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Clinical Integration: What Hospital Board Members Need to Know

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

Clinical integration (CI) is also often confused with accountable care, and clinically integrated networks (CINs) are sometimes called commercial accountable care organizations or ACOs.

This article, however, will concentrate on the concept of value-based care delivery and how CI is the necessary first step toward the creation of a healthcare system that reliably provides high-quality per unit of cost. This way of looking at CI is becoming more important as providers attempt to re-tool care processes and procedures to operate successfully in a reimbursement environment inexorably moving toward pay-for-value and away from pay-for-volume.

Defining Value

With the publication of the Institute of Medicine's report on medical errors in U.S. hospitals, healthcare providers across the country dramatically focused their efforts on improving quality and patient safety.[1] The Institute for Healthcare Improvement, led by Don Berwick, 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, *Redefining Health Care: Creating Value-Based Competition on Results*, and popularized the notion of value in the healthcare industry being equal to quality divided by cost.

Value-Based Changes in the Healthcare Economy

Ultimately, Porter and Teisberg envisioned a new marketplace opening up where competition among healthcare providers would center around 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 occurred entirely, there is no doubt about the 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 percent of their reimbursements based on value by the end of 2018. Commercial payers 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.

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 ACO, which consists of multi-specialty physician groups and hospitals that 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. More recently, CINs have also been formed by physicians and hospitals to drive high-value healthcare delivery. However, the term CIN usually refers to ACOs that contract with commercial payers or directly with employer-sponsored health plans as opposed to those that contract with one of Medicare's shared savings programs also referred to as ACOs. While this nomenclature can be somewhat confusing, the basic principles underlying both ACOs and CINs

[1] Committee on Quality of Health Care in America, Institute of Medicine, *To Err Is Human: Building a Safer Health System*, National Academies Press, 2000.

are the same and going forward this article 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, 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 has proven to be simple to create and very 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:
    - Quality and cost efficiency
    - IT infrastructure
    - Finance and payer relations
    - Accountability
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 status is for the entity to negotiate viable contracts with payers, providers, or employers. Usually, these contracts are value-based. However, some CINs also enter into fee-for-service contracts and then leverage their ability to identify and eliminate non-value-added costs to preserve margins in a fee-for-service market where reimbursement rates are declining.
5. **Clinical operations.** Ultimately, the CIN must have a way to re-tool the frontline 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 are essential to making this happen. Merely reorganizing the providers into a CIN or ACO will not change long-standing clinical practice patterns. For these to change, there must be 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 ever ignore volume, 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 system 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 that 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 should be noted 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 Department of Justice, 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 entity to jointly contract for services. It should be noted, however, that any group of providers who intend to form a CIN need to seriously consider hiring outside legal counsel experienced in this area 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 also will need to time their transition from a volume-based production system to a value-based production model to not find themselves in front of or behind their particular market as this change takes place. CIN development and the timing of it 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 coming value-based healthcare marketplace. Key takeaways for hospital board members to know about clinical integration and CIN development include:

- 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 Governance Institute thanks Ellis "Mac" Knight, M.D., M.B.A., Senior Vice President and Chief Medical Officer, Coker Group, for contributing this article. He can be reached at mknight@cokergroup.com.

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