

POLICY FORUM

New Models of Care

Introduction

Although many of the details of the Affordable Care Act (ACA) are highly controversial, there is broad consensus that the US health care system is in need of repair. Health care costs are rising much faster than most other costs, consuming an ever increasing proportion of the nation's gross domestic product. Too many Americans die or are harmed from preventable medical errors, and only about half of Americans receive all recommended health care. Although the United States spends far more than other countries on health care per capita, our health outcomes are worse than those in most industrialized nations. As Don Berwick, administrator of the Centers for Medicare and Medicaid Services (CMS) and former president and chief executive officer of the Institute for Healthcare Improvement, has promoted, the United States must focus on the "Triple Aim" of improving patients' experience with care (including access, quality, and outcomes), improving population health, and reducing per capita health care expenditures.

Of course, it is much easier to talk about the Triple Aim than to achieve it. We know that increased health care spending does not always lead to better health outcomes. And we have great examples of what has worked in some communities to improve quality and patient outcomes while reducing health care expenditures. Yet what works in some communities will not necessarily work in others. Many of the recognized high-performing systems, including Mayo Clinic and Geisinger Health System, are built on long-standing integrated delivery systems. This model may not work well for solo practitioners or small group practices in rural North Carolina or in the highly competitive health systems found in many of the state's urban environments.

It is for this reason that the ACA included provisions to test novel payment and delivery models. The ACA created the Center for Medicare and Medicaid Innovations (CMMI) within the CMS to test and evaluate new models of care. The CMMI, with the support of \$10 billion in funding for fiscal years 2011-2019, was directed to test and evaluate a wide array of new payment and delivery models that range from broad-scale activities to reform payment and delivery systems to comparatively narrow models intended to improve care and reduce costs for a specific population or type of health service.

North Carolina is a national leader in some of the new models envisioned under the ACA. A notable example involves Community Care of North Carolina (CCNC), whose leadership with respect to patient-centered medical homes has long been recognized. North Carolina is also home to many other regional and system-level innovations that have yielded promising results. The efforts of CCNC and many of these new programs are highlighted in the policy forum of this issue.

Our state should take advantage of the new opportunities offered within the ACA to test new delivery and payment models. We must learn what works and, of equal importance, what does not work within specific North Carolina communities. We have a strong base on which to build, yet we must continue to explore other options that can help us improve health care quality and outcomes, population health, and access to care, while reducing unnecessary expenditures.

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