A Physician Hospital Organization's Approach to Clinical Integration and Accountable Care

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Memphis, Tennessee, tends to lag behind the nation in health care delivery trends. However, it seems to be catching up at an accelerated pace as some of the health care macroeconomic forces assume national prominence. Memphis is an unusual town in that there are 2 major health care systems, and patients are driven to one system or the other based on the exclusivity of insurance contracts. Physicians are contracted with most payors, but this arrangement has created 2 separate hospital networks with large subspecialty groups driving most of the care and a smaller primary care population that is rapidly consolidating. During the past year or two, there has been increasing consolidation, primarily from hospitals acquiring practices at escalating rates. This includes a focus on primary care but also includes large subspecialty practices. In addition, there are 2 large subspecialty practices of national accord in Memphis specializing in neurosurgery and orthopedics, respectively, that are aligned with the University of Tennessee.

Health Choice is working on a number of projects through a physician hospital organization structure. Health Choice is a 50/50 joint venture between Methodist Le Bonheur Healthcare and MetroCare Physicians. Methodist Le Bonheur Healthcare is an integrated health care delivery system with 7 hospitals in the Memphis area. It has an inner city hospital affiliated with the University of Tennessee, as well as 3 suburban hospitals, a pediatric hospital, a rural hospital, a long-term acute care hospital, and a skilled nursing facility inside a large academic medical center. MetroCare is an independent physician association composed of approximately 1500 physicians in the Memphis metro area. This joint venture has been in existence since 1985 and is currently focused on the messenger model of managed care contracting. We also partner with physicians and their staffs, hospitals and ancillary facilities, insurance companies, brokers, and consultants to provide a myriad of services such as resolution of global claims issues, physician and staff education, credentialing, customer service, and insurance services.

Accountable care and clinical integration have been a challenge in Memphis. Up to this point, care has been fragmented, with a preferred provider organization–type market with direct access to specialty care. In addition, electronic medical record adaption has been slow and is still fragmented, with many groups not having any type of electronic medical records. This includes some very large groups. The groups that do have electronic medical records often have different systems, and few of the systems are linked together. Methodist Le Bonheur Healthcare has recently completed the rollout of computerized physician order entry in all of its hospitals and is continuing down the road to achieve meaningful use and information technology integration. It is early in the thought process to expect full clinical integration and coordination of care among their providers. As more physicians are employed or affiliated via a provider services agreement and other mechanisms, an accountable care organization becomes practical.

Getting into the Medicare Shared Savings Program or creating a Medicare Accountable Care Organization was contemplated. After reviewing the initial rules, there was concern. Although the subsequent rule changes alleviated some concern, it still presented significant challenges. Attribution of members was one challenge, since the final attribution was not resolved until the end of the study period. There is no way to keep the patient from going to competitors either out of network locally or out of network on a national basis. This can add additional cost and complexity and limit the ability for care to be managed. There is also the issue of administrative complexity, with numerous quality indicators and multiple items that must be tracked and trended. While this is prudent, it also adds a tremendous amount of administrative cost. This current payment structure seems somewhat counterproductive in a hospital centric system and leads to some hesitancy in developing this model in the short term since much of the savings is based on eliminating preventable admissions and readmissions to the hospital. Currently, the risk model that the Centers for Medicare and Medicaid Services has designed does not allow enough upside compensation to cover the intensive infrastructure that is required.

Health Choice believed that dealing with Medicare Advantage plans first might be a good entrée into the accountable care arena. Medicare Advantage plans offer the advantage of knowing the full attribution up front so that the physicians will know who is in the plan. They also have the luxury of a panel with the ability to track referrals and specialist referrals and get claims data quickly and easily from

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the managed care organizations. The risk model (upside and downside) can also be tailored to current strategies and interventions.

Health Choice has started an accountable care organization. It is a commercial-based product in which one of the payers has worked through their administrative services organization to fund primary care physicians in their move toward a patient-centered medical home model and to make them accountable for cost and quality. The project, called MACH1 (Memphis Accountable Care Home), has 27 primary care physicians in 7 practices working together in a collaborative effort. Payment is fee-for-service; however, there is an additional payment in the form of a per-member per-month. Health Choice provides assistance with transformation of the practices, care management, and analytics. Health Choice also helps link data from hospitals and practice electronic medical records to manage the patient population. This is also a shared savings payment based on bending of the trend curve at the end of each year. Any savings in this model is shared equally with the physicians and the employers (who are funding this project through the payer). The practices have committed to achieving level 3 National Committee for Quality Assurance certification as a patient-centered medical home. Many quality metrics are part of this process, as well as a commitment to improve quality and reduce overall costs. There is a strong focus on population health and a dedicated care manager in each office, a centralized care manager, and a health plan–employed case manager (at our physician hospitals organization). Future plans include adding specialists and hospitals into the risk portion of this project.

Discussions are ongoing with other commercial payers using similar models, including pay-for-performance, pay-for-quality, and bundling models. There is no doubt that these new payment models are coming, and Methodist Le Bonheur Healthcare and Health Choice are actively looking at ways to move toward clinical integration, patient-centered care, and population-based care. It is important that payment models not lag too far behind the care integration models and that the appropriate infrastructure is in place before undertaking any aggressive risk arrangements.

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