Creating Alignment between an Independent Medical Staff and Hospital through a Physician-Hospital Organization (PHO)

Exploratory paper

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Introduction

The purpose of this paper is to explore the concept of the physician-hospital organization (PHO) that supports the independent physician model. Upon review of this paper, the reader will understand what a PHO and clinically integrated network (CIN) is and the current environment that is driving PHOs and CIN models to care. Additionally, the reader will gain an understanding of the components required to establish a PHO and CIN, the benefits associated with this model of care, an overview of antitrust considerations, and reasons why these models of care sometimes fail. Information is derived from literature reviews and personal interviews and discussions.

A PHO is a legal entity generally formed by physicians and one or more hospital with the purpose of working together on improving care and being rewarded for their success due to controlling costs while delivering high-quality care, while also complying with anti-trust guidelines. It is the starting point, or the basis of developing a CIN model, resulting in increased care coordination, integrated health information technology, increased patient engagement, provider network development, managed care contracting, and risk and financial management.

A clinically integrated network is the integration of providers and healthcare delivery modalities from a structural and functional standpoint, including the flow of clinical and financial information across a continuum of services including, preventive, outpatient, inpatient acute hospital care, post-acute care, skilled nursing, rehabilitation, home health services, palliative care, etc., leading to increased coordination to improve the value of the care provided, reduce the associated costs and improve the patients’ care experience. (Mudge-Riley, 2014)

Goals of a clinical integration should include:

- Reduce unnecessary utilization, improve efficiency, and control the cost of care.
- Enable joint contracting with payers and health plans based upon demonstrated ability to improve performance, with financial incentives for continued improvement.
- Align financial incentives for all those involved in health care delivery.
- Ensure that program initiatives are designed to achieve likely improvements in health care quality and efficiency.

**Background**

Over the last several years, physician practices, hospitals, and payer organizations have engaged and created alignment in the delivery of patient care in their communities. A continuous transformation has been underway, linked to several factors driving change throughout the healthcare industry. For instance, the industry has seen significant growth in the formation of new clinical business models of provider collaboration to meet today’s challenges with increasing competition in the marketplace and reductions in reimbursement.

The realization of massive future costs and care burdens of an aging population, the need to shift from a volume-driven to a value-driven model of care, medical technology innovation, health information adoption, and increased awareness of the impact of social determinants on the health of a population, has created an industry paradigm shift which may be called the “Care Revolution Era”. Today, in the Care Revolution Era, we are entering a new time where the relationship dynamics between patient and physician, and physician and hospital, and all three of these groups are making a paradigm shift in their relationships with each other and with payers. New and innovative models to care have been introduced in reaction to the new emphasis on population health and requirements related to the provisions of the Accountable Care Act (ACA). These new models of care include accountable care organizations (ACOs), physician-hospital organizations (PHOs), and clinically integrated networks (CINs). (Yale, 2015).
The movement towards independent and otherwise competing providers of care, aligning and creating a clinically integrated model to providing care, results in better management of costs and quality across the entire spectrum of care. Hospitals are constantly working to strengthen their bonds with their medical staff and developing the framework of a PHO is a vehicle for hospitals and physicians to align their efforts to care for patients through active care coordination and information sharing.

PHOs are essentially associations of competing physicians and other ancillary health providers, sponsored by one or more hospitals. The usual purpose of a PHO is to develop a clinically integrated network with primary care physicians, specialists, hospitals, skilled nursing facilities, pharmacies, and other ancillary health providers that will attract contracts with payers and employer groups. The model of organizing competing providers into a network marketable to payers also presents a variety of antitrust issues. While the writer explores the concept of developing a PHO, she will also address the role of strategic planning and population health, antitrust issues that relate to PHO, managed care contracting activities, barriers and reasons why these networks sometimes fail, and ultimately the benefits of developing and joining a PHO.

Current Environment

Across the nation, physicians and hospitals are challenged with continued pressure to reduce healthcare costs while not jeopardizing quality. In addition, a transition is taking place with a shift from more volume-based models of payment to accountable care and value-based models that are tied to quality metrics, outcomes, and utilization. Hospitals and health care providers are being faced with the need to take on population health management capabilities and patient engagement models for more efficient and effective care.

The transformation to value-based payments is rapidly accelerating. The Department of Health and Human Services (HHS) Secretary, Sylvia Burwell, announced on January 26, 2015 a
goal of tying 30% of fee-for-service (FFS) Medicare payments to quality or value through Alternative Payment Models (APMs) by the end of 2016, growing to 50% by 2018 (HHS, 2015). Secretary Burwell also outlined a goal for 85% of all Medicare fee-for-service payments to be tied to quality or value payment incentives by 2016, and 90% by 2018.

On April 16, 2015, President Obama signed into law, legislation that was overwhelmingly passed by bipartisan votes in the House and Senate. H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) or the SGR Repeal Bill, is far more than a simple reversal of the long standing proposed deep cuts in physician payments. This new law actually has many other health care transformation elements that will rapidly accelerate the shift from pay for volume to pay for value. There is broad support for clinicians joining new APMs that align incentives for more patient-centric care, coordinated with high-quality care across the continuum, such as bundled payments and shared savings arrangements.

In addition, starting in 2019, Title I of H.R. 2 establishes a two-track system for Medicare’s payments to physicians. The combined shift to value creates a penalty to physicians of up to 11% of their Medicare payments or a bonus of up to 5%. To achieve full bonus, physicians must earn 25% of their Medicare income in 2019 from APMs and meet yet to be defined quality metrics. By 2023, the threshold for physician income increases to 75% including payments from APMs from other payers. (H.R. 2, MACRA 2015)

This transformation of the U.S. healthcare system is driven by the needs of payers, patients, and providers for new and improved population health management services and evolving to better serve individual consumers as new technologies such as predictive analytics enable a retail approach. Ironically, this new individual consumer approach encourages distributed technologies that can enable improvements in health and care for the population as a whole (Yale, 2015).
The Role of Strategic Planning

The magnitude of change facing the U.S. healthcare system is enormous. The pace of technological change, impact of federal reforms, continuous changing of laws and regulations by Congress and Executive branches of government, seemingly annual negotiation of vendor and payer contracts, and increasing need for greater patient engagement, all contribute to the volume of change and complexity of the system. But ultimately, the one key priority for every healthcare organization in dealing with change should be the focus on “superior patient value” (Porter & Teisberg, 2006a).

In light of the need for strategy that ultimately leads to superior value for the patient, every CIN or PHO or accountable care organization (ACO) should have multi-disciplinary teams that focus on short-term and long-term strategic planning, with the patient in mind. In order to effectively drive strategic planning and strategy development, an understanding is also needed of the complexity characteristics of every provider, payer, hospital relationship dynamic and the patient population.

Strategy team members help increase awareness of changes in the community environment in which the organization operates, and help ensure legal compliance and reporting requirements are met, as well as changing requirements of private and public payers. Organizations can use many different processes in developing the strategic plan; however, some basic questions should be answered at the inception of the planning process, including:

- What is our mission and vision for the future of our organization?
- What is the demographic composition of the patient population we serve?
- What is the composition of the physicians who could be part of a network we develop, and what are the political dynamics among the different provider groups?
- What services do our patients need today and in the future?
• What resources (staff, technology, financial capital) are needed?

• What payers currently exist in the community, how is the payer mix changing, and what do we anticipate future payers will look like?

• What goals and objectives related to the organization’s clinical operating efficiency, financial performance, quality, and safety will enhance our delivery of healthcare services for the population served?

The answers to these questions will vary depending on the provider organization’s environment, resources, and capabilities. (Yale, 2015)

**Population Health**

Population health is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These groups are often geographic populations such as communities, but can also be other groups such as employees, patients in an ACO, PHO, or CIN, or enrollees in a Health Plan.

The inherent value of a population health perspective is that it facilitates integration of knowledge across the many factors that influence health and health outcomes. The passage of the Patient Protection and Affordable Care Act of 2010 (PPACA) addresses population health in four ways:

First, provisions to expand insurance coverage (i.e., the individual mandate, Medicaid expansions, state insurance exchanges, and support for community health centers, etc.) aim to achieve population health by improving access to the health care delivery system, a critical component of a community’s population health production system.

Second, other provisions aim at improving the quality of the care delivered.

Third, less well-known provisions seek to enhance prevention and health promotion measures within the health care delivery system. Perhaps the biggest change is the promotion and
implementation of ACOs to incentivize providers to take responsibility for population health outcomes.

Fourth, the final set of provisions aims at promoting community-and-population-based activities, including the establishment of the National Prevention, Health Promotion and Public Health Council, which has already produced the mandated National Prevention Strategy (by the Department of Health and Human Services in 2011) as well as a new Prevention and Public Health Fund. (PPACA, 2010)

Health Plans are now adopting a payment model where health systems take on risk to manage a population for their care including primary care, hospital care and post-acute care. It is likely this type of reimbursement will become the norm versus the typical fee-for-service model of reimbursement. Health care providers have to accept responsibility for the cost and quality of care for a defined population, therefore changing the way they are paid. Regardless of what happens politically over the next few years, integration of providers, payers, and hospitals will likely continue.

**Antitrust and PHO Contracting Activities**

PHOs present a variety of antitrust issues. PHO formation and expansion by merger, acquisition, joint venture or other forms of affiliation may raise competitive concerns under the Clayton Act §7, which regulates such forms of competitor affiliations. (Rovner, 1995)

PHO negotiation for managed care contracts is highly antitrust sensitive. Unless the PHO is “economically integrated” such that all of its participants as a group are at a substantial financial risk, its negotiation for managed care contracts will usually constitute collective seller activity. Such collective seller negotiations are very suspect under the antitrust laws as they inherently facilitate seller collusion and can readily lead to price fixing, market and customer
allocation, and group boycotts, all of which can be per se violations of the antitrust laws. (Rovner, 1995)

The antitrust enforcement agencies have taken a restrictive line regarding PHO contracting activities. As reflective in Statement 9 of the September 1994 Justice Department and Federal Trade Commission (FTC) Statements, which provide “analytical principles relating to multiprovider networks” (defined as “ventures among providers that jointly market their services to health benefits plans and other purchasers”), these agencies view any collective negotiation by PHOs as highly suspect unless the PHO markets products that put the PHO participants at substantial financial risk (such as contracts based on capitation or on discounted fee-for-service with significant withholds) or the PHO uses the pure “messenger model”. (ABA, 2008)

Any variation from these two operational approaches (e.g. the “opt-out” model, using a PHO participant as the “messenger”, having the PHO or a consultant collect from and share with PHO participants competitively-sensitive price and market data) carries substantial antitrust risk of challenge by the Justice Department or the FTC, and in a private action by a buyer of provider services, such as an insurer. While the outcome of such a challenge would turn on the particular facts and circumstances (more specifically, whether the proofs demonstrate sufficient economic integration of the PHO participants to establish a “legitimate joint venture” legally capable of negotiating as a “single economic entity”, which should subject the process to rule of reason analysis, and, if not, whether the PHO’s collective negotiation has resulted in any overt or tacit agreements of the PHO participants on price, markets, or whether to deal at all), the reality is that a non-integrated PHO and its participants face a substantial proof problem in avoiding price fixing or similar per se antitrust violations when engaging in collection negotiation that strays from the pure “messenger model”. (Creighton, 2004).
The FTC also provides guidance on conduct to avoid for models such as this including ACO’s. This includes:

“Improper Sharing of Competitively Sensitive Information Regardless of an ACO’s PSA shares or other indicia of market power, significant competitive concerns can arise when an ACO’s operations lead to price-fixing or other collusion among ACO participants in their sale of competing services outside the ACO. For example, improper exchanges of prices or other competitively sensitive information among competing participants could facilitate collusion and reduce competition in the provision of services outside the ACO, leading to increased prices or reduced quality or availability of health care services. ACOs should refrain from, and implement appropriate firewalls or other safeguards against, conduct that may facilitate collusion among ACO participants in the sale of competing services outside the ACO”. (White, 2013)

The FTC is most concerned with local market economic impact of organizations controlling the supply of services, especially if they focus on profit maximization for the benefit of their own organization, instead of improving the value of care delivered to the consumer. Ensuring fair trade and preventing the development of monopolies is a major concern.

Negotiation and contracting activities require the services of legal professionals as intermediaries and counsel to PHO, CIN, and managed care executives, especially given potential changes in antitrust regulations and waivers. Preventing market dominance while allowing for the growth of clinical integration programs that produce precompetitive benefits is a goal of the FTC and crucial to the success of PHOs/CINs/ACOs. (Yale, 2015)

**Developing a PHO/CIN: Work Plan**

As part of the development of a PHO or CIN, a work plan should be developed and revisited periodically to record progress, and change and update as the situation warrants. An example of a set of work plans that has proved to be sustainable is provided below from another
established PHO/CIN. As part of its business plan, the team developed work plans around key strategic components of organizational functions: financial management, operations, quality and utilization, and information technology. Timelines with start and end dates should also be to keep the project on track. (Raskauskas, 2015)

- Financial Management & Budget Development
  - Identify initial network of providers.
  - Estimate patient population.
  - Identify IT capital needs.
  - Develop dashboard reports.
  - Develop initial disbursement plan.
  - Contract with payers.

- Operations Development
  - Readiness assessment.
  - Gap analysis.
  - Structure/Governance.
  - Training.
  - Accreditation.
  - Credentialing.

- Quality and Utilization Review Development
  - Establish quality metrics.
  - Develop dashboard quality reporting.
  - Develop provider quality compliance program.
  - Develop patient satisfaction survey.
  - Develop utilization metrics.
  - Develop dashboard utilization reporting.
• Survey PCPs for Patient-Centered Medical Home (PCMH) readiness.

• PCMH accreditation for PCPs.

• IT Development
  o Provider EHR survey.
  o Provider meaningful use survey.
  o Provider PQRS survey.
  o Provider e-prescribing survey.
  o Initial IT capital requests.
  o Develop initial IT rollout map.
  o Implement IT rollout.
  o Report programming development.
  o Population health management survey and rollout.

Adding timelines to each of these areas helps keep the organization on task and serves as a roadmap for the development strategy as an eventual clinically integrated network. Regardless of the path or work plan chosen by healthcare leaders and teams implementing a PHO or CIN, each of the elements described above should be addressed. Ultimately, understanding business operations and organizational governance involves the ability to facilitate a corporate work plan, define organizational culture, and create an environment and develop processes that support the best possible patient encounters. (BOK MGMA, 2009).
The diagram below also illustrates a three-phase work plan for developing a CIN with recommended timelines.

**Building a CIN: Three-Phase Work Plan**

<table>
<thead>
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<th>Phase 1 Assessment / Strategy</th>
<th>Phase 2 Design</th>
<th>Phase 3 Implementation</th>
<th>Operations</th>
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<td>• Begin aligning exec team, Board, MDs</td>
<td>• Structure</td>
<td>1. Align Board, executive team</td>
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<tr>
<td>• CIN / ACO readiness assessment</td>
<td>• Governance</td>
<td>2. Build collaborative culture</td>
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<td>– Health system</td>
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<td>3. Develop Board, committees</td>
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<td>– Market</td>
<td>• Management organization</td>
<td>4. Develop network mgmt team</td>
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<tr>
<td>• Network strategy</td>
<td>• Participation agreement</td>
<td>5. Recruit / credential participants</td>
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<tr>
<td>– Geography</td>
<td>• Business plan</td>
<td>6. Create CI program</td>
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<tr>
<td>– Size / mix</td>
<td>• New shared values</td>
<td>7. Select / deploy CPRS*</td>
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<tr>
<td>– Existing groups</td>
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<td>8. Engage practices in CI</td>
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<tr>
<td>– Link with other initiatives (e.g., EMR / EHR)</td>
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<td>9. Design incentive program</td>
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<td>10. Develop payer strategy</td>
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<td>11. Negotiate value-based contracts</td>
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*Timing: 2-4 months / 2-4 months / ~1 Year

*CPRS = Clinical Performance Reporting System. (BDC Advisors, 2011).

**Opportunities for Reducing Healthcare Costs**

With quality and cost savings as key drivers in developing a PHO/CIN, the mechanism used to reduce costs will also be important so as not to impact quality. Some of these mechanisms can be pursued primarily through the actions of primary care practices; some can be achieved primarily through the actions of hospitals and specialists; and some will require efforts by a broad range of providers in the community acting in concert. Therefore, PHOs involving various combinations of these providers will be able to achieve different types and levels of cost reductions. The common element of all the changes is finding better ways to deliver and coordinate services so as to ensure all patients receive the right care, at the right time, at the right location, from the right provider. (Miller, 2009)
There is growing evidence of the role that a strong primary care model can play in reducing healthcare costs. Some examples of the opportunities for reducing costs solely or primarily through the efforts of primary care include:

- **Improved access to care.** Use of physician extenders, emails, phone calls, same day scheduling, group visits, school visits, urgent care centers, and other techniques can reduce costs and improve patients’ access to effective primary care.

- **Improved prevention and early diagnosis.** Many illnesses can be prevented through interventions such as immunizations, diet and weight management, and the severity of illnesses can be reduced through regular screenings for cancer or heart disease for example, that lead to early diagnosis and prompt treatment.

- **Reductions in unnecessary testing, referrals, and medications.** Use of evidence-based treatment guidelines and shared decision-making tools can enable reductions in unnecessary or even potentially harmful tests, interventions, and medications.

- **Use of lower cost treatment options.** The use of generic drugs or lower-cost alternatives where available and appropriate can reduce expenditures on pharmaceuticals and increase patient adherence to treatment regimens that prevent the need for more expensive services.

- **Reductions in preventable emergency room visits and hospitalizations.** Studies have shown that rates of ER visits and hospitalizations for many patients with chronic disease and other ambulatory-sensitive conditions can be reduced by 20%-40% or more through improved patient education, self-management support, and access to primary care. (Miller, 2009)

Hospitals represent 40% of healthcare costs, and studies continue to show significant inefficiencies and quality problems in hospitals. Some examples of the opportunities for reducing costs and improving quality solely through the efforts of hospitals and specialists include:
• **Improved efficiency of patient care.** Hospitals that have utilized industrial techniques have been able to significantly reduce waste and improve efficiency. Gain-sharing and bundled-payment strategies have found that the costs of surgeries can be reduced by 10%-40% through improved cooperation between hospitals and surgeons to achieve greater overall efficiency, through means such as more efficient scheduling and purchasing of medical devices.

• **Use of lower-cost treatment options.** Reductions in pre-term elective inductions and reductions in the use of Caesarean sections for normal deliveries can reduce labor and delivery costs as well as improving outcomes for both mothers and babies.

• **Reduction in adverse events.** A significant number of patients still experience preventable healthcare-acquired infections and other adverse events. Work pioneered by the Pittsburg Regional Health Initiative and replicated in other parts of the country proves that such events can be dramatically reduced or even eliminated through low-cost techniques.

• **Reduction in preventable readmissions.** Some hospital-acquired infections and adverse events manifest themselves after discharge and result in preventable readmissions to the hospital; these can be reduced through the same techniques as listed above. In addition, several studies have shown that readmissions rates can be reduced for a broad range of patients by improving the patient’s transition to home or another setting following discharge, through a combination of improved preparation for discharge and improved support services following discharge. (Miller, 2009)
Some opportunities for cost reduction require coordinated involvement of primary care practices, hospitals, specialists, and patients; some require the presence of development of new methods or settings for care; and some require coordination between healthcare and non-healthcare services, including:

- **Improved management of complex patients.** Patients with multiple diseases, individuals with rare conditions, drug abusers, and chronically mentally ill, etc., require multiple, often expensive services from multiple physicians and/or facilities. Lack of care coordination among these various providers can lead to overuse of testing, overmedication and potential adverse reactions to medications, or even misdiagnosis and inappropriate treatment. Managing these patients cost-effectively requires a coordinated effort among multiple physicians, facilities, and services.

- **Use of lower-cost, more accessible settings and methods for delivery of care.** In a number of situations, alternative approaches to treatment and different settings for care can significantly reduce the costs of care while maintaining or improving
quality. For example, an uncomplicated labor & delivery in a birth center costs only a quarter as much on average as a comparable delivery in a hospital. Improving prenatal care outreach to low-income expectant mothers can improve birth outcomes and reduce costs. However, these alternative settings and care approaches need to exist in each community, and the patient’s insurance or some other funding source is needed to cover the costs.

- **Use of lower-cost, high quality providers.** For many kinds of treatment in many communities, there are multiple high-quality providers of the treatment, and costs may differ significantly between the providers. Spending on those treatments could be reduced if more patients would use the lower-cost, higher-value providers; however, this would require those providers to have a clear “price” for these services, the patients would need coverage and a financial incentive to use the lower-cost providers, and for hospital care, the patient’s physician would need to be on medical staff and have admitting privileges.

- **Coordinated health and social services support.** Many individuals’ health problems are caused or exacerbated by non-medical challenges they are facing, such as homelessness or poverty. Effective solutions to their health needs will likely require access to social service supports as well as health care services. Often times, patients are not even familiar with the social programs that are available to them in their community. (Miller, 2009)

It is important to recognize that all of the above listed opportunities can not only reduce costs, but also improve outcomes for patients. Prevention strategies can detect and avoid illnesses, be of benefit to patients, and reduce costs. Helping chronic disease patients stay out of the hospital through active care coordination and chronic disease management and preventing hospital-acquired infections also benefits the patient, in addition to reducing costs. These efforts
illustrate the movement towards health care providers collectively creating clinical integration, resulting in better management of costs and improved outcomes across the entire spectrum of care.

**Why PHO’s and CIN’s Can Fail**

While new healthcare payment models have evolved from those that proved unsustainable in the past, in addition to antitrust concerns to consider when developing a PHO, physician resistance can also be an issue and a reason why a PHO/CIN can fail. In MGMA Connection 2014, Dr. Michelle Mudge-Riley states that, “one of the biggest barriers to successful integration is physician resistance because they aren’t used to thinking and acting in concert with hospital executives and others. They just weren’t trained to think that way. Unfortunately, many physicians don’t fully understand the integration process. It’s not explained to them, so they don’t realize that it might be a very positive thing for them and their patients. But physicians understand data and processes, and they want to take back some of the leadership and autonomy surrounding the selection of clinical guidelines and associated medical decision-making. This autonomy and leadership help them feel involved and satisfied with their life’s work because physicians are born leaders and can drive change. But they need to be empowered to do so because they start to feel burned out and de-motivated if they are told what to do and how to do it”.

Clinical integration is one of the few effective models found for getting physicians and hospitals to work together on improving care and to be rewarded for their success. However, not all CI networks that look good on paper end up succeeding in the real world. Laura Sprung of The Advisory Board offers these three reasons as to why good CI networks fail:

1. **The network is not truly physician-led.**

The legal rules for organizing CIN require that physicians take a leadership role in the
network, although the hospital can set up the infrastructure and the network itself can provide administrative support.

This can be a hard balance to achieve, as too much independence can lead to redundancy or even rivalry among care management efforts, in some markets. Big inefficiencies can develop when the CIN is not sufficiently aligned with health system administrators and other system-affiliated physician entities, such as employed medical groups. However, the CIN needs to be sufficiently independent and physician-led that physicians want to participate. So when a health system sets up the CIN, it also needs to make sure that there are true physician champions, including independent physicians, not just at the table but driving the discussion.

2. The CIN never gets appropriate contracts, and the hospital does not help.

A CIN only works if payers or employers agree to provide performance-based incentives to the network. And the reality is, not every market has payers or employers eager to create those kinds of contracts.

How can CIN thrive in a market that is not on the forefront of value-based reimbursement? Many health systems start by creating incentives around caring for their own employee population. But beyond that, they health system needs to help bring payers to the table and be willing to use its analytics, its expertise, and even concessions on the contract terms to get a favorable CIN contract in place.

3. The financial case for the CIN relies too heavily on shared savings contracts.

Although we have not seen many shared savings-related failures yet, the reality of shared savings programs, including MSSP, is that not all participants will be able to generate the anticipated savings. Across the next several years, CINs that are banking on shared savings payments to bolster the case for participation are likely to see physicians back out if the shared savings payments do not live up to initial projections. CINs may want to consider shared savings as “maybe money”, nice if it materializes but not what anyone
should be relying on to get or keep physicians engaged in performance improvement efforts.

**Success Factors for a PHO and CIN**

As hospitals and health systems continue to make the transition from fee-for-service to value-based care, a new generation of partnerships is emerging. Physicians, hospitals, and health systems are forming PHOs and regional CINs that enable them to partner with other players without the governance and financial barriers of mergers and acquisitions. (Warden, 2013)

In most cases, hospitals and health systems are recognizing the significant time and expense associated with developing the capabilities to succeed in a shared-savings or at-risk environment and are teaming up with other organizations to share development costs and intellectual capital. Most importantly, organizations understand that the key to success in value-based care is capturing as broad a geography and as large a population as possible in order to mitigate risk. As a result, PHOs/CINs are forming locally, regionally, and statewide among market-leading organizations.

The CIN strategy is not just for large systems, however. Many community hospitals and smaller health systems are recognizing that the regional CIN option means they may not have to merge with a larger health system in order to remain market competitive and afford the increasingly expensive infrastructure required to effectively manage risk-based contracts. At the same time, larger systems that are initiating CIN strategies welcome the fact that they do not need to spend precious capital or obligate themselves to talking on the balance sheets of smaller hospital/health system partners in order to achieve broader geographic impact. (Warden, 2013)

As these alliances continue to form, it will be particularly important for community hospitals and smaller health systems to recognize the critical success factors that will help them
lead PHO/CIN efforts or be considered worthy partners by larger or more progressive players, including:

1. **Develop a primary care base that is as broad and strong as possible.**

   Primary care drives organizational success in value-based care. The majority of patients are attributed to CINs through primary care physicians. The successful management of at-risk patients is dependent on the development of an effective and efficient primary care delivery model. If the community hospital or small health system has locked up relationships with primary care physicians in its geography, larger organizations will have no choice but to partner with it in order to serve the area.

2. **Identify a strategic vision for clinical integration within the market.**

   Every organization must define its overall market strategy and clearly understand the role that clinical integration will play. Leadership, including executives and board members, must be accepting of the uncertainty and potential downside associated with risk-based contracts. In order to be successful as part of a PHO/CIN the hospital/health system must establish its own integrated structure in its own market/geography among its physicians and medical staff. Larger regional network partners will be able to assist by sharing experiences and leveraging infrastructure and capabilities, thereby reducing duplication. Engaging physicians now in advancing the organization’s own clinical integration strategy and capabilities is essential to assure that a local network is capable of attracting and managing patient populations as quickly as possible.

3. **Remember that employed and independent physicians are equally important but require tailored strategies.**

   Clinical integration can become the “great equalizer” between employed and
independent physicians from a quality and financial perspective as it encourages equal expectations and equal financial incentives across the network. That said, if there are a significant number of independent primary care physicians and specialists in the market, it will be important to structure the PHO/CIN in a manner that is attractive to independent physicians and integrates care between independent and employed physicians.

4. **Focus on physician leadership.**

The success for value-based care strategies will be highly dependent on the ability of physicians to lead the charge. Without formal, substantial commitment of physician leadership and key champions for clinical integration in the organization, it will be difficult to be a successful partner with larger networks. Educating physicians and encouraging them to either attend conferences or join in “field trips” to meet physicians from other markets with more experience with population health management is critical.

5. **Take an integrated care management approach.**

An important early step in moving forward with clinical integration is managing care across the continuum. While senior leadership works with physician leaders to develop clinical integration capabilities, it will be crucial to understand the significant impact that care coordination across the continuum will have on quality and costs. Transitions of care, managing chronic disease patients outside of the hospital, and end-of-life care are all major opportunities for cost reduction and quality improvement that will require increased integration and coordination between inpatient and outpatient care management functions. The utilization of electronic medical records and electronic care management and analytic tools, tied to health information exchanges and clinical data repositories that enable providers and care
managers to access patient information at all points along the continuum will be a prerequisite for successful care management.

Focusing on these factors will not only set the organization up for its own success, it will make it more attractive to larger organizations seeking a partner in the market. (Warden, 2013)

**Benefits of a PHO and CIN**

The fee-for-service model cannot continue. Healthcare costs must be contained. Payers continue to move toward value-based and population-management models that are tied to quality metrics, outcomes, and utilization. A PHO/CIN is a vehicle for physicians and hospitals to align their efforts to care for patients through active care coordination and information sharing. The movement towards clinically integrated models of care results in better management of costs and quality across the entire spectrum of care. The alternative is to continuing to accept less for doing more or providing a different type of care that’s more coordinated among different providers with an emphasis on information sharing and prevention strategies. A clinically integrated network delivers a different product than fragmented providers can deliver.

In a PHO/CIN, independent or group-practice physicians collaborate with health systems to maximize the efficiency of care and costs. The FTC characterizes clinical integration as “an active and ongoing program to evaluate and modify practice patterns, in order to control costs and ensure quality”. In such a model, the health system equips physicians with resources needed in order to be successful, i.e., a strong information technology infrastructure resulting in better access to patient data across the continuum. This in turn, allows the health system to develop market-specific partnerships with health plans and employers, as well as shared-savings and incentive-based delivery models to care.

Current Medicare programs, including the Medicare Shared Savings Program and Pioneer Model, are requiring providers to assume greater accountability for population health. To
succeed, physicians and providers need strong partnerships to effectively manage both care quality and cost outside of their four walls. There will be more risk sharing in the future as the Centers for Medicare & Medicaid Services (CMS) continues to transition away from passive payer to active purchaser of value. (Yale, 2015). With quality and cost savings as key drivers, health systems and physicians who share the same philosophy and patient-centered goals, will align to work together toward better communication, smoother transitions of care, and standardization of care (Warden, 2013).

Joining a network also provides the physician with a strategic advantage for health care reform and more efficient patient-centered care. This is largely attributed to the fact that PHOs/CINs are physician-led and physician-driven. It will also help physicians access the resources needed to condition their practice to meet the new merit-based incentive payment system (MIPS) as well as managing risk under the Alternative Payment Models (APMs) as Medicare transitions to a new payment system.

An organized framework for the PHO/CINs, one that puts the physicians in control also comes with huge responsibility. Physicians are not only held accountable for care but also for compliance with the network. This can be accomplished through a willingness to measure, share, disseminate and benchmark data. The recommended model should be organized the following way:

1. Establish the clinical integration program as a wholly owned subsidiary.
2. Create an operating agreement to outline the relationship between the parent company and the physician network.
3. The PHO provides back-office support for the network.
4. The network is governed by a board of managers, which is largely composed of participating physicians.
5. The board is supported by several physician-comprised committees (ex., an initiatives or quality committee, a payer-relations committee, and a remediation and education committee).

Creating an ongoing quality optimization and accountability guidelines prepare and enhance the physician’s capability to produce quality care. This type of CIN model will continue to be less fragmented due to continued improvements in communication between providers, the sharing of medical records and other clinical information, care coordination and case management, and chronic disease management. (Raskauskas, 2015)

Conclusion

The structure of healthcare in America is evolving and in a period of both transformational and institutional change. PHO’s and CINs along with ACOs have emerged as new care delivery and financial models and taken hold as the institution of American healthcare has progressed through technological advances and transitioned to value-based care. Providers of care who choose to embrace it, and gain experience in managing populations and improving on what they are doing clinically and financially, will benefit and gain an edge on those who cannot or will not.

Improving quality of care and reducing costs to benefit consumers must be a principal goal for otherwise independent providers, to align in a PHO/CIN structure that is in agreement with FTC and antitrust guidelines. Beyond regulatory requirements, improving on quality and managing costs further benefits providers by enabling them to focus on outcomes, diminish variations in care, and improve processes to prevent medical errors. Members of PHOs, CINs, and ACOs are focusing and making it a priority to improve the health of their populations rather than increase volume or the number of procedures or tests. This requires providing a different
type of care that is more coordinated among different providers with an emphasis on information sharing and prevention strategies.

The basic idea behind PHO/CINs is that patients are best served when primary care physicians, specialists, hospitals, and post-acute care entities work together in a single integrated network to cohesively optimize care. Physicians also benefit from the quality-optimization standards as well as from the resources and support from the health system or sponsoring hospital. In addition, they are better able to obtain transparent information regarding their patients that provides a full view of their healthcare experience. Physicians can receive all of these benefits while still maintaining their independent practices and autonomy. Furthermore, by maintaining control through such physician-driven clinical networks, doctors are better positioned to instill change in both patient care and health care reform. It may also be to their benefit to build on a reputation of quality care through integration with other top physicians, health systems, and other high-value ancillary facilities.

To reiterate, benefits of a PHO/CIN include:

- Enhanced community impact.
- Alignment with a health system and providers who share a commitment to the triple aim – better health for populations, improved patient experience, and lower cost of care.
- Access to a coordinated infrastructure and use of care management resources provided by the health system.
- Access to business intelligence information technology.
- Data visibility across the full continuum of care.
- Ability to identify and measure best practices.
- Ability to improve outcomes for patients.
- Potential for enhanced reimbursement.
• Ability to receive financial rewards for positive clinical outcomes, value-based outcomes, and cost-management achievements.

In conclusion, these networks are set up to attempt to improve overall patient outcomes, improve the patient experience, and improve the health of individuals in the community, in a continuum of care that is focused on quality, performance, efficiency and value. What comes next is ultimately up to us, providers and consumers of care alike, to support this new approach to care and promote healthier populations today and for years to come.
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