Four Value-Based Care Models Every Healthcare Executive Should Know

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Ever since the passage of the Affordable Care Act (ACA) and its counterpart, the Health Care and Education Reconciliation Act, the rate of change within the healthcare industry has been consistently accelerating. Governmental and commercial payors continue to develop new reimbursement models to shift financial risk to healthcare providers. In response, forward-thinking hospitals, health systems, and physician organizations are working, often together, to effect positive changes in their delivery systems that will ultimately result in improved access, coordination, quality, and cost efficiency.

The transformation of our healthcare delivery system continues to progress, and healthcare providers are constantly being asked to evaluate new delivery models for relevance, replicability, and fit. This task gets increasingly more difficult as the menu of next-generation delivery models expands and the alphabet soup of associated acronyms becomes even harder to sort out. As a result, board members, senior executives, and physician leaders run the risk of investing significant financial, political, and emotional capital on well-intentioned initiatives whose results, whether positive or negative, may vary considerably from what was expected by the project's various stakeholders.

One of the first steps in mitigating this risk is to develop a shared vocabulary with clear definitions for some of the most commonly referenced – and frequently misunderstood – models of delivery system transformation.

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ACCOUNTABLE CARE ORGANIZATION

Over the past few years, it has been hard to have a conversation about delivery system transformation without the term "accountable care organization" coming up. According to studies published by The Leavitt Partners in July 2014 [1] and December 2015,[2] the number of accountable care organizations (ACOs) has grown from fewer than 100 in 2010 to 782 throughout the country as of December 2015. The study estimates that more than 23 million unique patient lives are being covered by some sort of ACO.

Although the idea has recently gained prominence in healthcare circles, the term "accountable care organization" is often credited to Elliott Fisher, M.D., when he addressed the Medical Payment Advisory Committee as the Director of The Dartmouth Institute for Health Policy and Clinical Practice in 2006.[3] Today, many people tend to associate the ACO model with a specific structure proposed within the Centers for Medicare & Medicaid Services' (CMS's) Medicare Shared Savings Program (MSSP) participation guidelines. While MSSP ACOs must incorporate certain structural components to participate in the program, at its core an ACO is **any healthcare organization that assumes financial accountability for the overall value, in terms of cost and quality, of care delivered to the population of patients/beneficiaries the organization's providers serve.**

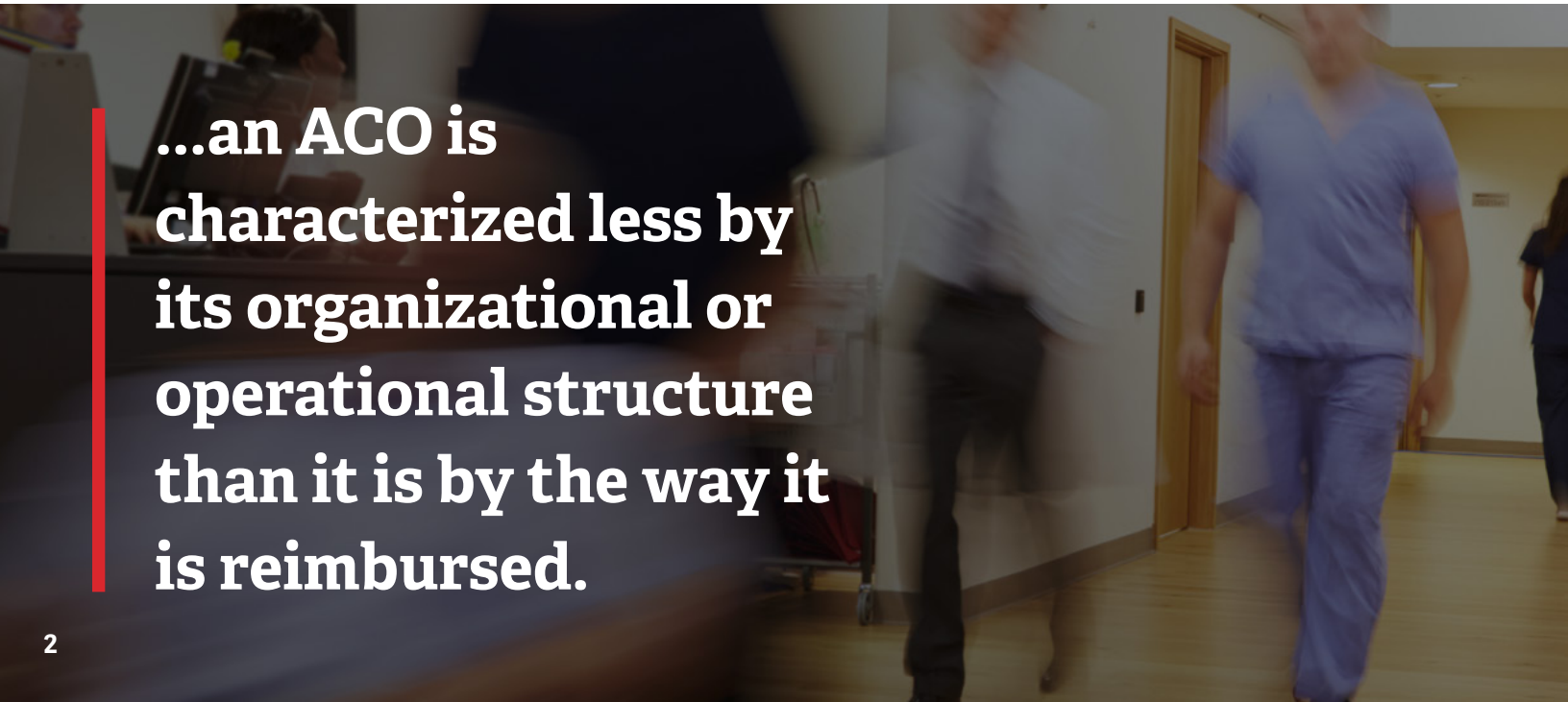
This practical definition implies that an ACO is characterized less by its organizational or operational structure than it is by the way it is reimbursed. Under this definition, not only can healthcare organizations engaging in some sort of shared savings arrangement (like that described in the MSSP) be considered ACOs, but so can provider groups that put a significant portion of their overall reimbursement at risk through pay-for-performance, bundled payment, global payment, or capitated reimbursement arrangements. This description accounts for the fact that there are differing financial arrangements and varying structural requirements for a spectrum of governmental (Pioneer ACO, MSSP ACO, Next Generation ACO, etc.) and commercial ACOs.

Depending on how they are reimbursed, other transformative healthcare delivery models can be appropriately labeled as ACOs, including clinically integrated networks (CINs), select patient-centered medical homes (PCMHs), and population health service organizations (PHSOs).

[1] http://leavittpartners.com/2014/06/growth-dispersion-accountable-care-organizations-june-2014-update/

[2] http://leavittpartners.com/2015/12/projected-growth-of-accountable-care-organizations-2/

[3] http://tdi.dartmouth.edu/faculty/elliott-fisher-md-mph.



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CLINICALLY INTEGRATED NETWORK

While ACOs may be the most popular topic related to care model transformation, CINs rank a close second. The most notable characteristic of ACOs is the way in which they are reimbursed; however, CINs are primarily defined by the manner in which care is provided within the clinical delivery system. In the most general terms, a CIN is **any group of providers that has effectively coordinated the clinical services provided to their patients across the care continuum.**

Unlike ACOs, CINs may or may not be held directly financially accountable (i.e., through clearly defined risk-based or pay-for-performance arrangements) to patients or payors for the cost and quality of care they provide. CINs are held indirectly financially accountable for their performance through a practical need to establish a value-based business case that healthcare consumers are willing to pay for, as well as a regulatory requirement to increase the level of value-based competition in their relevant market (see sidebar #1). For this reason, many people initially associated ACOs with governmental payors and shared savings arrangements, and CINs with commercial payors and fee-for-service contracting.

A second significant differentiating factor between ACOs and CINs is that while the governance and organizational structure of ACOs has been somewhat defined by CMS's regulations pertaining to its MSSP, the FTC and DOJ have, to date, been relatively hesitant to mandate a specific structure for CINs. Given that the causality of value-based improvements has not been well established, the FTC and DOJ have not been inclined to stymie delivery system innovation. That said, these two regulatory bodies, through rulings and advisory opinions, have provided general guidance to help would-be CINs determine what characteristics, capabilities, investments, and actions would place them at more or less regulatory risk.

Despite the differences between ACOs and CINs, they do share commonalities. Similar to ACOs, CINs tend to be based on a broad network of providers spanning the continuum of care (i.e., inpatient, outpatient, post-acute,

Legally Speaking

The concepts of clinical integration and CINs have been opined upon by the Federal Trade Commission (FTC) and Department of Justice (DOJ) as a means to evaluate the legality of joint fee-for-service contracting among otherwise competing healthcare providers that are not otherwise financially integrated (as providers within an ACO would be, to some extent). This type of joint contracting among competitors would typically be considered an illegal, anti-competitive attempt to fix prices. In select cases where sufficient clinical integration has been exhibited by a physician network joint venture, the FTC and DOJ have ruled that the CIN's potential to coordinate care, improve clinical quality, optimize the utilization of healthcare services, and rationalize the cost of services being provided may outweigh the potential negative effects of decreased competition.

and ambulatory care settings). Both are required to balance their efforts to optimize the management of acute illness or injury with preventive care, wellness, and health maintenance activities. In order to demonstrate continual improvements in the cost and quality of care, many CINs make similar in-vestments as their ACO counterparts in information technologies and human resources. Finally, many mature CINs eventually choose to accept some level of financial risk, thereby technically also becoming ACOs.

PATIENT-CENTERED MEDICAL HOME

When it comes to the spectrum of next-generation delivery models, the PCMH is the elder statesman. The medical home concept was first proposed by the American Academy of Pediatrics (AAP) in 1967. The concept remained relatively stagnant for 35 years and then was reignited during the first decade of this century.

"Patient-centered" refers to the model's focus on understanding the comprehensive healthcare needs of each patient, involving patients in care plan development, and engaging patients in the management of their own health. "Medical home" relates to the model's emphasis on the establishment of a deep relationship with a primary healthcare provider (and the care team embedded in that provider's practice) who will be responsible for coordinating all of the healthcare services required by the patient.

The PCMH model has become a popular means for providing willing physicians with a structure and resources to address the waste, inefficiencies, and suboptimal patient outcomes assumed to result from a highly fragmented healthcare system.

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The Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA), The Joint Commission (TJC), and Utilization Review Accreditation Commission (URAC) have each offered their interpretations of the PCMH through accreditation, certification, and recognition programs. With nearly 11,433 recognized sites as of May 2016, NCQA PCMH recognition appears to be the most widely pursued validation of a practice's successful incorporation of the Joint Principles into its daily work flows. Despite the breadth of options pertaining to PCMH accreditation, certification, and recognition, a number of primary and specialty care practices have successfully transitioned themselves into PCMHs without submitting themselves to an external review.

Distilling the model down to its core, **the PCMH is a model of care that emphasizes the critical role of a single, patient-selected physician (often a primary care provider) who quarterbacks a practice-based care team that is ultimately responsible for planning, delivering, coordinating, and monitoring patient care both within the designated physician's practices as well as across the continuum of care.**

The PCMH model incorporates fundamental principles of population health (i.e., practice-based population health management) and continuous quality improvement. Due to this fact, high-functioning PCMHs frequently serve as the linchpins of successful ACOs and CINs. That said, ACOs and CINs tend to be based on broader networks of providers, including a higher proportion of specialists than PCMHs. It has been recognized that PCMHs with a myopic focus on primary care may not realize their full potential in regard to value creation. To address this issue, complementary and more inclusive second-generation patient-centered care models, including the Patient-Centered Specialty Practice (PCSP) and the Medical Neighborhood, have emerged.

[4] http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh

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Thirty-five years later, the AAP expanded its medical home concept in a policy statement released in 2002. The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) released their own proposed medical home and advanced medical home models in 2004 and 2006, respectively. In 2007, the American Osteopathic Association (AOA) joined the AAP, AAFP, and ACP in publishing shared Joint Principles of the Patient-Centered Medical Home[5], **which proposed that:**

- PCMHs should offer enhanced access so that patients can receive required healthcare services in a reasonable time frame
- Every patient should designate a personal physician (typically a primary care physician) to oversee his/her care
- Each patient's personal physician should direct the patient's care and lead the care team that is involved in providing the necessary healthcare services
- Each patient's personal physician should ensure that all of the patient's healthcare needs are appropriately addressed throughout all stages of the patient's life
- Each patient's personal physician should be responsible for ensuring that the patient's care is coordinated across providers and sites of care
- Each patient's personal physician should ensure that the patient receives the highest-quality, evidence-based care from all providers involved in the patient's care
- Physicians and physician practices that are capable of meeting the aforementioned criteria on a consistent basis should receive compensation commensurate with the additional effort invested by the personal physicians and their support staff

[5] http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

POPULATION HEALTH SERVICE ORGANIZATION

Although the PCMH is an increasingly popular care model, many organizations find that transitioning their primary care practices into effectively functioning PCMHs requires the repurposing of existing – and often the addition of new – practice resources. One effective strategy being employed to offset higher expenses frequently associated with a PCMH is to capture supplemental per capita care coordination payments from health plans (i.e., $3 per member per month). Another strategy that is becoming increasingly prevalent among hospital and health system PCMH sponsors is to supplement the model with a more centralized model of care: a population health service organization (PHSO).

The PHSO is a new name placed on an old concept. It is a term that, until recently, has been used in relatively small circles. In the past, especially during the heyday of the health maintenance organization (HMO), health plans or third-party care management vendors could have been classified as PHSOs. Given the increasing level of financial risk being transferred to provider organizations, and in light of evidence that care management efforts are more successful when they include engaged physicians, more and more provider organizations are building PHSOs.

Technically, a PHSO is **any organization that provides the resources and programs to deliver rule-based care to effectively and efficiently manage the health of patient populations.** By this definition, one can see that PHSOs and PCMHs are not mutually exclusive concepts. Both strive to identify and optimize care for high-risk and at-risk patients. That being said, PCMHs are intended to provide patient-centric care to all patients attributed to a designated provider while PHSOs tend to focus their resources on prioritized patient populations (high- and rising-risk patients, high-cost patients, high utilizers of healthcare services, patients with one or more chronic condition, etc.).

Another key difference between PCMHs and PHSOs is the level of emphasis each model places on population health activities. As the PHSO's name implies, the model's sole focus is the provision of population health services (e.g., engagement, outreach, education, care coordination, chronic disease management, complex case

management). Alternately, PCMHs balance their time between optimizing acute care for individual patients and proactively identifying and addressing the needs of specific patient populations.

Finally, PCMHs are differentiated from PHSOs by the resources through which they provide population health management services and the location in which those resources are housed. PCMHs rely on a physician-led, practice-based model. Alternately, PHSOs tend to provide centralized population health management services through nonphysician, often allied or nonclinical, personnel (e.g., patient access center or call center). Economies of scale that may be achieved through centralization position PHSOs to have a greater ability to accumulate both a broader and more specialized pool of human resources, including data analysts, care coordinators/nurse navigators, health coaches, and care managers. As a result, PHSOs tend to be the repository for specialized knowledge, processes, human capital, and information resources to engage in focused wellness, chronic disease management, and complex care management activities.

As previously stated, the PCMH and PHSO are overlapping and often complementary models. In order to reduce the incremental costs (e.g., additional practice-based FTEs and IT infrastructure) and operational burden (care coordination, patient outreach, etc.) experienced by their PCMHs, some organizations supplement the practice-based population health efforts of their PCMHs with centralized support based in a PHSO. Just like a PCMH, PHSOs may be critical components of ACOs or CINs.

Care Model Comparison

Clinical Services	ACO	CIN	PCMH	PHSO
Assumes performance-based financial risk	●	▨	▨	▨
Establishes a value-based business case	○	●	○	▨
Physician-directed care model	○	○	●	▨
Primary-care-directed care model	○	▨	●	▨
Coordinates clinical care	▨	●	●	▨
Employs a team-based approach to clinical care	○	●	●	▨
Proactively manages patient populations	○	○	○	●
Practice-based population health management	▨	▨	●	●
Centralized population health management	▨	▨	●	●
Patient-centric care	○	○	●	○

● defining attribute
▨ program dependent
○ implied (but not defining)
● contrary to care model

A COMMON VOCABULARY FOR A SHARED VISION

Healthcare is in a period of dramatic change, and organizations are looking to position themselves as value-based enterprises (i.e., integrated, scaled, rationalized, informed, and responsive). A practical path for many of them may be to gradually adopt a transformational care model(s), including an ACO, CIN, PCMH, or PHSO. Whether evaluating their initial or next step, healthcare leaders should take the time to develop a clear and common understanding of the model(s) they are endorsing.

This can be difficult, because although the ACO, CIN, PCMH, and PHSO models have distinctive attributes, they also tend to include complementary, reinforcing, and frequently overlapping characteristics (see Table 1 and Figure 1). Despite this fact, it is critically important for the sponsors of any clinical delivery system transformation to have a clear understanding of what they are trying to achieve so that appropriate investments can be made, reasonable expectations can be set, and success can be objectively measured.

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