Community Hospital100®

Kurt Salmon

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Special Report: Clinical Integration

Kurt Salmon and Community Hospital 100

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Clinical Integration Background

Provider organizations across the country are exploring opportunities to accept greater clinical and financial accountability for the populations they serve. Many organizations see the strategic value in considering options for increased accountability through integrating members of its physician community and the development of a clinically integrated organization. While clinical integration (CI) is currently not well defined in our industry, we categorize it as delivering patient care across conditions, providers, settings and time in order to achieve care that is safe, timely, patient focused and that effectively utilizes health care resources. The clinically integrated organization offers the ability to have an aligned group of independent physicians actively cooperating to control hospital costs, improve quality and achieve pay-for-performance targets.

Currently, significant numbers of clinically integrated organizations do not exist, but as the ACO wave has gained momentum, many providers are developing and implementing CI strategies. Additionally, the timing now is right, whereas in the past, the infrastructure to achieve meaningful integration did not exist or networks were assembled for the wrong reasons. Physicians have found a new motivation to achieve CI because:

1. There is a realization that to make a meaningful difference in their patients' lives, those patients need to be managed in an integrated network of care—it is the correct thing to do from a professional perspective.
2. There are increased pressures of markets and economics to reduce operating costs and improve margins—it is the smart thing to do from a business perspective.

About the Survey

Kurt Salmon and Community Hospital 100 sent out a brief 15-question survey to Community Hospital 100's contact list of C-level leaders from community-based hospitals and health systems in early July of 2013. The survey questions focused on how CI is currently unfolding and how the participants perceive that it will continue to unfold in their markets. There were 118 respondents to the survey. The first five questions allowed us to categorize the rest of the responses based on the type of organization in which the participant is affiliated. These questions allowed us to filter the data by category:

1. System Affiliation
2. Scale—Bed Size and Revenue
3. Tax ID—For-Profit or Not-for-Profit
4. Location—Rural, Urban or Suburban

Key Survey Takeaways

After examining the survey responses and filtering the data based on the categories above, a number of key takeaways became apparent. These takeaways are shared below.

Clinical Integration Is Becoming Pervasive

Hospitals working toward CI with their physician partners seem to be pervasive throughout the country, with 77% of respondents answering that CI initiatives are occurring in their market. An examination of the data shows that all categories of respondents had roughly the same answers, leading us to believe that CI initiatives are happening in all types of markets.

The Kaiser Permanente Vision

While most respondents say that hospital-sponsored clinically integrated networks (CINs) in their market will be a combination of employed and independent practitioners (70%), many responded that the large regional health systems in their markets are positioning themselves to own the entire integrated care continuum (61%). The respondents representing systems were even more likely to agree with this idea (69%). Additionally, 81% of respondents felt that the CINs in their markets would either develop their own insurance product or develop one through collaboration with a payor. The respondents from the very large organizations ($3 billion+ revenue) were more likely to believe that CINs in their market would develop their own insurance product (36% vs. 26% for the overall respondents).

Significant Uncertainty

A telling trend from the survey was the lack of certainty that many respondents had about the impact of CINs and the requirements needed for them to be successful. This is perhaps not surprising, as CI is a relatively new occurrence for many health care providers and no one can be certain how this current period of rapid change in health care will unfold. The following questions had the highest percentage of unsure respondents:

1. Will CINs in your market achieve savings? (32.4% unsure)
2. Will CINs in your market take on increased financial risk for reimbursement? (20.4% unsure)
3. Will CINs in your market develop in-house data systems and analytical capabilities? (25.9% unsure)
4. Will the patient-centered medical home (PCMH) be a requirement for CINs in your market? (38% unsure)

Large Hospitals/Health Systems Will Drive the Development of CINs

Most survey respondents felt that CIN development is attainable only by larger hospitals/systems (only18.5% of respondents felt that hospitals with fewer than 300 beds could develop CINs). Additionally, throughout the survey we have noted that the responses from individuals affiliated with large health systems suggest that large health systems will drive the development of CINs, accept more financial risk and own more components of the network.

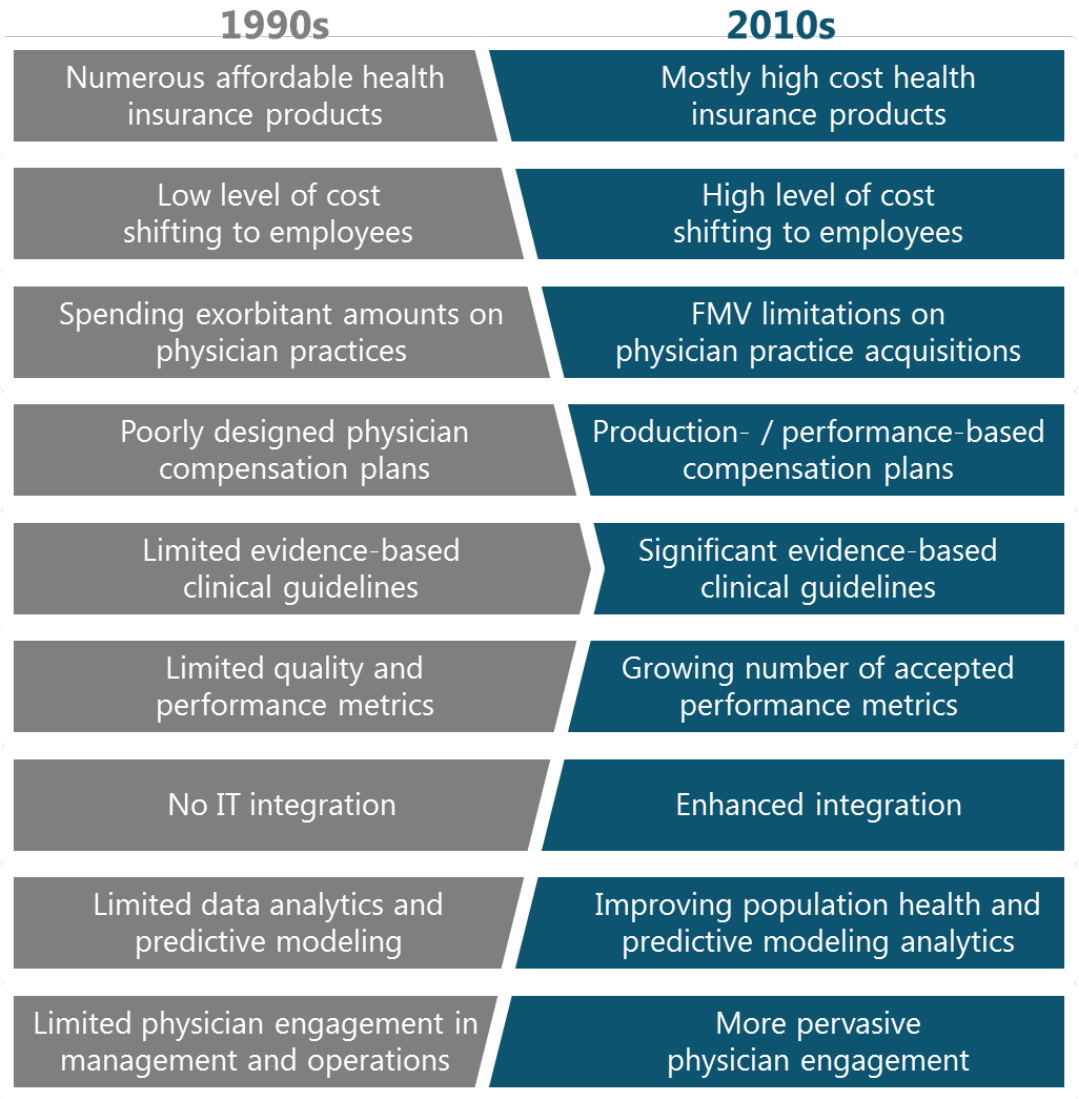
FIGURE 1: Differing Perspectives from Respondents Affiliated with Small Rural Hospitals and Large Health Systems

	Small Rural Hospitals	Large Health Systems
CIN DEVELOPMENT	PARTNER	ORGANIZER
REIMBURSEMENT	LIMITED-RISK MODELS	HIGH-RISK MODELS
CARE CONTINUUM	OWNS COMPONENTS	OWNS MOST
CIN INFRASTRUCTURE	OUTSOURCED	IN-HOUSE

Kurt Salmon Predictions

For many physicians and health care executives that were practicing in the early 1990s, there is a healthy skepticism about where the health care delivery system is now moving in regard to network development, physician alignment and increased financial risk. This is not surprising given that these individuals lived through this trend once, saw it be unsuccessful and are now witnessing its rebirth. It is our belief that this is much more than a cyclical trend seen in other industries. The current economic environment is now mandating that the health care reimbursement and delivery system go through real and permanent change. Figure 2 (page 4) shows the differences between the current health care environment and the one in the 1990s.

FIGURE 2: Generational Differences in the Health Care Environment



As we consider what transpired in the 1990s, examine the current state of the health care market and consider the drivers that are changing the current landscape (i.e., economic trends, health care reform, and advancements in technology and evidence-based clinical practices), we believe that predictions can be formulated about how CINs will develop over the next five to ten years.

1. **Health Systems Will Drive Development**—The transformation from hospitals to CINs will be led by the large health systems. There are three major factors that will drive this:
    - *Access to Capital*—Over the last decade, the capital needs for most hospitals focused on facility updates and expansions as well as replacement and acquisition of new technology and equipment. The development of CINs and the move to population health are now priorities for many organizations. This includes development costs for setting up the CIN structure, economic alignment models with physicians (including employment), distributing EHRs to physicians, integrating

IT systems through health information exchanges (HIEs) and developing/ purchasing data analytics capabilities. Estimates for the development of clinically integrated networks are as high as $82,000 per physician.[1]

- *Requires Select Skills and Expertise*—The CIN transformation also requires that hospitals shift their focus beyond the traditional focus of inpatient/hospital-based care. Since this is outside of most hospitals' core services, additional expertise will be required. Bringing on individuals with this expertise is more cost-effective for systems that can spread the cost across multiple facilities.
- *Complete Service Offering*—CINs will eventually consist of the full continuum of health care services. The large systems have more robust service offerings than their independent community hospital counterparts; therefore, there will be less reliance on outside providers to fill their gaps in the continuum.

2. **CINs Will Eventually Accept Full Risk**—Over the last several years there has been an introduction of numerous reimbursement models that have shifted financial risk to health care providers. These include the demonstration projects introduced by CMS as part of the health care reform legislation (e.g., Medicare Shared Savings Plan and bundled payments) and a number of value-based models that providers have developed with commercial insurers. These models are likely interim steps that will conclude with global payments (full capitation with performance metrics) or something similar. Some organizations in places like Massachusetts, Seattle and Minneapolis have already transitioned many of their contracts to global payments, which enables them to keep all generated savings. If reimbursement inflation stagnates, as many health care economists predict, many organizations will find global payments their best option for enhancing their financial position. Additionally, global payments are likely the best way to incentivize CINs to provide population health.
3. **The CIN Governance Structure Will Grow in Importance**—The governance and leadership structure of the CIN will gain importance above that of the hospital or health system. Payor contracting will shift from the independent parties to the CIN, which will increase its influence. Additionally, the wellness and care management provided by the physicians will have a greater impact on the profitability of the CIN than taking cost out of the services traditionally controlled by the hospitals. The strong influence that physicians will have on the success of the network will elevate their status in the CIN.
4. **Most CINs Will Not Consist of a Single Organization**—The health systems that move to replicate the Kaiser Permanente model will be a small minority. While it is likely that nearly all systems will grow their portion of the care continuum (e.g., through additional physician employment), the majority of systems will not own the entire continuum for several reasons:
   - *Cost Prohibitive*—The relatively low margins generated in the provider sector mean most health systems are not flush with capital and must be selective about investment. Purchasing services that are "downstream" in the care continuum will

[1] Source: The Work Ahead: Activities and Costs to Develop an Accountable Care Organization, American Hospital Association, April 2011

not add revenue in a global payment environment and will create additional costs to manage.

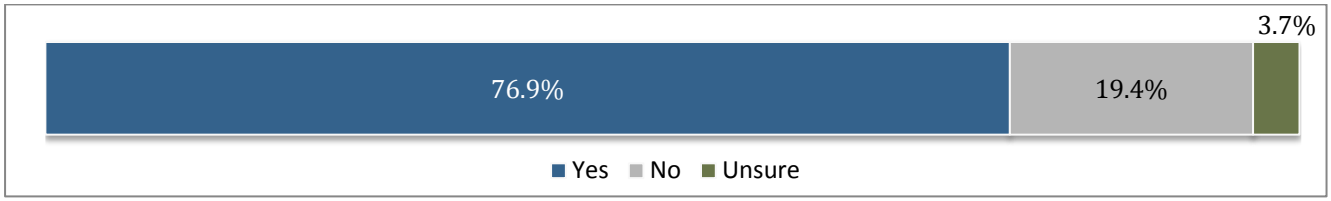
- *Others Provide Better Service*—There are large regional/national organizations that specialize and have significant scale in select components of the continuum (e.g., Kindred Hospitals, HealthSouth and Apria Healthcare). It is likely that in most cases partnering with these organizations will be more cost-effective and will provide patients with better service than a health system doing this on its own.
- *Aligned Incentives*—If CI is fully achieved and financial incentives are aligned, the need to control each component through ownership diminishes significantly.

5. **Non-Hospital-Led CINs Will "Vendorize" Hospitals**—Not all CINs will be developed by hospital systems. These non-hospital-based CINs will consist of large physician networks that will take on full financial risk. They will use hospitals as contracted vendors and provide them with little or no control. These CINs will be driven by physician organizations (e.g., IPAs or large multispecialty groups), managed care organizations or large corporations (e.g., DaVita Health Partners). Some of these organizations will take on national growth strategies.
6. **The End of the Solo Practitioner**—Over the next 10 years, very few solo practitioners and small groups will remain. Even though joining a CIN can provide physicians with the benefits of being part of a large network, the financial security of joining a group will become more enticing and the independent physicians that retire will not be replaced by the generation of physicians now coming out of residency. This requires CINs currently consisting of significant numbers of independent practitioners to be prepared to transition to physician employment models in the future.
7. **Outsourced Informatics and Analytics**—The IT infrastructure health care organizations have developed over the last decade allows the collection of significantly more data than ever before, and as these organizations form CINs with shared data capabilities and are obtaining access to claims data from the payors, a nearly complete understanding of a population's utilization of health care services will become available. Being able to use this big data to develop disease registries, trigger testing and screening protocols, and conduct predictive modeling and risk assessment will be key in being able to effectively manage the health of a population.

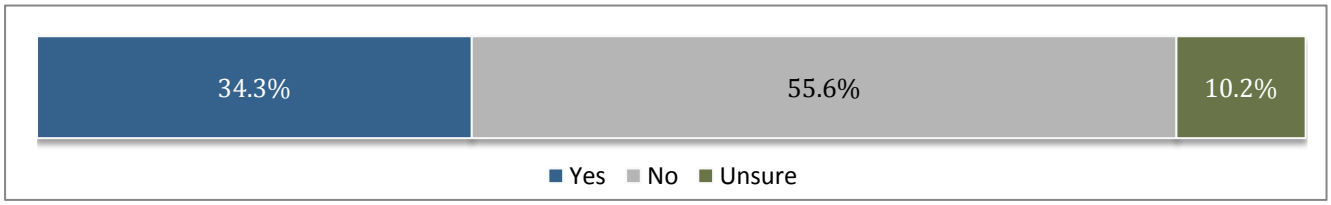
   In many ways, organizations are facing the same make-or-buy decision they faced a decade ago when deciding whether to develop in-house EHRs or use a vendor's product. The same scenario will play out with data analytics as occurred with health care IT. The vendors' products will advance beyond those developed in-house by hospitals because of the vendors' scale advantage in their core services.

Survey Responses

Are physicians and hospitals in your market working together to transform care through clinical integration activities?

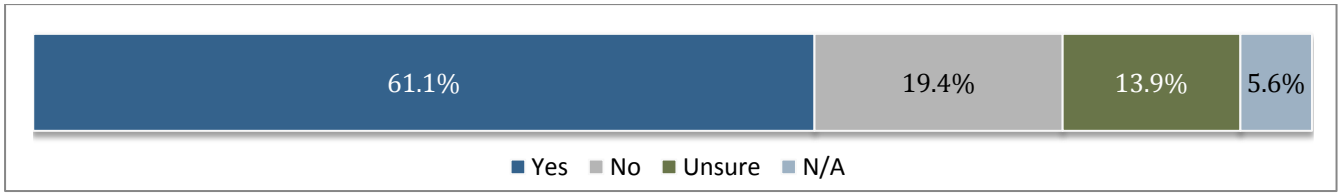


Are physicians in your market working toward care transformation activities independent of hospitals and health systems?

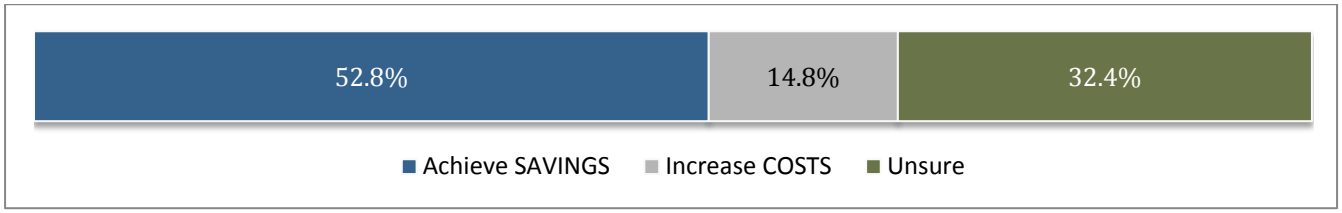


As hospital-sponsored clinically integrated networks (CINs) mature in your market, will they be made up of mostly employed physicians, independent physicians or a combination of the two?

Are large regional health systems in your market positioning themselves to own the full continuum of health care services in their networks (i.e., become integrated delivery systems with physicians, SNFs, home health, rehab, etc.)?

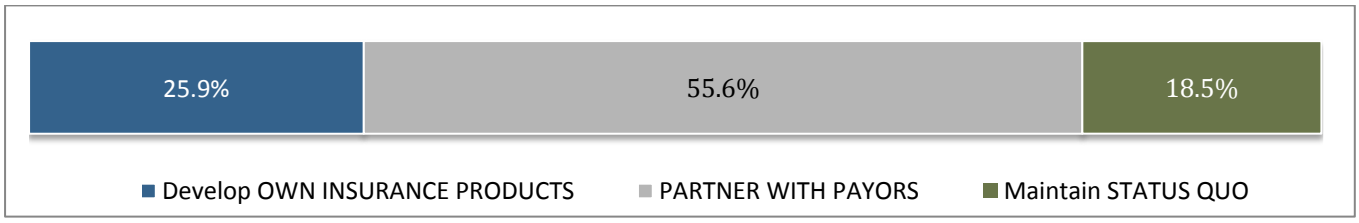


Will CINs in your market achieve savings through care improvement and enhanced efficiencies, or will they increase costs by wielding greater leverage over managed care organizations?

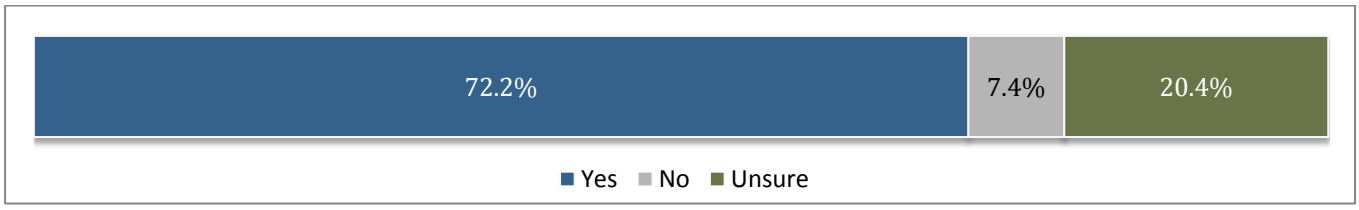


Survey Responses *(continued)*

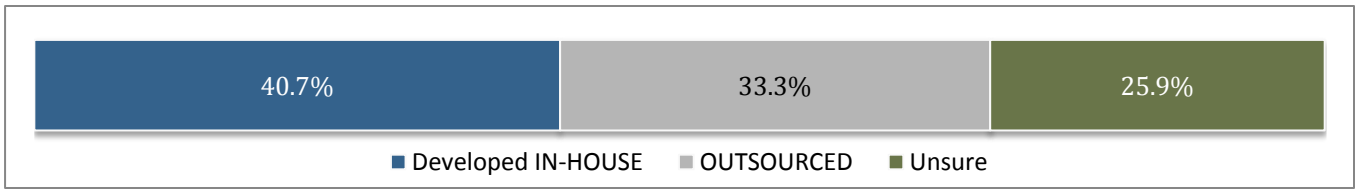
Will CINs in your market develop their own insurance product, partner with payors to develop value-based insurance products, or will the providers and payors maintain the status quo?



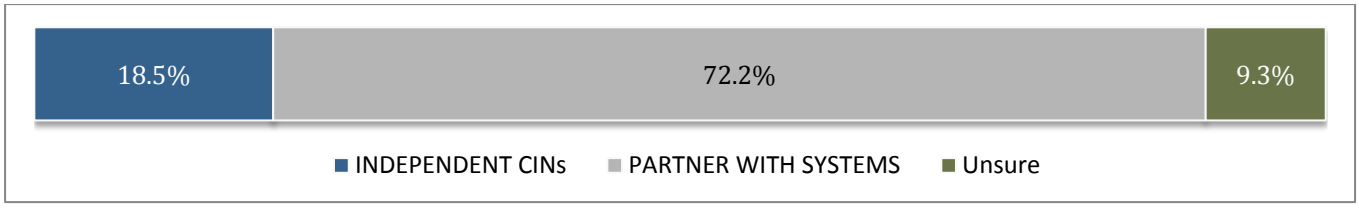
Will the clinically integrated networks in your market take on increased financial risk for reimbursement (i.e., shared savings, partial capitation or full capitation)?



Will the CINs in your market develop in-house data systems and analytical capabilities to provide population health services, or will these capabilities be outsourced to technology companies, payors or other health system collaboratives?



Will small to medium-size community hospitals in your market (i.e., up to 300 beds) be able to develop successful independent CINs, or will they need to partner with larger systems to achieve scale?



Will the patient-centered medical home be a mandatory requirement for the CINs in your market?