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## From Fragmented to Clinically Integrated Care

Behind the Trend of Medical Homes, Health Homes, and Accountable Care Organizations

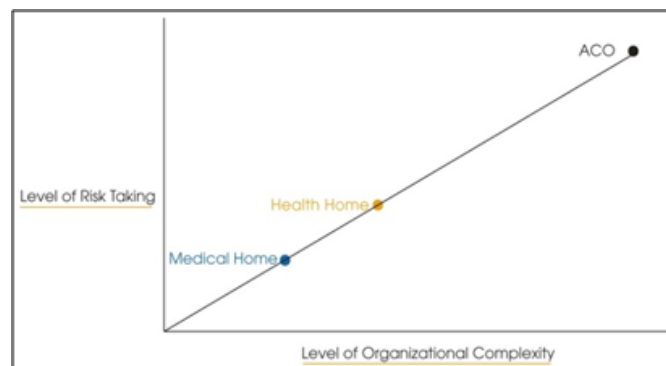
Market and political forces are converging to encourage independent doctors and hospitals to become more collaborative and aligned in clinical integration. Under our current fragmented care delivery system, doctors and hospitals have been operating independently from one another. New programs (like the Affordable Care Act's Pioneer ACO demonstration project or Medicare's Shared Savings Program) are motivating providers to organize into groups that can jointly enter into innovative, collective reimbursement arrangements with purchasers like health plan providers.

Such arrangements with purchasers are intended to leverage the power of economic rewards, as an incentive to provide better quality and more efficient health care. Clinically integrated provider groups must still steer clear of antitrust laws. However, regulators are now more likely to view provider mergers favorably than formerly. They will take into account any potential to improve patient access to critical health care services, to manage clinical quality through shared access to a common information system, and to align the financial interests of the care team in controlling costs over the long-term.

Three prominent models of clinical integration are gaining rapid market traction: the **Patient-Centered Medical Home (PCMH)**, the **Accountable Care Organization (ACO)** and the **Health Home**. In each model, the goals are to manage care coordination better - as in hand-offs when patients move from setting-to-setting - to follow agreed-upon care guidelines, and to identify gaps in care. At the same time, the focus remains on continuously measuring for quality improvement and managing cost of populations.

Each of these models varies in several ways, including: (1) complexity of its organizational structure; (2) the amount of financial risk the group of providers is willing to manage; and (3) the amount of investment the group is willing to make in collaborative information technology infrastructure. The following explanation elaborates on these variations.

Figure 1



## Patient-Centered Medical Homes

The patient-centered medical home is a basic model of clinical integration, in terms of relative levels of financial risk taking and requisite organizational complexity. A medical home is staffed by a team of caregivers and led by a primary care doctor. The care team typically includes personal health nurses (nurse navigators, care managers), as well as nutritionists and pharmacists, who work in tandem to remove barriers to care access. These team members identify risks that can be minimized through proactive care management; use tools for targeting highest risk patients; coordinate care with other physicians and caregivers; ensure compliance with evidence-based guidelines; and advocate healthy behaviors and general wellness among a managed population.

Early practitioners of the PCMH model focused in particular on managing people within a population with a chronic condition (diabetes, hypertension, etc.), or multiple chronic conditions (e.g., diabetes and depression). Typically, patients targeted by medical homes are under the care of multiple physicians and are poly-pharmacy users. In consequence, they are more likely to have high rates of preventable medical errors, such as during care transition, and require regular care guidance around care plans and options.

A PCMH generally takes little or no financial risk for managing these activities. Rather, a health plan provider directly rewards the care team with bonus payments for achieving agreed-upon clinical goals, like compliance of diabetics to evidence-based guidelines. These extra payments provide a practice with sources of funds from which to staff an extended care team, and enable primary care doctors to follow-up and support patients in carrying out the doctor's care guidelines. The extra payments also help primary care doctors finance more sophisticated electronic medical record systems, comprising of data analytics tools and medical management technology, which help the care team coordinate among themselves and stay informed about the health status of the population under management.

The PCMH's extended medical record system includes extensive claims history, prescription history, and lab result history beyond what occurred within the four walls of the practice itself. This provides a more complete picture of the patient and creates a virtually integrated care experience. Complete records enable the care team to conduct population research and proactively identify high risk individuals, who may require medical intervention. Within the systems a medical home staff has the capability to receive automated alerts when, for example, a potential drug-to-drug interaction risk might occur if multiple physicians are writing scripts for the patient. Care teams also can access the medical records anywhere, even remotely from home after-hours, so they can support patients 24/7. Patients of a medical home also have convenient ways to communicate electronically with their care teams, including

online self-service to schedule appointments, request prescription refills, and review care plan reminders.

Traditional fee-for-service reimbursements alone do not cover the expenses of establishing these multiple functions of a medical home. Though the organizational structure is not complex, significant investments are needed to set up a PCMH, both in extra people (nurses, nutritionists, etc.) and in sophisticated information technology. Most primary care practices struggle to come up with these financial resources, or lack sufficient leverage to structure bonus payments with health plan providers to get off the ground.

### Accountable Care Organizations

Accountable care organizations are a much more comprehensive model of clinical integration. Their organizational structure, unlike that of a PCMH, brings together an entire medical neighborhood of care for a population as a one-stop shop – starting with a primary care medical home and incorporating acute care hospitals, long-term care facilities and so forth. Because they rely greatly on primary care practices to coordinate care across the medical neighborhood, going forward, ACOs will be a catalyst and a funding source for more medical homes.

Antitrust laws make it extremely challenging to merge different provider types into a medical neighborhood structure, like an ACO, and then to jointly contract with purchasers as a single legal entity. For this and other reasons, ACOs are today more of a theoretical concept than a common practice. But the recently enacted Affordable Care Act has established a demonstration program (Pioneer ACOs). It includes safe harbor protections for participating groups that wish to move forward with integrating their operations and aligning incentives to manage care for defined populations. Medicare's involvement in funding Pioneer ACOs has significantly increased the appeal for providers to enter into merger discussions and to integrate their operations clinically.

A purchaser, such as Medicare or a commercial health plan, directly engages with an ACO to develop incentives around both clinical and financial goals, in a similar manner as for a PCMH. Ultimately, the purchaser should incentivize the ACO to slow the growth of health care costs, as compared to trend, without impacting quality. ACOs take direct risk for this accountability and, therefore, have greater responsibility for the global medical budget of a population than does a PCMH. The upside to owning that risk is that an ACO can retain the savings it achieves, or share it with the purchaser, depending upon the contractual arrangement negotiated. ACOs require a sophisticated operational infrastructure for managing a global budget, and for coordinating

care for patients across the medical neighborhood. For example, ACO care teams need to easily share comprehensive electronic medical records and clinical areas of expertise across the organization's broad geography. ACOs also require a robust infrastructure for financial reporting to plan sponsors, which may be contracted out to a traditional insurer that serves in a back office claims operation capacity.

In fact, many types of organizations have the potential to become the catalyst of an ACO, including hospitals, insurers and physician groups. The operating entity itself, however, must be able to tie together a broad set of competencies. These might include providing direct care to patients, managing population health, conducting wellness services, receiving and distributing payments or savings to staff, managing relationships with other providers (i.e. contracting), or building out sophisticated IT infrastructure that supports both clinical and financial requirements across multiple clinical disciplines.

An ACO, unlike a PCMH, can function completely independently of insurers and can go directly to groups to contract for services. It is true that ACO organizational structures are significantly more complex than those of PCMHs, and require greater investments in technology. Nevertheless, ACOs have the most potential to align incentives of a care team to reduce costs without compromising quality.

## Health Homes

The health home is a third model of clinical integration for aligning providers, and falls somewhere between the PCMH and ACO platforms. Its organizational structure, like that of an ACO, brings together a medical neighborhood of care for the patient, but the linked providers are organized to focus on a specific population – those who require care coordination inclusive of medical services, behavioral health care, and social services, such as family support, housing, and other community support services.

Like in a PCMH, the participating care team of primary care doctors, nurses, counselors, and social workers share common information systems in order to meet dual medical and social needs. Moreover, the care team takes little or no financial risk; instead, they are rewarded with bonus payments for achieving agreed-upon clinical and social goals for the managed population.

The Affordable Care Act specifically provides States with funding opportunities (i.e. via temporary federal match rates, or FMAP) to finance health homes for Medicaid recipients who have, or are at risk for, at least two chronic conditions (e.g., asthma, diabetes, heart disease, obesity, mental conditions or substance abuse); or who have a serious and persistent mental health condi-

tion. Providers designated under the Medicaid health home program coordinate care through a shared information system. They must also offer access to mental health and substance abuse services; to comprehensive medical management (disease management, case management, etc.); to individual and family support services; and to community and long-term care support services.

## Conclusion

Providers that have operated independently from one another are starting to come together into clinically integrated organizations. Three prominent models of clinical integration are PCMH, ACO and health homes. While these models vary, providers organizing under these structures should become better equipped and incentivized at coordinating care on behalf of patients. This should result over time in a reduction of costs for health plan providers, with no compromise in care quality. Health plan providers should start to factor this trend into their contracting strategies. That may involve developing strategies to steer patients through plan design into clinically integrated groups, and/or directly engaging with clinically integrated groups around contracting for outcomes specific to the plan's goals.

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