

# Clinical Integration: The First Step in Moving Toward Value-based Reimbursement



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November 2018

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## INTRODUCTION

More than a decade ago, disparate groups of providers comprised of hospitals and physicians within the Advocate System in Chicago, came together and successfully convinced the Federal Trade Commission (FTC) and the courts that they could contract jointly as a result of being clinically integrated. Since then, the term *clinical integration* is regarded more as a legal concept than a way of organizing healthcare delivery.

Clinical integration (CI) also is often confused with accountable care, and clinically integrated networks (CINs) are sometimes called commercial accountable care organizations or ACOs. The formation of a CIN is a critical first step for any group of providers who wish to succeed in an environment that is inexorably moving toward pay for value and away from pay for volume.

This paper will concentrate on the concept of value-based care delivery and how CI is essential in the creation of a healthcare system that reliably provides high quality per unit of cost. This way of looking at CI is becoming more critical as providers attempt to re-tool care processes and procedures to operate successfully in a reimbursement environment in a value-based healthcare marketplace.

## DEFINING VALUE

With the publication in the late 90s of the Institute of Medicine's (IOM) report on medical errors in U.S. hospitals, healthcare providers across the country dramatically focused their efforts on improving quality and patient safety. The Institute for Healthcare Improvement (IHI), led by Don Berwick, who later become CMS Director under President Barack Obama, introduced many initiatives around quality. Berwick also introduced the concept of the Triple Aim, where quality, population health, and cost control were suggested as the overarching goals around which the U.S. healthcare system should be concerned. Subsequently, in 2006, Michael Porter and Elizabeth Teisberg published their book titled *Redefining Health Care: Creating Value-based Competition on Results* and popularized the notion that value in the healthcare industry as being equal to quality divided by cost.

Porter and Teisberg's definition of value, however, flew in the face of the primary concerns of the healthcare delivery system, which had historically focused on volume production and, more recently, on quality improvement. Fortunately, or unfortunately depending on one's perspective, most providers had never given much thought to cost efficiency, which was the most difficult of the three components of the Triple Aim to impact.

Porter's solution to this challenge was to ask providers to coordinate their efforts around clinical conditions in what he called integrated practice units (IPUs). The outputs of IPUs, both quality and cost, could then be continuously measured, and data-driven process improvement methods could be used to modify and refine IPUs so that continuous value production would result.

## VALUE-BASED CHANGES IN THE HEALTHCARE ECONOMY

Ultimately, Porter and Teisberg envisioned a new marketplace opening up where competition among healthcare providers would center on the delivery of value (quality/cost) as opposed to delivering volume (number of patient visits, procedures, tests, etc.). Although this change in the healthcare economy has not yet entirely occurred, there is no doubt about its movement in that direction. More payers, both governmental and commercial, are coming forth with value-based reimbursement models. The Centers for Medicare and Medicaid Services (CMS), for instance, is committed to having 95% of their reimbursements based on value by the end of 2018. Also, the merit incentive payment system (MIPS) for physicians and the value-based reimbursement system (VBR) for hospitals, both of which have rolled out in the last few years, are proof that they are following through on that commitment. Commercial payers, as is often the case, are following CMS's lead, and the largest private health plans in the country (Aetna, United, and Blue Cross) all have value-based reimbursement models of various types.

The Affordable Care Act (ACA), which President Trump and the Republican-led Congress of 2016 vowed to repeal, included many components, such as the Medicare Shared Savings Programs, that have incentivized the transition to value-based care over recent years. Whether such programs will survive the demise of or adjustments to the ACA is at the time of this paper's publication up in the air with the changes in congressional control in January 2019. Nevertheless, it is important to note that opposition to the ACA seems much more directed toward its expansion of insurance coverage, particularly Medicaid, than to its promotion of value-based care delivery, which historically has had bipartisan support. As an example, the Medicare Access and CHIP Reauthorization Act (MACRA), which will dramatically move CMS payments to physicians and other providers from a fee-for-service to a value-based model, passed through Congress in 2015 with relatively little opposition.

## ORGANIZING PROVIDERS AROUND VALUE-BASED CARE DELIVERY

Changes in the reimbursement system over the last decade toward a more value-based model have also driven organizational changes on the provider side. First among these was the accountable care organization (ACO) that was initially described by Elliott Fisher and others at Dartmouth and then made a part of the Accountable Care Act (ACA) when enacted in 2010. ACOs consist of physician groups and hospitals who come together for the express purpose of driving quality and cost efficiency (value) and are rewarded for this through the sharing of savings with payers, e.g., Medicare in the ACA legislated ACO model. More recently, clinically integrated networks (CIN) have also been formed by physicians and hospitals to drive high-value healthcare delivery. The term CIN, however, usually refers to accountable care organizations that contract with commercial payers or directly with employer-sponsored health plans as opposed to those who contract with one of Medicare's shared savings programs. While this nomenclature can be somewhat confusing, the basic principles underlying both ACOs and CINs are essentially the same, and going forward this paper will refer to both as CINs.

## KEY COMPONENTS OF A CIN

As mentioned, the overarching purpose of a CIN is to drive higher value in the healthcare delivery system. To accomplish this somewhat arduous task, CINs must include several key components:

1. **Legal structure.** Most CINs are set up as single or multi-member, limited liability corporations owned by their physician or hospital sponsors. This structure is simple to create and flexible as the CIN operates as either a for-profit (the usual case) or a not-for-profit entity.
2. **Governance structure.** Physician leadership is key to the success of a CIN for the simple reason that physicians have the most proximate control over the quality and cost expenditures in the healthcare system. Additionally, one of the critical criteria that the FTC looks for in determining whether an organization meets the definition of being clinically integrated is the degree to which it is physician led. While hospitals and physicians often both participate in CINs and hold seats on the governing board of these organizations, physicians are usually in the majority on both the board and the various subcommittees of the board.
3. **Management structure.** A CIN is generally managed by a small group of full-time employees who work in close collaboration with a set of board-appointed subcommittees made up of key physician and hospital CIN participants. These subcommittees focus their activities on the following areas:
  - a. *Quality and Cost Efficiency.* This subcommittee determines the initiatives that will be the focus of activities for the CIN and selects the specific metrics by which each provider participant in the CIN will be evaluated. These metrics are usually specialty specific and may change over time as new initiatives are brought online by the CIN. Performance measured against these metrics also is used to reward participant's activities within the CIN and/or to determine whether remediation is necessary for those who perform poorly on selected measures.
  - b. *IT Infrastructure.* This committee selects and monitors the IT infrastructure that is needed to ensure that the CIN functions effectively and efficiently to drive high-value care delivery. Specific components of the IT systems used by a CIN may vary from one organization to another. Commonly, these components include:
    - i. Electronic health record systems;
    - ii. A health information exchange that serves to move information from one health record to another in an interoperable fashion;
    - iii. A centralized database that can house physician performance metrics and generate performance reports on a regular basis; and
    - iv. A population health analytic system that allows a CIN that is managing population health to identify hot spots and areas of concern toward which resources need to be selectively allocated.
  - c. *Finance and Payer Relations.* This committee is responsible for setting the CIN's budget on an annual basis, monitoring the financial performance of the CIN, determining the method of distributing any income out to the CIN participants, and, most importantly,

contracting with payers (government and commercial) for the collective services provided by the CIN's participants.

- d. **Accountability.** This committee carries the critical role of holding CIN participants accountable for their activities within the CIN. This oversight can include a combination of rewards where participants are financially incentivized to perform well on their specialty-specific metrics or remediating participants when they fail to meet pre-established standards of performance on selected quality or other performance standards. Ultimately, the committee may have the task of discharging a provider from the CIN who fails to achieve pre-established performance thresholds. However, in practice this event is rare, and most participants respond positively to incentives, peer pressure, and the opportunity to design care delivery that results in better value for their patients.
4. **Business Operations.** As with any start-up, a CIN must have a sound business plan that can quickly lead to its profitability and financial stability. While most CINs initially rely on investments from their sponsors, grant funds from governmental or non-governmental agencies, and dues from their participants to get off the ground, ultimately the CIN must become financially self-sufficient. The key to achieving this is for the entity to negotiate viable contracts with payers, providers, or employers. Usually, these contracts are value-based, i.e., part of the payment is contingent on achieving certain quality or cost efficiency targets. However, some CINs also enter into fee-for-service (FFS) contracts and then leverage their ability to identify and eliminate non-value-added costs to preserve margins in an FFS market where reimbursement rates are declining.
5. **Clinical Operations.** Ultimately, the CIN must have a way to re-tool the front-line clinical enterprise so that it reliably produces high value as opposed to just producing high volume. Management tools, such as lean value-stream mapping of common care processes and procedures, time-driven activity-based cost accounting, process management automation technology, and data-driven process improvement methodologies can contribute to making this happen. Merely reorganizing the providers into a CIN or ACO will not change long-standing clinical practice patterns. These changes require a systematic approach to transforming the delivery system from a volume to a value production model. Note, this does not mean that healthcare production can ignore volume or patient demand, as the aging of the population and expansion of affordable health insurance will likely ensure high demand for services into the foreseeable future. That said, those providers who can deliver both high-volume and high-value care delivery will indeed succeed in the healthcare marketplace of the future.
6. **Care Management Infrastructure.** CINs will likely become more involved over time with population health management. To do so, they will need to augment their clinical operating systems with a care management infrastructure that can deliver population health management services. Care managers include chronic disease managers, care coordinators, health educators, social workers, pharmacists, nutritionists, and others. These professionals will need to be organized into physician-led teams who can then be deployed where most needed. The patient-centered medical home (PCMH) model is an example of where team-based care is already happening. Thus, the primary care and some specialty components of a CIN need to strongly

consider implementing this model as they take on more population health management responsibilities. Reimbursement models are also changing to incentivize the PCMH model and other primary care innovations as exemplified by the all-payer Comprehensive Primary Care Plus (CPC+) model that is being introduced in several regions of the country.

7. **Compliance.** It is important to note that bringing together disparate providers into a CIN is fraught with compliance issues, mostly related to antitrust concerns. Despite this difficulty, many of these organizations have now been formed, and regulatory agencies, such as the FTC and the Justice Department, now consider the benefits of clinical integration to be a legitimate justification for allowing groups of providers who are not all employees of the same legal entity to jointly contract for services. It should be emphasized, however, that any group of providers who intend to form a clinically integrated network need to seriously consider engaging outside legal counsel who are experienced in this area and who can guide them through the somewhat arcane rules and regulations related to this process.
8. **Marketing.** As stated, a clinically integrated provider network will be at a distinct advantage once the reimbursement climate transitions from a predominantly volume-based model to a more value-based model. Nevertheless, CINs will need to demonstrate, through a well-thought-out marketing plan to payers, providers, and employers, their proven capabilities to deliver higher value. CINs will also need to time their transition from a volume-based production system to a value-based production model in order to not find themselves in front of or behind their particular market as this transition takes place. CIN development and its timing is not a one-size-fits-all process. Each market will require CIN developers to tailor their approach and timing to make sure they are optimally successful.

## CONCLUSION

CIN formation is a critical first step for any group of providers who wish to succeed in the future value-based healthcare marketplace. Successfully developing a CIN requires attention to the major components that make up these organizations and carefully timing the conversion with the move of the local market toward a value-based reimbursement model.

A systematic approach guided by those experienced in this process and by those who understand the legal ramifications of clinical integration can accomplish this transition process while minimizing disruptions in ongoing operations and maximizing the success of transforming the system into a more value-based delivery model.

In the end, the volume-to-value shift accomplished through the development of a CIN will benefit patients, providers, and even payers. The transition will not be smooth. Change is challenging, and the risks are high, especially in healthcare where extreme deviations or wrong decisions can put lives in danger. Nevertheless, the healthcare system of today must adapt and meet the demands of delivering the so-called Triple Aim (excellent care, improvements in population health, and lower costs) and CINs can help providers organize to deliver all three of these lofty goals.