Clinical Integration
Better Clinical Quality Through Physician Alignment

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Credits: This presentation contains Slides & content developed by Hogan Marren, Ltd.
Today’s Presentation

- The Fee-for-Service Payment System is Flawed
- The CI Network: Meeting the Challenges of Health Care Reform
- What is Clinical Integration (CI)?
- How does CI work?
- CHC & The Medical Center’s Approach
The Fee-for-Service Payment System is Flawed
Ethical and Economic Flaws of Fee-for-Service

- Rewards overutilization
- Undervalues quality
- Ignores care coordination
- Creates an unsustainable trend
H. R. 3590

One Hundred Eleventh Congress
of the
United States of America

AT THE SECOND SESSION

Began and held at the City of Washington on Tuesday,
the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE. TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improvements in Health Care Coverage for All Americans

Sec. 1001. Amendments to the Public Health Service Act.

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS"

"SUBPART I—EXPANDING COVERAGE"

Sec. 2711. No lifetime or annual limits.
Sec. 2712. Prohibition on rescissions.
Sec. 2713. Coverage of preventive health services.
Sec. 2714. Extension of dependent coverage.
Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.
Sec. 2716. Prohibition of discrimination based on salary.
Sec. 2717. Ensuring the quality of care.
Sec. 2718. Bringing down the cost of health care coverage.
Sec. 2719. Appeals process.
Sec. 1002. Health insurance consumer information.
Sec. 1003. Ensuring that consumers get value for their dollars.
Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.
Sec. 1102. Reinsurance for early retirees.
Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.
Sec. 1104. Administrative simplification.
Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

"PART I—HEALTH INSURANCE MARKET REFORMS"

Sec. 1201. Amendment to the Public Health Service Act.

"SUBPART I—GENERAL REFORM"

Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.
Sec. 2705. Fair health insurance premiums.
Sec. 2702. Guaranteed availability of coverage.

APPROVED
MAR 23 2010

Barack Obama
Accountable Care: A New Language?

ACOs  Value-Based Purchasing

Quality Contracts  P4P

Shared Savings  Tiered Networks

Narrow Networks  Pioneer ACOs

Clinical Integration
The CI Network: Meeting the Challenges of Health Care Reform
CI and Health Care Reform

• CI functions as an Accountable Care Organization
• CI provides the infrastructure for Medical Home
• CI creates conditions for “meaningful use” of IT
• CI facilitates “gainsharing,” “pay-for-performance,” and “shared savings” arrangements

• ...and allows physician networks to assert themselves forthrightly in collective negotiations with PPO health plans
Health Care Reform = Increased Risk & Accountability

- Pay for Performance
- Hospital-Physician Bundling
- Episodic Bundling
- Shared-Savings Model: ACO
- Cap

Risk -> Accountability
The Answer: Physician-Hospital Alignment

Employment Models

JVs/Co-management/Etc.
The Answer: Physician-Hospital Alignment

Clinical Integration
What is Clinical Integration?
The Foundations of Clinical Integration

**FTC Advisory Opinions**

- MedSouth
- gripa
- Suburban Health Organization

**FTC Enforcement Actions**

- BROWN & TOLAND PHYSICIANS
- Advocate Health Partners
- North Texas Specialty Physicians

**FTC /DOJ Policy Statements**

- Improving Health Care: A Dose of Competition
  
  
  Issued by the U.S. Department of Justice and the Federal Trade Commission
  
  August 1996
“...an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.”
Our experience indicates that in order to qualify as legitimately clinically integrated pursuant to this definition, the following conditions must exist:

1. a network of physicians willing to demonstrate "a high degree of interdependence and cooperation," through

2. a program of initiatives designed to "control costs and ensure quality," which

3. is supported by an infrastructure that allows the physicians to "evaluate and modify practice patterns."
3-Part Legal Analysis for CI

An analysis of any physician network’s clinical integration program is essentially a three-part test which asks:

1. whether the network’s clinical integration program is “real” containing authentic initiatives, actually undertaken by the network, which involve all physicians in the network, and apply to the physicians’ practice patterns relative to patients who obtain health benefits under fee-for-service health plans;

2. whether the initiatives of the program are designed to achieve likely improvements in health care quality and efficiency; and

3. whether joint contracting with fee-for-service health plans is “reasonably necessary” to achieve the efficiencies of the clinical integration program.

Real CI effectively creates a “new product”
How does CI work?
Developing a Value Proposition

- **Physicians** need a legitimate means of joint contracting that rewards better performance, provides access to the technological infrastructure necessary to demonstrate that performance, and realigns the otherwise perverse financial incentives in the fee-for-service health care system.

- **Hospitals** view physician alignment as a way of mobilizing a loyal “vanguard” within the voluntary medical staff, driving improvements in utilization and length of stay, and providing incentives for the adoption of advanced clinical technologies – thereby competitively positioning the hospital in the market based on quality.
Developing a Value Proposition

- **Payors** (whether employers or health plans) will value a relationship with aligned hospitals and physicians if this collaboration can show an ability to generate cost savings and better employee productivity through better health.

- **Patients** benefit from physician alignment by receiving health care through organized, evidence-based processes that focus on some of the most common, most costly, most treatable, and yet most debilitating illnesses in their communities.
Core Components for Success

• Understand the forces affecting physicians; design strategic offerings to meet the needs of local physicians
• Understand the system-wide and market specific capabilities and infrastructure in the context of the communities served
• Ground physician-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets
• Ensure strong physician participation, leadership and governance
• Use technology to connect with physicians
Committees undertake necessary activities for CI

Core CI Steering Committee

Participants (Total 9-12):
- Physicians – selected to represent key constituents (inpatient/outpatient, independent/employed, primary care/specialist, key groups) – 6-8
- Administrative – practice leadership, quality, IT, presumed CI leadership – 2-4

Responsibilities: Overall project oversight and direction, appointment of initial and subsequent committees
- Administrative Support staff – 2-3

Organization

Responsibilities:
- Adapting Organizational Structure to Support CI
- Approving formational documents and policies
- Securing Physician Participation

Initiatives

Responsibilities:
- Developing Inpatient and Outpatient CI Initiatives
- Adopting Scoring Methodology
- Establishing Remediation Process

Infrastructure

Responsibilities:
- Developing Technology Infrastructure and Staffing Plan Necessary to Monitor and Report Progress
**Typical CI Business Structure – Single Hospital**

**Key issues:**
- Financing the ACO
- Ownership
- Governance
- Operations
- Existing MCO relationships

Hospital establishes CI Organization as a wholly-owned subsidiary, with governance predominated by physicians.

CI Operations Co. contracts with hospital for “back office” services (staff, technology resources, etc.).

Physicians execute Provider Network Agreements with the CI Organization, whereby they elect to participate in the CI Program.

CI operations company enters into CI contracts with payors, including the hospital's self-funded employee benefit plan.
For multi-hospital health systems, we typically recommend that physician leadership from each local hospital participate, provide guidance and oversight, and hold final decision making authority on key issues during the clinical integration development process. A predominantly physician Governance would provide final approval of recommendations from the subordinate committees. Further, at each health system hospital, we recommend the establishment of CI/ACO “Local Chapters,” with a committee of physicians affiliated with each site providing site-specific leadership and local enforcement of the CI Program.

*Established following CI Program development and once sufficiently confident of infrastructure.
Establishing Consensus

• Identify the key stakeholders you need to engage
• Candidly address the internal obstacles
• Address any significant skepticism
• Determine an organized way to manage the process
• Present a compelling value proposition case for all stakeholders
• Align CI with other physician integration strategies within your organization
The CI Narrative

• Look to the history between and among your hospital and physicians to show how it led you to your decision to attempt CI

• Discern the connection between joint contracting and quality improvement

• Identify the gaps in current organizational, technological, and personal resources

• Determine a plan for moving forward
Building the Organization

• Draft key physician leaders
• Determine appropriate staffing for the start-up of your CIO
• Educate rank-and-file physicians about CI
Developing CI Initiatives

• Build upon existing quality initiatives
• Engage health plans and employers in the development of CI initiatives
CHC & The Medical Center’s Approach
CHC & The Medical Center

- Commonwealth Health Corporation
- The Medical Center At Bowling Green
- Enspire Quality Partners

**Physician led Board!**
Operationalizing the Network

CHC

Enspire

MCBG

Staff & Network Operations

Resources to Launch
- Hogan Marren Consulting & Legal
- IT Solutions

Physician Led Committees
Resources & Tools

Legal Expertise
- Hogan Marren, Ltd.
- Formation of Legal Entity & Structure
- FTC Compliance

Technology Infrastructure
- Advisory Board’s Crimson Suite
- IT Infrastructure
- Analytics & Decision Support
Any questions?

Thank you.