status may look to large, existing models such as the Mayo Clinic for guidance; but success will likely come slowly.

II. THE MEDICAL HOME

A. Introduction

There is no consensus definition of the "medical home,"[26] a term first introduced by the American Academy of Pediatrics in 1967. A fluid, patient-specific regimen of care is essential to the implementation of the medical home and sponsors of the model reject the establishment of a rigid definition as the antithesis of the innovative care delivery concept. Mathematica Policy Research, Inc. describes the Medical Home as a model providing, "accessible, continuous, coordinated and comprehensive patient-centered care, managed centrally by a primary care physician with the active involvement of non-physician practice staff."[27]

In 1978 the World Health Organization "laid down some of the basic tenets of the medical home and the important role of primary care in its provision."[28] Specifically, the WTO declared, primary care "is the key" to attaining "adequate health . . . [and] a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity."[29] Adequate health is "a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal."[30] The concept of the medical home has been refined over the years to include: 1) Personal Physician; 2) Physician Directed Medical Practice; 3) Whole Person Orientation; 4) Care is Coordinated and/or Integrated; 5) Quality and Safety; 6) Enhanced Access; and 7) Payment Reform.[31]

---

26 John K. Iglehart, No Place Like Home – Testing a New Model of Care Delivery, 359 THE NEW ENGLAND JOURNAL OF MEDICINE 1200 (Sept. 18, 2006).
27 MATHEMATICA POLICY RESEARCH INC., SUMMARY: MEDICAL HOME MODELS.
28 World Health Organization, International Conference on Primary Health Care Declaration of Alma-Ata, WHO CHRON. 1978; 32(11):428-30.
29 Id.
30 Id.
31 NATIONAL COMMITTEE FOR QUALITY ASSURANCE, GUIDELINES: PHYSICIAN PRACTICE CONNECTIONS, PATIENT CENTERED MEDICAL HOME, available at: http://www.ncqa.org/Portals/0/Programs/Recognition/RPtraining/PPCPCMH_Training.pdf.

1. Personal Physician

The personal physician (often but not always a primary care physician), is directly accountable to patients for their range of care, and "rather than being a 'gatekeeper' who restricts patient access to services, a personal physician leverages the key attributes of the advanced medical home to coordinate and facilitate the care of patients . . . Personal physicians advocate for and provide guidance to patients and their families as they negotiate the complex health care system."[32] Ideally, the physician and the patient jointly identify specific health care objectives and needs, thus, "responsibility for care and care coordination resides with the patient's personal medical provider working with a health care team."[33]

2. Physician Directed Medical Practice

The personal physician leads "a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients."[34] Such teams are flexible, adjusting to the complexity and the nature of the needed care. Physicians help to integrate and individualize the care, and when needed, specialist care is accessed. It is expected that the patient will have a relationship with the entire medical home team, "some of whom will be outside of the practice, but which readily share information . . . teams will have to develop explicit strategies and systems to ensure clarity of roles and how they contribute to sustained relationships."[35]

3. Whole Person Orientation

The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care at various life stages and acuity needs such as acute

---

[32] AMERICAN COLLEGE OF PHYSICIANS, Position Paper: The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care, 4 (2005).
[33] Thomas C. Rosenthal, M.D., The Medical Home: Growing Evidence to Support a New Approach to Primary Care, 21 JOURNAL OF THE AMERICAN BOARD OF FAMILY MEDICINE 427, 427 (Sept.-Oct. 2008).
[34] THE ROBERT GRAHAM CENTER, THE PATIENT CENTERED MEDICAL HOME: HISTORY, SEVEN CORE FEATURES, EVIDENCE AND TRANSFORMATIONAL CHANGE, 10 (Nov. 2007), available at: http://www.adfammed.org/documents/grahamcentermedicalhome.pdf.
[35] THE ROBERT GRAHAM CENTER at 11.

care, chronic care, and preventive services. Ideally, the medical home will be accountable for the right care in the most appropriate setting and at the most appropriate time.

4. Coordinated and/or Integrated Care

Though the primary care physician is expected to facilitate care coordination, "the role of . . . care coordination is not fixed or determined by a defined set of tasks."[36] Instead, it is a dynamic process driven by the health status and developmental progress of the patient, the specific needs of the patient and the family, the primary care physician's expertise with the special health care needs presented, and the ability of the patient, the family and other professionals to participate in care coordination. "The primary care physician in the medical home should be aware of the array of available subspecialty services, know when these services are needed, know how to gain access to and advocate for subspecialty care within health plans, and know how to use subspecialists' recommendations and communicate the subspecialists' reports to the family"[37] and the patient. In effect, the medical home team functions as strategic access managers facilitating the broad range of the particular patient's care across all elements of the health care system; the aggregate effect is to minimize overtreatment or under-treatment and efficiently allocate resources while improving the overall quality of care.

5. Quality and Safety

Underpinning coordinated care, the physicians "in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement."[38] To ensure proper and safe performance measurement, synchronization, and accountability, practices are expected to "go through

---

[36] American Association of Pediatrics, Care Coordination in the Medical Home: Integrating Health and Related Systems of Care for Children with Special Health Care Needs, 116 PEDIATRICS 1238, 1239 (Nov. 2005).
[37] Id.
[38] THE AMERICAN COLLEGE OF PHYSICIANS, JOINT PRINCIPLES OF PATIENT CENTERED MEDICAL HOME (2007), available at: http://www.acponline.org/pressroom/pcmh.htm.

a voluntary recognition process by an appropriate non-governmental entity[39] to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model."[40] The decision-making is guided by evidence-based medicine and the patients actively participate in the process of quality improvement.

6. Enhanced Access

Enhanced access to care "is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff."[41] The medical home is continuously available and accessible with patients having multiple points and means of contact (e.g. in-person, email, internet). Indeed, the amorphous nature of the medical home "suggests that some of these interactions are asynchronous, fitting the needs of patients and their schedules for non-urgent issues."[42]

7. Payment Reform

Institutionalizing the medical home will require a reformulation of reimbursement policy in which payment appropriately recognizes the added value provided to patients who have a medical home.[43] The current health care payment systems encourage utilization and consumption, however, "a new financing system that rewards continuity, patient-centered care and accountability will be needed"[44] for the successful implementation of the medical home model. Primary care physicians must be fairly compensated for coordinating care and educating patients, which the current fee-for-service payment model does not address. "Ultimately, the payment of primary care physicians might be a blend of fee for service, monthly fees for practices serving as

---

[39] Presumably the MATHEMATICA, INC. tiered system of evaluating medical home or the Medical Home Index (MHI), a self-administered, quality improvement tool with 25 themes organized under 6 domains. *See,* W. Carl Cooley et al., Improved Outcomes Associated with Medical Home Implementation in Pediatric Primary Care, 124 PEDIATRICS 358, 359 (2009).
[40] THE AMERICAN COLLEGE OF PHYSICIANS, JOINT PRINCIPLES OF PATIENT CENTERED MEDICAL HOME.
[41] THE AMERICAN COLLEGE OF PHYSICIANS, JOINT PRINCIPLES OF PATIENT CENTERED MEDICAL HOME.
[42] THE ROBERT GRAHAM CENTER at 17.
[43] Id.
[44] Id.

patient centered medical homes, and additional bonuses for meeting quality and efficiency performance goals."[45]

B. Support for the Medical Home Model

Proponents of the medical home model "believe care coordination facilitates the provision of recommended services, eliminates redundancies or unnecessary care, and encourages increased communication with patients as well as patient adherence to [treatment] regimes."[46] The medical home model is endorsed by the American College of Physicians, the American Academy of Family Practitioners, the American Academy of Pediatrics and the American Osteopathic Association. The advanced medical home acknowledges that the "best quality of care is provided not in episodic, illness-oriented, complaint-based care – but through patient-centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine."[47] In a recent publication, the Institute of Medicine identified overly complex and uncoordinated care as a major reason for "a chasm…that exists between the health care that we now have and the health care that we could have."[48] Multidisciplinary teams including people with varied skills and specializations "increases the number of possible solutions that will be generated. In the one case, patients receive care from a broader base of knowledge and expertise, and physician-level expertise is reserved for individualizing and integrating care."[49] Where the primary care physician orchestrates the health care team, there can be increased effectiveness of care through broader bases of knowledge, increased efficiency and reduced costs. Evidence tends to show that "primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care."[50] Additionally, "primary care (in contrast to specialty care) is associated with a more equitable

---

[45] THE ROBERT GRAHAM CENTER at 19.
[46] MATHEMATICA POLICY RESEARCH INC., SUMMARY: MEDICAL HOME MODELS.
[47] AMERICAN COLLEGE OF PHYSICIANS, Position Paper: The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care, at 3 (2005).
[48] INSTITUTE OF MEDICINE, Committee on Quality Care in America, Crossing the Quality Chasm: A New Health System for the 21st Century: Washington, DC: National Academy Press (2001).
[49] THE ROBERT GRAHAM CENTER at 10.

distribution of health in populations,"[51] and according to some primary care practitioners, "[the medical home] is our last, best hope to save primary care."[52]

C. Opposition to the Medical Home Model

Medical home models "remain untested and would depend, even at the outset, on the development of new payment mechanisms."[53] Critics questions the current NCQA standard measurement criteria of the medical home,[54] and a recent report warns that "payers should wait for additional evaluations regarding which specific processes and structures produce better outcomes before establishing or utilizing strict standards for which organizations can serve as medical homes."[55] Physicians may have little motivation to acquire the skills and build the infrastructure to operate within the medical home model.[56] Such additional responsibilities may actually interfere with the clinical integrity of a primary care visit.[57] Consumer analysts warn that "the term 'medical home' makes many consumers think of nursing homes, with all the unfortunate connotations"[58] and may revive the criticism often attached to the "gatekeeper" models of the early 1990s."[59]

D. Conclusion

Though no standard implementation has been recognized, the medical home may offer a paradigm of being the "focal point through which all individuals – regardless of age sex, race, or socioeconomic status – receive their acute, chronic, and preventive

---

[50] THE ROBERT GRAHAM CENTER at 12.
[51] Id.
[52] Julie Appleby, Old-Fashioned Docs Inspire New Medical Homes, USA TODAY, (13 July 2008).
[53] Elliott S. Fisher et al., Creating Accountable Care Organizations: The Extended Hospital Medical Staff, 5 HEALTH AFFAIRS w44, w45 (5 Dec. 2006) (Web exclusive available at www.healthaffairs.com).
[54] See note 6, *supra*.
[55] Andis Robeznieks, Medical Home Inspection, 39 MODERN HEALTHCARE 17 (Apr. 2009).
[56] THE NEW AMERICA FOUNDATION, Health Reform: Accountable Care Organizations – The Real Thing This Time?, HEALTH POLICY, (Jul. 2009), available at: http://www.newamerica.net/blog/new-health-dialogue/2009/health-reform-accountable-care-organizations-real-thing-time-13385.
[57] Thomas C. Rosenthal, M.D. at 434.
[58] Elliott S. Fisher, Building a Medical Neighborhood for the Medical Home, 359 THE NEW ENGLAND JOURNAL OF MEDICINE 1202 (Sept. 2008).
[59] Id.

medical care services,"[60] though most proponents admit that this model is, most likely at best, aspirational. In light of the model's intrinsic focus on the specific needs of the patient, the lack of definitional consensus regarding the medical home reflects the conceptual understanding that successful implementation depends upon the achievement of the aforementioned core features and characteristics.[61]

Despite the fact that North Carolina saved $231 million in 2002-03 through medical homes in its Medicaid program,[62] the national experience and potential remains uncertain. Recently initiated medical home pilots include Seattle's Swedish Medical Center-Ballard Campus as well as IBM Corp.'s Tulsa initiative,[63] Geisinger Heath Care's medical home project in Pennsylvania, and Dartmouth-Hitchcock's New Hampshire project.[64] It is too early to effectively evaluate the progress and operational success of such programs. America's Affordable Health Choices Act of 2009,[65] mandated the establishment of a medical home pilot project to test the model to the extent that it increases quality of care and reduces Medicare and Medicaid spending for high-need beneficiaries. It is clear, however, that integration is "complex, time-consuming work; improving primary care's performance in integrating care"[66] will require significant changes to the current culture of medical care providers.

---

[60] THE ROBERT GRAHAM CENTER at 5.

[61] See note 6, *supra.* Additionally, the AAP believes that comprehensive health care should encompass: (1) improved access and communication; (2) use of data systems to enhance safety and reliability; (3) care management; (4) patient self-management support; (5) electronic prescribing; (6) test tracking; (7) referral tracking; (8) performance reporting and improvement; and (9) advanced electronic communications. AMERICAN ACADEMY OF PEDIATRICS, Policy Statement, The Medical Home, 110 PEDIATRICS 184, 184 (2002).

[62] Julie Appleby, Old-Fashioned Docs Inspire New Medical Homes, USA TODAY, (13 July 2008).

[63] Andis Robeznieks, Medical Home Inspection, 39 MODERN HEALTHCARE 17 (Apr. 2009).

[64] MATHEMATICA POLICY RESEARCH INC., SUMMARY: MEDICAL HOME MODELS.

[65] H.R. 3200 111th Cong. § 1302 (2009).

[66] THE ROBERT GRAHAM CENTER at 13.