



# The Strategic Physician Network: Crossing the Payment Crevasse

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Affinity Group Teleconference Series**



Boston • Cleveland • Dallas • Denver • Miami • San Francisco • Washington, D.C.

# Getting from Here to There

How to get from A to B?

## Paralyzed by the Crevasse



### FEE FOR SERVICE

- A system we know – all about volume
- Declining margins, but we can “make it up on volume”
- Reinforces work in silos
- Little incentive for real integration

Whither Margins?

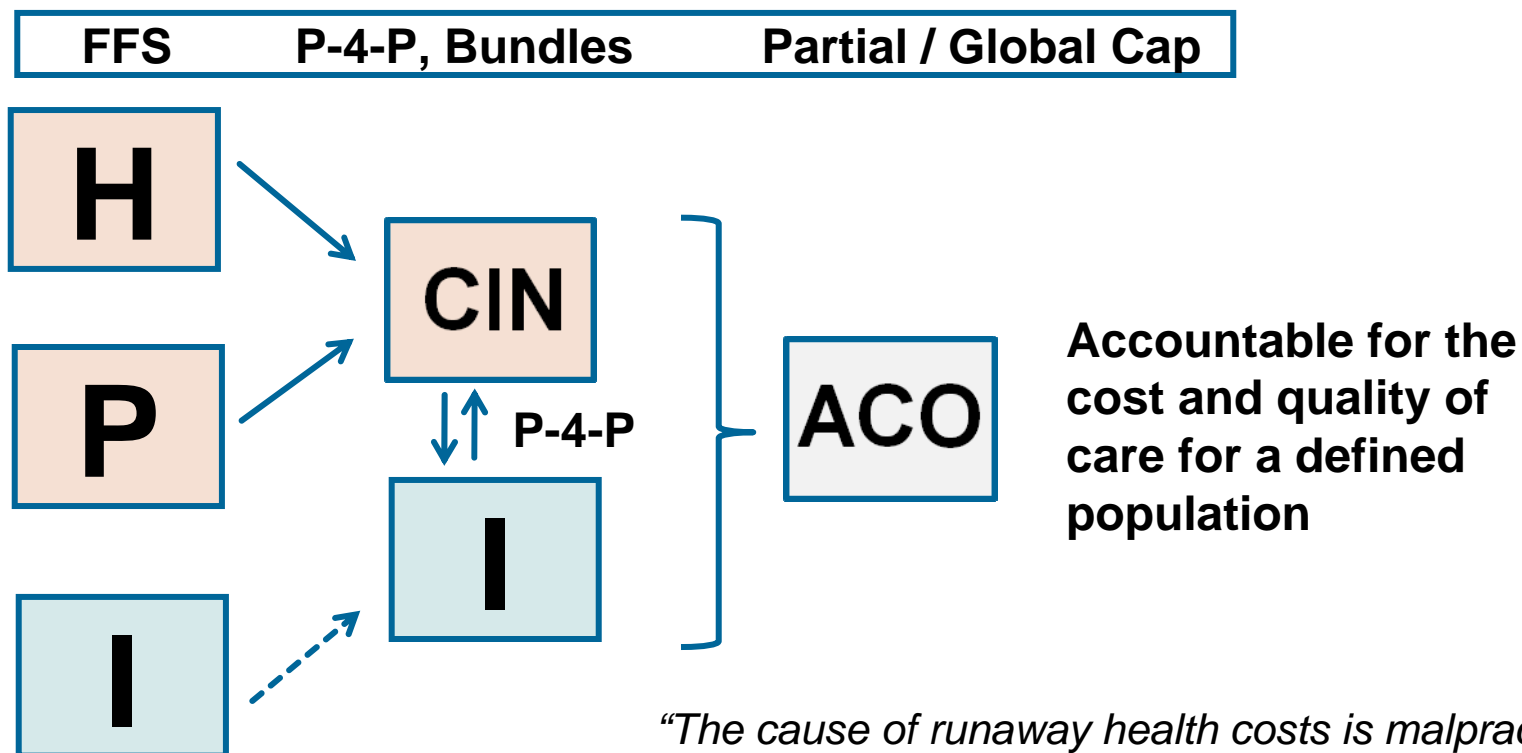
### BUNDLED PAYMENT

- Seems so “90s”
- Got burned on this 15 years ago
- Fad or enduring trend?
- Can providers share in the upside of improved quality and lower cost?

Clinical Integration is a way for physicians and health systems to bridge the gap between FFS reimbursement world and tomorrow’s value-based payment world.

# The Path to the ACO - Delivery System Reform

*Integrating the three components of the delivery system into a single entity*



H = Hospital

P = Physicians

I = Insurers

CI = Clinical Integrated Network

ACO = Accountable Care Organization

*"The cause of runaway health costs is malpractice, but not the medical kind. Rather, we're guilty of **business model malpractice** on a grand scale."*

*Clayton Christensen – BusinessWeek March 2010*

# Clinical Integration

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*The promise of clinical integration is a superior system of care delivery*

## Clinical Integration (Shortell)

*Clinical integration is defined as the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units so as to maximize the value of services delivered. Clinical integration includes both horizontal integration (the coordination of activities at the same stage of delivery of care) as well as vertical integration (the coordination of services at different stages).*

*Stephen Shortell, 1996, page 30.*

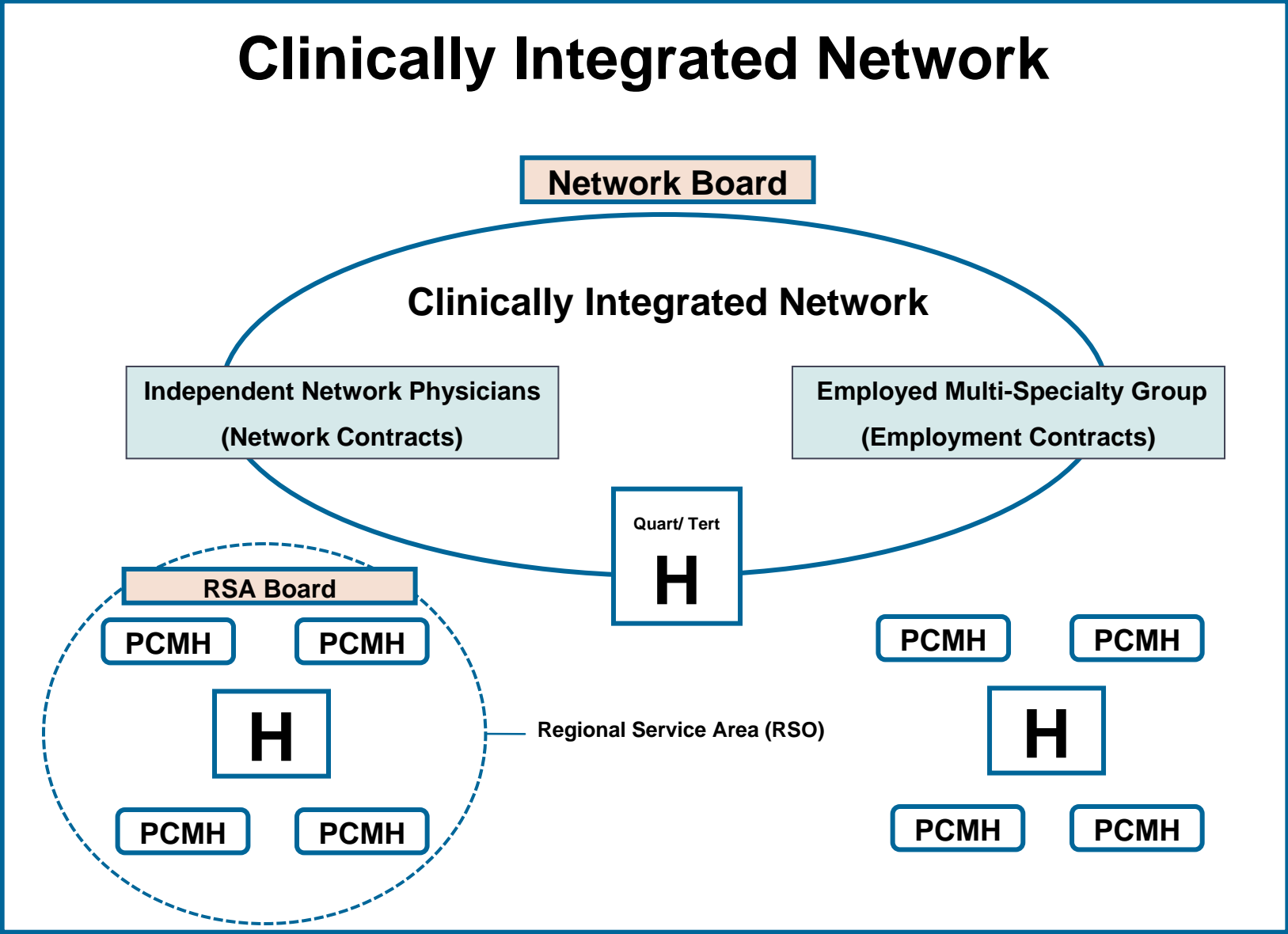
## Clinical Integration (FTC Definition)

FTC, a “qualified clinically integrated arrangement” is:

*...an arrangement to provide physician services in which: 1. all physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of, interdependence and cooperation among these physicians in order to control costs and ensure the quality of services provided through the arrangement; and, 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.*

(Statements of Antitrust Enforcement Policy in Health Care by the FTC and the U.S. Department of Justice, Statement 8, <http://www.ftc.gov/reports/hlth3s.htm#8>.)

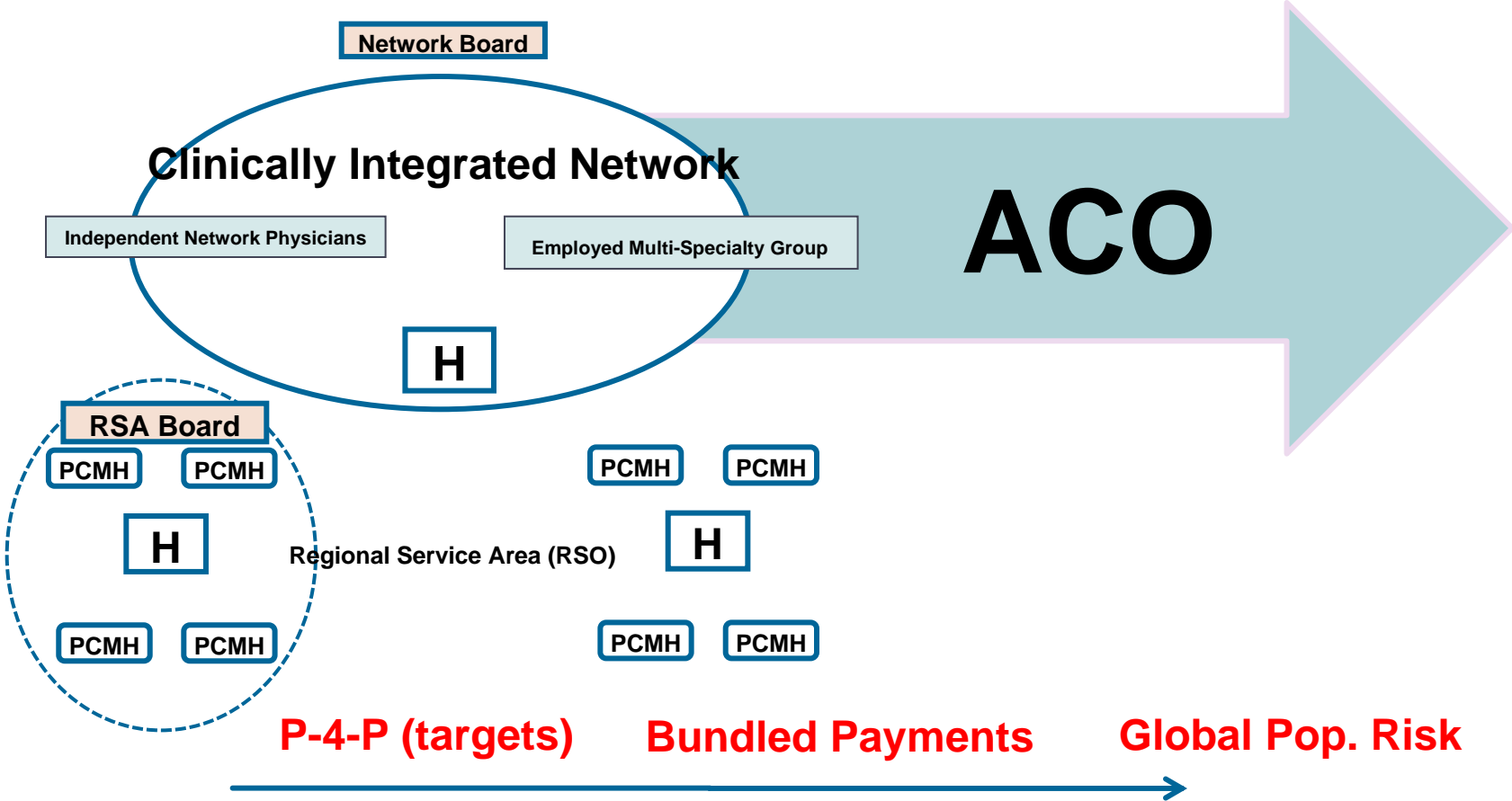
# Vision of a "Generic" CIN



# Uncertainty of Criteria to Claim “ACO” Status

*Definition of ACO remains ambiguous as industry pilots various models*

When does an organization with a clinically integrated network (CIN) become an Accountable Care Organization?



# CIN to ACO Transition – One Point of View

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*Transition to an ACO involves taking meaningful risk for the care of a defined population*

## CIN

- Organized Network Structure
- Performance-based contracts
- Value-based payment

## ACO

- Responsibility for quality and cost for a defined population
- Global or modified cap payment, e.g.
  - HMO (Kaiser)
  - Mass AQC
- Professional cap for MA product
- Independence at Home certified network or practice

# Legal Hurdles in Becoming a CIN / ACO

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*Creating a CIN requires careful study of federal and state regulatory rules and a network design that will meet all requirements*

- Antifraud Laws
- Antitrust Laws
- NFP (tax exempt) Requirements
- Licensing Requirements
- State Laws Prohibiting “Fee-splitting”
- State Insurance Laws
  - Risk assumption requirements
  - Reserve requirements
  - 3<sup>rd</sup> party administration functions

## **Antitrust Considerations:**

- (1) Whether the program is “*real*,” i.e. composed of *legitimate, well-founded* initiatives, involving all the physicians in the network;
- (2) Whether the program is designed to create *likely efficiencies in terms of* better health care quality or lower cost; and
- (3) Whether joint negotiations with fee-for-service health plans is “*reasonably necessary*” to achieve the *efficiencies sought by the program*.

*FTC/DOJ Enforcement Guidelines*

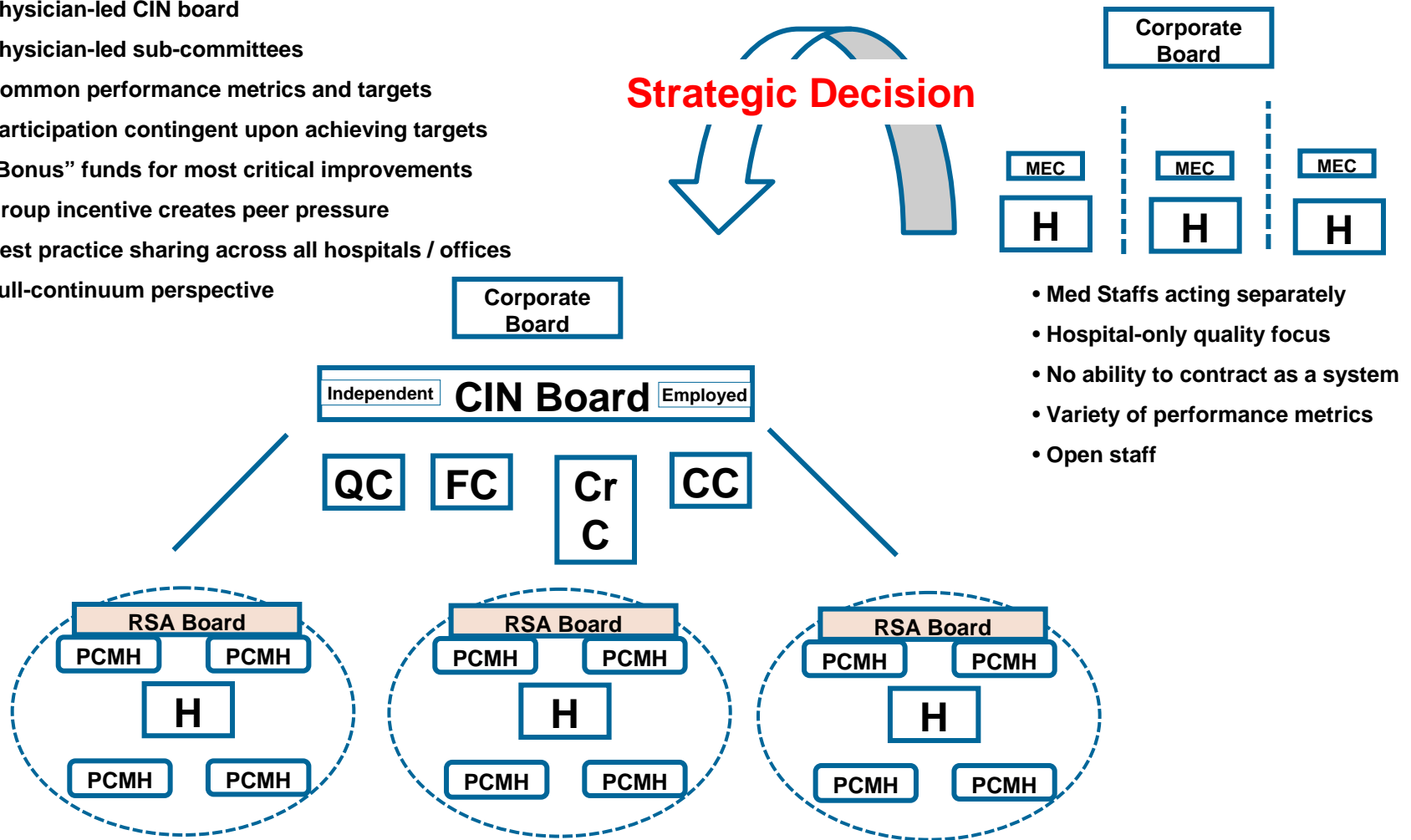
# Creating a CIN is a Major System Transformation

## Clinically Integrated Network

- Physician-led CIN board
- Physician-led sub-committees
- Common performance metrics and targets
- Participation contingent upon achieving targets
- “Bonus” funds for most critical improvements
- Group incentive creates peer pressure
- Best practice sharing across all hospitals / offices
- Full-continuum perspective

## Traditional Hospital System

**Strategic Decision**

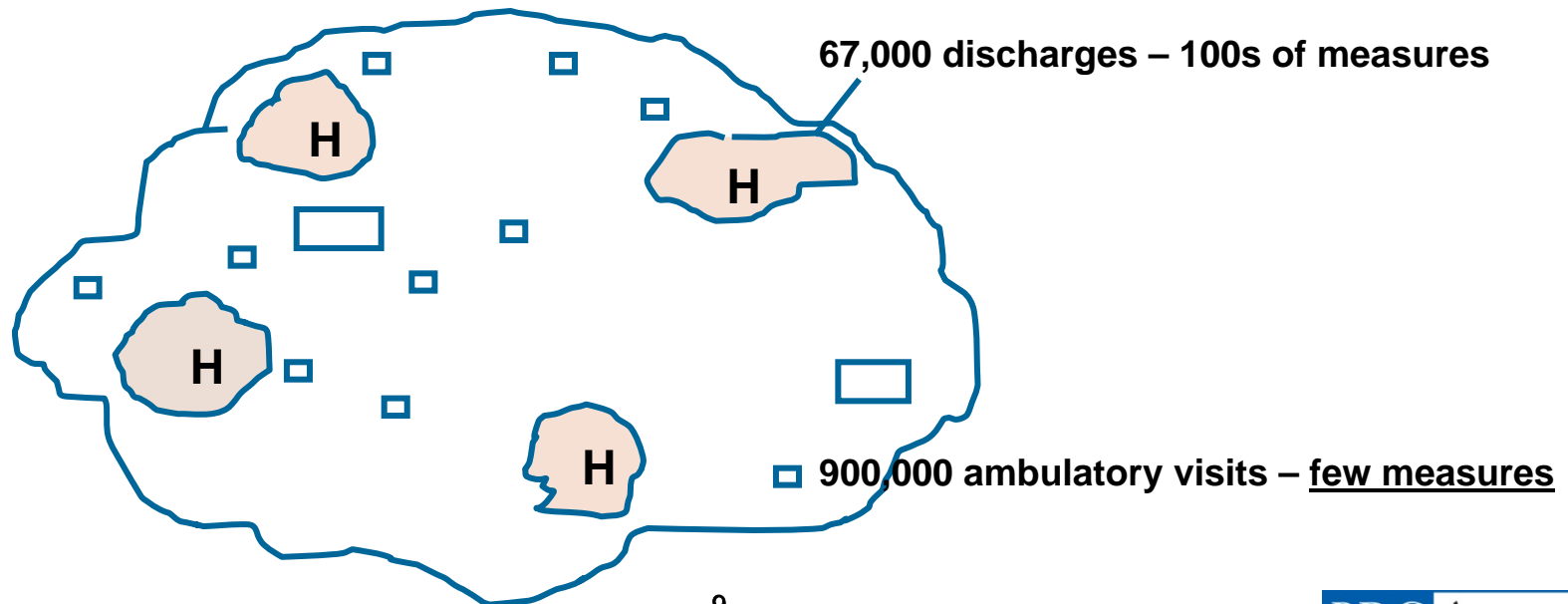


CIN = Clinically Integrated Network, RSA = Regional Service Area, PCMH = Patient Centered Medical Home, QC= Quality Committee, FC= Finance Committee, CrC = Credentials Committee, CC = Contracting Committee,

# Why a Hospital-Sponsored CIN?

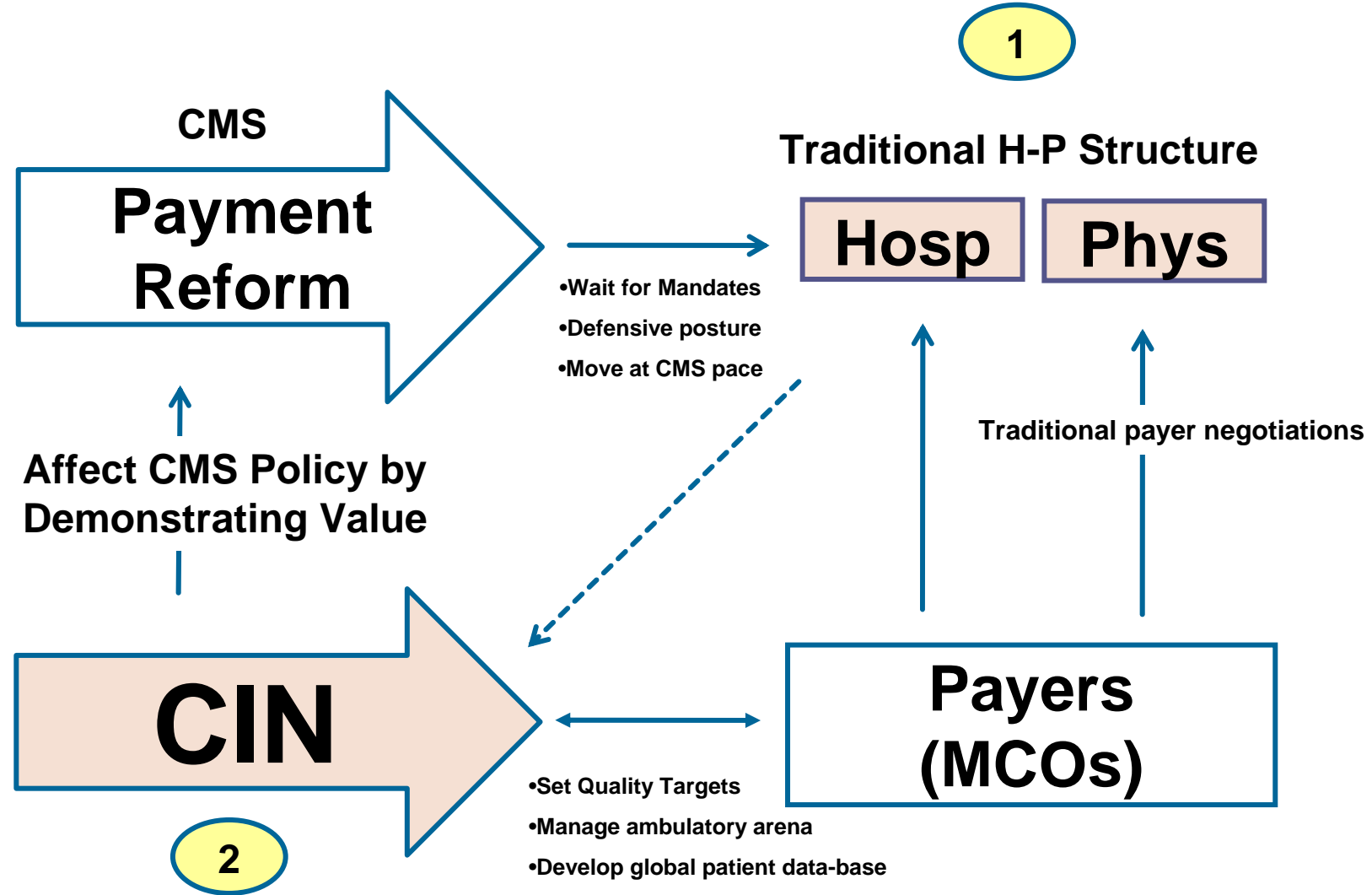
*A hospital-aligned clinically integrated network creates opportunity to leverage the quality improvement capabilities of the system across the patient-care continuum.....*

- Quality Improvement Leadership
  - PDSA / Lean / Six Sigma Capability
  - Analytic Workforce
  - Clinical Information Systems – EHRs
  - Patient Safety Leadership
  - Sentinel Event / Root Cause Analysis
  - Metrics / Measurement Reporting Systems
- +
- Capital
  - Ability to participate in value created through more efficient use of hospital resources



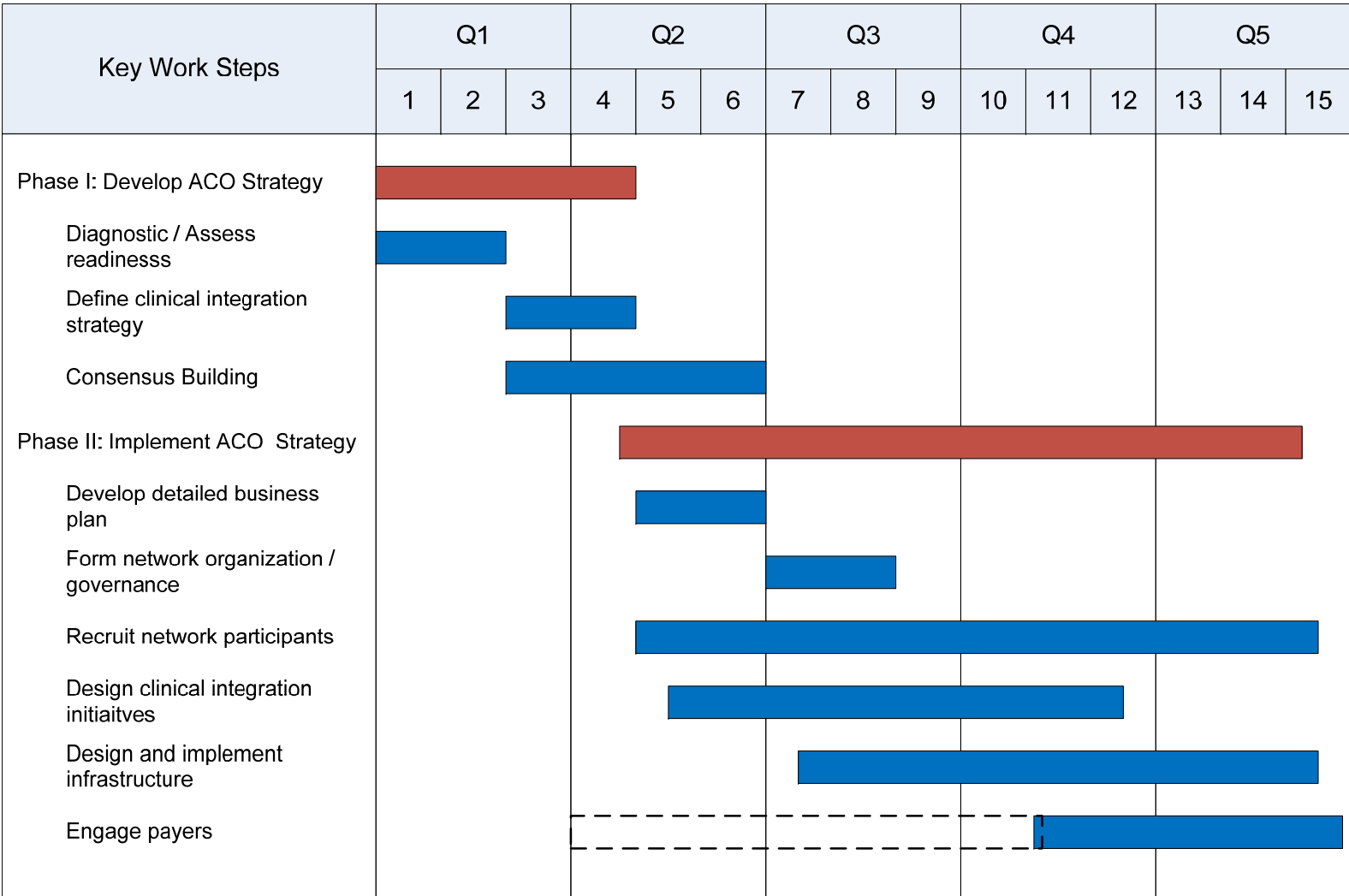
# Drivers of Healthcare Reform

Which position would you rather play from?



# Generic Timeline for CIN Roll-out

*12-18 Months from Conception to first Contract*



# CIN / ACO Readiness

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*CIN / ACO Readiness Assessment involves identifying the gaps in provider and payer community and organizational capabilities.....*

1. Governance
2. Executive Leadership
3. Clinical Leadership
4. Organizational Design
5. Primary Care
6. Specialty Care
7. Physician Network
8. Quality and Safety
9. Care Management
10. Process Management
11. Measurement / Analytical Capability
12. Information Technology
13. Practice Management
14. Physician Employment
15. Financial Position and Cost Management
16. Strategic Alliances
17. Patient / Consumer Focus
18. Payer Market
19. Local Healthcare / Regulatory Market

**.....System CEOs need to focus attention on preparing the organization for success as a CIN or ACO!**

# Health System Strategic Approach to Reform

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*CEO and Board to set a direction – lead time for change is significant*

## **Option #1 - Defend the Current Model**

- *Actively strengthen the hospital position in the market through acquisitions, pricing, and contracting to prevent the incursion of managed care, employer or physician initiatives to change the market.*

## **Option #2 - Wait for a Mandate**

- *Maintain and continue to invest in current hospital volume-based model (beds and towers) waiting for payment reform to be adopted before announcing or acting on the need for a business transformation.*

## **Option #3 - Hedge your Bets / Begin the Transformation**

- *Maintain and invest in the current hospital volume-based model, but begin investing profits in building infrastructure and capabilities that will support a business transformation. Requires fundamental changes to the organizations' relationship with both physicians and payers. Major commitment to primary care through investment in a primary care network.*

## **Option #4 – Lead the Transformation**

- *Announce the current model “dead” and set a new direction by aggressively building the new organization capable of offering bundled pricing of services, managing chronic disease in the ambulatory setting, and contracting with payers for quality premiums, a share of savings, and risk contracts. Embrace the opportunity (strategic).*

## **Option #5 - Find a Niche**

- *Recognize that transformation into an ACO is too great a change for the organization to achieve and pursue a niche that can provide a unique service to the market.*

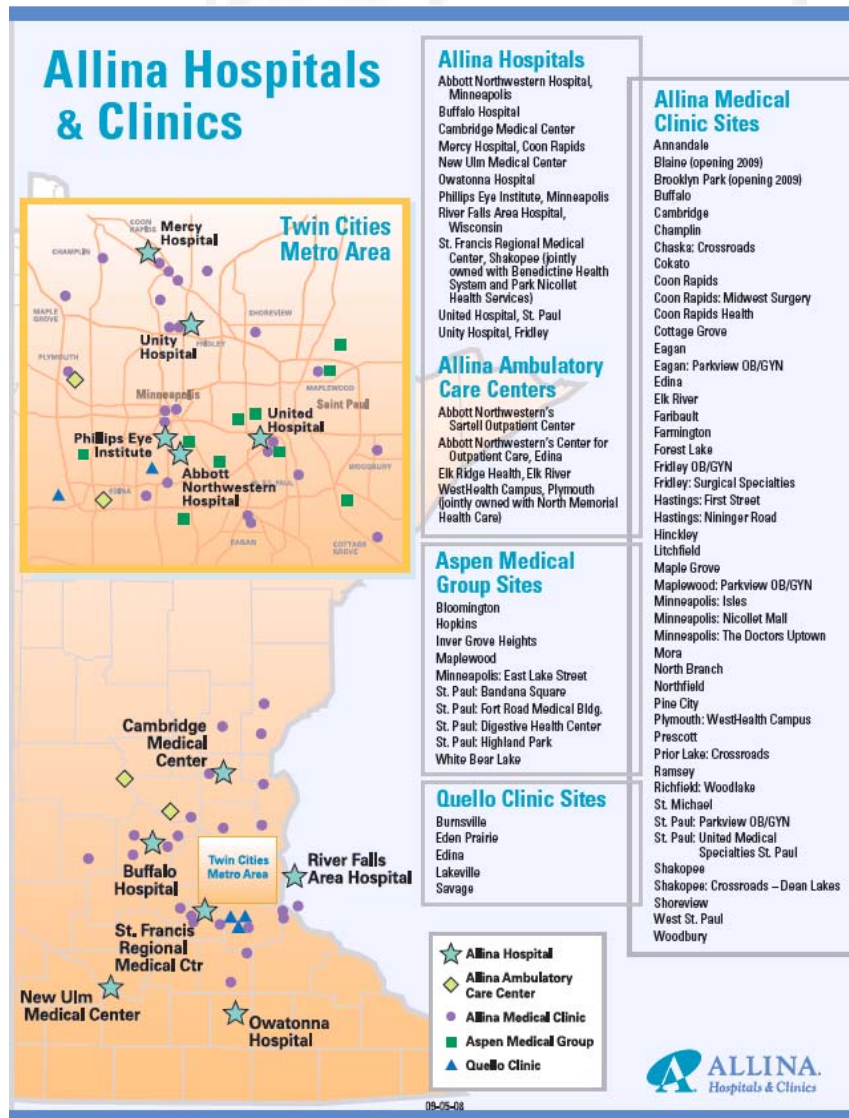


Allina Hospitals & Clinics

*Clinical Integration*

April 28, 2010

# About Allina...



- **33% market share for inpatient in the Twin Cities**
- **11 hospitals**  
**1,786 staffed beds**
- **90 clinics**
- **About 24,000 employees, including 1,200+ physicians**
- **2008 key statistics:**
  - **\$3 billion in revenue**
  - **5.5 million work RVU's**
  - **113,000+ inpatient admissions**
  - **1.1 million+ outpatient admissions**

# Our Mission...Allina Hospitals & Clinics

*We serve our communities by providing exceptional care, as we prevent illness, restore health and provide comfort to all who entrust us with their care*

# Market Assumptions

- *Payment rates will decrease over time* – will be the result of ‘bend the trend’ incentives and payment reform (‘across the board’ cuts)
- *Reimbursement will be linked to performance* – Payment will be linked to outcomes, with much greater risk for cost management
- *We will be paid for bundles and episodes of care* – Hospital, physician, ambulatory and home services will be bundled into one payment to the system
- *Consumers will have greater responsibility for the health care buy, making price sensitivity important* – Pricing transparency will become commonplace
- *The market will transition from fee for service to pay for performance over three years* – The change will be inconsistent and spotty, requiring that we live in two worlds for some period of time

# Market Realities

- We have high market share. Ability to grow through further acquisition is limited
- Specialists have consolidated. Most procedural specialties have aggregated into 1-2 market wide mega-groups
- Market has a strong comparative performance ethic (e.g. Minnesota Community Measures)
- The health plan market is open access and fee-for-service. Almost no capitation
- Health plans looking for new options. (e.g. Northwest Alliance Total Cost of Care Contract)

# Critical Organizational Issues

- *Bridging Two Worlds* – We must learn how to live in two worlds; fee for service and some form of managed care / capitation
- *Over Capacity* – Do we have too much capacity if payment change slows demand?
- *Price and Cost* – We think our prices are higher than our competition from the point of view of the consumer
- *Managed Care* – We do not have the infrastructure to manage care, health and wellness, utilization and integration
- *Translation of Health Care Reform* – The connection of reform to our business model is needed by staff

# Key planks in the strategy platform

*Better care, better service, better value will drive community, organizational and financial health and will lead to growth...*

**Strategic  
Pricing  
& Cost  
of Care  
Mgmt**

**Patient  
Care  
Model  
Re-  
design**

**New  
Patient  
and Pre-  
Patient  
Channels**

**Clinical  
Service  
Lines**

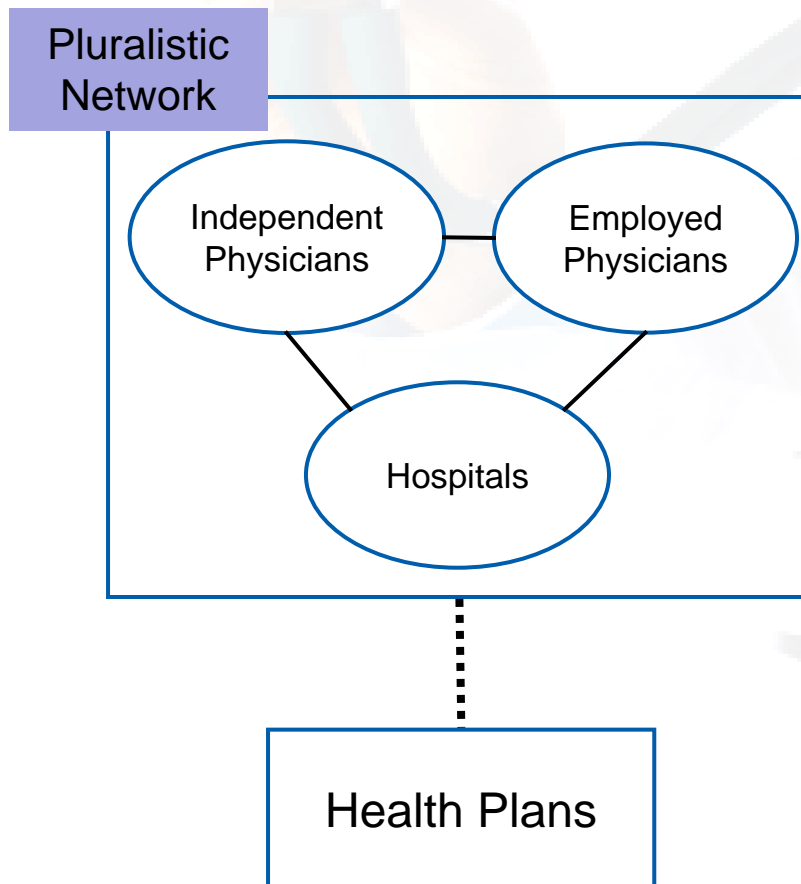
**Community  
Engagement**

**Health  
Network**

## **Operating Excellence**

Employee Engagement, Physician Engagement, Quality, Patient Experience, Supply Chain, Hospital Standardization, Appropriate Days, Productivity, Non-labor Expense Management

# Allina Integrated Medical Network



## Key Structural Elements

- **Clinical management infrastructure**
  - Sharing information in support of higher quality and lower cost for system as a whole
  - Evidence based clinical protocols to reduce variation in care
- **Rewards and penalties** for joint agreed on attainable goals (Payer-blind – System administers carrots and sticks)
- **Joint contracting** for hospital and physicians (employed and private) to enable sharing value for improved performance
- **New physician governance construct** to support physician-hospital decision making, flow of information, quality initiatives

# AIM Network Goals

1. Create a provider network dedicated to coordinating care for a patient population in a way that improves health outcomes, enhances patient satisfaction and lowers the total cost of care.
2. Establish physician-governed legal entity that allows providers to share in the value (higher quality / lower cost) they create for payers via the Network.
3. Support physicians choosing to practice in an independent model through:
  - Information technology
  - Practice support services
  - Better integration with care delivery system
  - Standards of care to support more efficient practice
4. Access to participation in payment reform models (e.g. value-based reimbursement models, Accountable Care Organization, gain sharing, etc.)

# AIM Network Goals ... (cont.)

5. Help shape reform at state and payer level and have more effective interface with national and state mandates.
6. Demonstrate that the value of care in the Network is better than that outside of the Network and use this information to promote Network providers locally and regionally.
7. Identify and focus efforts on areas where there are significant opportunities to impact cost and quality via the Network—areas that neither hospitals nor physicians can effectively impact alone.
8. Allow physicians to identify and implement evidence based best practices that will drive health care decision making.
9. Provide physician and patient education to support the implementation of best practices.
10. Facilitate communication among providers and the sharing of patient information and best practices.

# Key Issues



- Broad vs. narrow development strategy
- How to integrate mega-specialty groups
- Role of network relative to clinical service lines
- Clinical informatics stretching across multiple IT platforms

## Contact Information

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