Repositioning from IPA to CIN

White Paper

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INTRODUCTION

As the healthcare industry moves slowly but inexorably toward a more value-based reimbursement environment, many independent physicians associations (IPAs) are looking at becoming clinically integrated networks (CINs). The difference between these two entities is not a matter of mere semantics. Instead, the distinction gets to the core of which model better allows physicians and other healthcare providers to enter into value-based contracts with confidence and perhaps become full-fledged population health managers.

The transition, however, is not easy nor is it without risks. This article will hopefully clarify much of the confusing nomenclature used in this area and provide the reader with a valuable roadmap to guide them through this often very complicated transformation process.

INDEPENDENT PHYSICIAN ASSOCIATIONS

WHAT ARE IPAS AND HOW DO THEY OPERATE?

IPAs have existed for many years. Typically, they are loosely formed (but nonetheless, separate legal entities) alliances among physicians. They could include other providers such as hospitals though often they are mostly focused on independent private practicing physicians. The intent of IPAs is for physicians to work together in specific areas but not merge into a single provider number. They work together in various ways, some of which are operational, such as combining certain management services. Examples are billing or information technology (IT)/electronic health records (EHRs). In general, their main purpose for formation is payer contracting. In the days where the reimbursement structure was based on managing large blocks of populations, usually through a capitated arrangement, IPAs could often represent a cross-section of practices in contract negotiations. Because the member constituents would be at risk for their reimbursement based on their overall services and not the volume of service, they had the ability to negotiate payer contracts. After the 1990s, fewer capitated contracts existed. In fact, virtually all forms of reimbursement throughout the United States were fee-for-service (sometimes also referred to as fee-for-volume). IPAs that were not clinically integrated could not (and still cannot today) negotiate payer contracts when their constituents are not at risk, meaning that they are just paid for the volume of services they perform. As a result, many IPAs have withered away and/or have functioned as only conduits for transferring information and payer rates (often referred to as a messenger model).

With the advent of the Accountable Care Act (ACA) in 2010, however, IPAs have realized a renewed emphasis and in many cases have been rejuvenated. This revival is because population health management is now becoming a frequent discussion topic with the

anticipation that it will someday become the norm. Moreover, within such a structure, not only will population health management become the standard, but also the reimbursement paradigm will change from fee-for-volume to an increase in the fee-for-value model.

Why Are IPAs No Longer Very Relevant in the Healthcare Industry?

IPAs are usually managed austerely with minimal staff and limited capital contributions. While they can be an entity that houses other services, i.e., management services, group purchasing, medical malpractice insurance purchasing, etc., in most cases, successful private groups have not seen significant value in IPAs, other than the potential for some payer contracting opportunities.

As we consider the relevancy of IPAs, it warrants a brief discussion as to the specific reasons (in addition to those listed) why in recent years this has been limited if at all. The following summarizes the key obstacles relative to the success of IPAs in recent years.

- **Lack of business plan/strategy.** IPAs have lacked the organizational maturity in many areas, but, in particular, they lack a strategy or an exact business plan to address to their constituencies. These shortfalls are the cause for many to flounder, limiting their ability to move forward in concert with their constituent members.
- **Lack of infrastructure.** Akin to a lack of a business plan or strategic goals and objectives is a limited infrastructure for implementing any such strategies or opportunities that would otherwise be available. This deficiency often equates to a lack of administrative and executive leadership—both in terms of commitment and actual positions within the organization.
- **Lack of capital.** Parallel to the lack of strategy and infrastructure, most IPAs suffer from minimal financial backing. If there were a defined business plan, there would be limited funds upon which to carry it out. Often, IPAs' only sources of income are minimal dues from their constituent member physicians, with no real business strategy going forward. A lack of capital further challenges the development of the business strategy as well as a management/leadership infrastructure.
- **Shift to hospital alignment.** Many physicians have found their solutions to industry challenges via direct alignment with health systems. While IPAs could still be a part of the equation, even when a physician aligns with a hospital, most of the time they are much less relevant.
- **Lack of contracting ability.** Previously, many IPAs lacked the legal and functional ability to contract successfully with commercial payers for acceptable rates. In many cases, the private groups can do as well as the IPA in contract negotiation. Because they can concentrate on their reimbursement, they prefer to not go through the intermediary IPA. A lack of being clinically integrated also contributes to this situation.

- **Lack of being clinically integrated.** Related to contracting inability is the incapacity for IPAs to negotiate fee-for-service contracts because they are not clinically integrated. This shortfall also relates to the lack of infrastructure and financial/capital commitment that the process of clinical integration requires. Specifically, the act of becoming clinically integrated requires a significant investment in information technology (IT) interoperability. Most IPAs have not been willing to take this step toward becoming clinically integrated for all these reasons.
- **Legal compliance challenges.** While certainly IPAs can be fully compliant and functional in the healthcare environment, there are genuine challenges related to their reimbursement structure and, in particular, as relates to anti-trust considerations. In an effort to maintain compliance, many IPAs have chosen to remain limited in their scope of services, infrastructure, etc., simply because of the threat of anti-trust assertions.
- **Physician-to-physician collegiality.** It is difficult to form IPAs—whether they are single or multispecialty. In many instances, private practices/physicians are reticent to share data, even limited information with what they often perceive to be competitor practices (also members of the IPA).
- **Market demand.** Over recent years, given the predominant fee-for-volume reimbursement environment, the market itself has not created a demand for forming and operating such consortiums.
- **Lack of results.** This final reason summarizes the essence of IPA challenges in recent years. That is, at the end of the process of considering all pros and cons of their structure, business plan, operations and strategies, the results they have provided have at best been mediocre.

While the reasons are valid and worthy of serious consideration, each can be easily addressed and effectively negated as IPAs convert to clinically integrated networks.

How Does Legal Structure Differ from an IPA? Major Regulatory Concerns

Interestingly, the legal structure between an IPA and a CIN does not vary considerably. Both entities develop a separate legal unit (usually a limited liability company) and have similar concerns relative to organizational structure and governance (see earlier section for discussion on organizational structure). As long as the CIN can function as a separate entity and not be in violation of any primary healthcare statute compliance requirements, it should operate within regulatory parameters. Just like an IPA, one of the serious concerns of the CIN is whether it conforms to anti-trust trade restriction requirements.

A major consideration for both the IPA and the CIN is whether they are clinically integrated. If either or both are clinically integrated, they can qualify to negotiate fee-for-service contracts

and function in a population health management contract environment (likely a combination of fee-for-volume and fee-for value reimbursement).

Thus, while the CIN may have more defined governance and infrastructure, given the fact that it is a more complex and a better thought through and formed entity than most IPAs, legally, there are few differences. The regulatory concerns are similar. Whether originating as a CIN or an IPA that converts into a CIN, both entities must attain competent legal counsel for forming and ongoing compliance.

Clinically Integrated Networks

What Are CINs and How Do They Operate?

A clinically integrated network or CIN consists of a group of providers who come together for the express purpose of improving quality and cost efficiency in healthcare delivery. Quite naturally, CINs are concerned with driving higher value (quality per unit of cost) to the consumer of healthcare services. They deploy many techniques in order to make this happen, including best practice, care process design through process improvement methodologies like Lean. They also measure true cost and outcome metrics via direct methods such as patient surveys and activity-based cost accounting methods. Finally, they can facilitate referral optimization by matching patient needs with those providers best capable of meeting those needs.

CINs also contract for services on behalf of their members. However, unlike IPAs who contract through a messenger model, CINs are allowed by the Federal Trade Commission and others to enter directly into contracts on behalf of their participants. In other words, whereas IPAs exist, in many cases, simply as contracting entities, CINs exist primarily to drive value. As a result, they enjoy a safe harbor from anti-trust prosecution when it comes to contracting for value-based services.

Finally, CINs usually include a care management or care coordination infrastructure as well as an IT infrastructure that serves multiple purposes. These include the seamless transfer of clinical information between providers, the measurement of both quality and cost performance metrics down to the individual provider level, the safe and efficient navigation of patients through an often complex and dangerous healthcare system, and the provision of expanded care services, such as disease prevention, wellness services, chronic disease management and even virtual diagnosis and treatment.

Why Are CINs Relevant In Today's Healthcare Industry?

Clinical integration and CINs are a response to the growing demand from payers and consumers for greater value in the healthcare industry. Many aspects of healthcare reform are designed to drive this move toward higher value.

Increasingly, both government and commercial payers are using value-based reimbursement models more frequently. Large, self-insured employers are also becoming very interested in the development of population health management contracts with providers. Physicians and hospitals are organizing themselves into accountable care organizations, either separately or together. Finally, consumers are demanding more price transparency and higher value now that the wider use of consumer-directed health plans has made them more personally responsible for payments related to healthcare services.

CIN development is not something that can be done by lay administrators on the behalf of physicians. Instead, physicians need to be engaged in the process every step of the way.

How Does An IPA Become A CIN?

IPAs that desire to become CINs face a rather daunting list of tasks to accomplish to make this transition successfully. This list includes:

- **Gain cultural "buy in".** The adage "culture trumps strategy every time" holds true in the case of the need to attain buy-in of the physicians. Physician members of an IPA who are trying to transition toward a CIN model must understand the differences between these two entities and fully support this move. CIN development is not something that can be done by lay administrators on the behalf of physicians. Instead, physicians need to be engaged in the process every step of the way.
- **Develop strategic partners.** Physicians who can function quite effectively in an IPA structure may struggle to do so in a CIN without strategic partnerships with hospitals, healthcare systems, and other providers. Effectively bringing these groups together, however, can be a significant challenge. It requires physicians and other healthcare providers to step out of their comfort zones and overcome often deep-seated distrust, which can easily disrupt such efforts.
- **Develop a firm business plan.** As with IPAs, a CIN cannot succeed without a sound business plan to guide its development and operation. This business plan must take into account the nuanced characteristics of each IPA or CIN entity and also be in sync with local market conditions. Value-based reimbursements and other changes are

emerging more slowly in some markets than in others. As an example, recent discussions with providers in Massachusetts and Maryland revealed that 65% to 85% of their reimbursements were now at risk for quality or cost-efficiency performance. In the Atlanta market, however, fee-for-volume continues to remain the dominant payment method with very little movement toward a fee-for-value mechanism.

- **Develop an effective CIN governance structure.** As with IPAs, many CINs are likely to consist of disparate groups of physicians or other providers brought together for the purpose of improving value in healthcare delivery. Organizing and governing this heterogeneous group effectively is a challenge that requires strong leadership, especially from physicians who are often not prepared with the leadership skills needed to function effectively in these roles.
- **Develop a robust IT infrastructure:** A successful CIN will require an IT structure that can provide the following:

  - ***Interoperable electronic medical records (EMRs).*** While many EMRs claim interoperability with other systems, very few can deliver on this promise or do so at a reasonable cost. Creating a CIN on a single vendor EMR platform is also not feasible from a cost standpoint for most clinically integrated organizations.
  - ***Population health data analysis***. Effective population health management requires an IT system that can convert population health data (claims, health risk assessments, quality outcomes, cost outcomes, etc.) into meaningful and actionable information for the CIN population health managers.
  - ***Provider and process performance.*** Quality and cost efficiency performance metrics need to be tracked down to the individual provider and care process level. These metrics can then be used for data-driven performance improvement and as criteria by which providers are incentivized or disincentivized. Referral optimization, for instance, where patient needs and provider performance are ideally matched, can be done by using performance data. And high performing physicians will be rewarded with more referrals.
  - ***Cost accounting***. Cost proxies, such as charge-to-cost ratios or labor RVUs, are not adequate accounting tools for a CIN that is negotiating bundled payments or capitation rates. More accurate, preferably time-driven, activity-based cost accounting methodologies need to be applied. This is most efficiently and effectively done through automated cost accounting systems.

Organizing and governing this heterogeneous group effectively is a challenge that requires strong leadership, especially from physicians. . . .

- ***Patient engagement and care management.*** Mobile technology (smartphones, iPads, etc.) has opened up a wonderful venue through which patients can be engaged in their care and managed effectively, often at a much lower cost. Health risk assessments, chronic disease management, health and wellness care, and remote diagnostic and therapeutic services are a few of the ways that mobile technology can be leveraged to augment or replace costly human resources in the care management infrastructure of a CIN.

- **Attain capital and operational financing.** Clinically integrated care delivery can require a considerable financial investment from those involved. IPA physician members are not likely to have the necessary capital reserves. Therefore, they often need to turn to hospitals or healthcare systems, whose pockets may be deeper. A disproportionate share of the financial risk can lead to resentments and disharmony between physicians and their hospital partners, however. Once again, cultural integration can be much more difficult to achieve than clinical integration.
- **Understand contracting.** As mentioned, contracting for CINs requires a different set of competencies and capabilities than those required by IPAs. Pricing and negotiating bundled payments, capitation rates, and even health plan premiums will necessitate that CINs acquire actuarial, claims tracking, claims payment, cost accounting and care management and utilization review skills that historically were more associated with payers than providers.
- **Implement marketing and business development.** CINs may be operating under a more fee-for-value reimbursement model, but they will still need to be concerned with volume, specifically the market-share volume of value-based contracts. Marketing and business development efforts, therefore, may be geared toward large employers and other payers that are interested in contracting for population health management services.

CONCLUSION

For a variety of reasons, a growing number of IPAs are looking to become CINs. The CIN model does seem to be a better fit for today's healthcare economy; therefore, this trend is likely to continue. The transition from IPA to CIN, however, involves much more than just changing the acronyms on the door. Those that choose to undertake this move will be wise to strive to understand the challenges involved fully and to enlist expert help in making the leap from one model to another.