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CLINICAL INTEGRATION FREQUENTLY ASKED QUESTIONS

Q: What is "clinical integration"?

A: ***Clinical Integration*** is an effort among physicians, often in collaboration with a hospital or health system, to develop active and ongoing clinical initiatives that are designed to control costs and improve the quality of health care services. Participation in an effective clinical integration program will provide independent physicians on St. Vincent's Health System's hospital medical staffs the ability to contract collectively with PPOs and other fee-for-service health plans without violating antitrust laws and to participate in hospital-sponsored Hospital Efficiency programs with STVPA physicians.

Q: What are the characteristics of effective clinical integration initiatives?

A: An effective clinical integration program will contain initiatives that (1) provide measureable results which (2) are used to evaluate physician performance and (3) result in measurable improvement of that performance.

Q: Why do a growing number of physicians and hospitals believe clinical integration to be a good business and health care strategy?

A: Physicians and hospitals nationwide are implementing clinical integration programs not merely for reasons of antitrust compliance, but also because they believe in its **value proposition**:

1. Clinical integration allows **physicians** to: (a) demonstrate their quality to current and future patients; (b) choose the clinical measures against which they will be evaluated, and avoid measures imposed by health plans; (c) enhance revenue through better management of chronic patients; (d) gather collective support for building necessary infrastructure; and (e) engage in group contracting.

2. Clinical integration gives **hospitals** the ability to: (a) demonstrate their quality to current and future patients; (b) enlist physician support for hospital initiatives, including compliance with "core measures", clinical pathways, standardized order sets, and supply chain management initiatives; (c) develop a better, more collaborative relationship with their medical staff; (d) improve performance on hospital pay-for-performance measures; (e) position themselves at an advantage in the market on the basis of quality.

3. Clinical integration provides **patients** with: (a) a better value for their health care dollar; (b) more effective case management and outreach from a trusted source, their physician; (c) more reliable information to support their choice of health plans, physicians, and hospitals; (d) more accurate and meaningful provider ratings; and (e) greater stability in their relationship with their doctor and hospital, and less likelihood that they will need to choose new health care providers every hear.

4. Clinical integration gives **employers**: (a) the ability to more effectively manage the health care costs of employees and their dependents through the purchase of better, more efficient health care services; (b) increased employee productivity and reduced absenteeism, through better management of chronic diseases; (c) lower health care costs over the long term, through the reduction of variation in physician practice patters; and (d) more reliable information to support conversion to consumer-driven health insurance products.

Q: In "real life", what does a clinically-integrated network of independent physicians look like?

A: In many instances, clinical integration has involved independent physicians on the medical staff of the same hospital or hospital system who join together in an organization that allows them to: (1) identify and adopt clinical protocols for the treatment of particular disease states, (2) develop systems to monitor compliance with the adopted protocols on both an inpatient and outpatient basis, (3) collaborate with the hospital or hospital system to encourage compliance with inpatient performance improvement processes and protocols, and (4) enter into physician-directed "pay-for-performance" and other contractual arrangements with health plans in a way that financially recognizes the physicians' efforts to improve health care quality and efficiency.

Q: How does clinical integration differ from the so-called "messenger model" as a method of contracting with fee-for-service health plans?

A: Although managed care organizations have for years reaped the benefits of "messenger model" contracting as an efficient, effective, "single signature" contracting vehicle, dozens of recent consent decrees from the FTC indicate that federal regulators will no longer recognize the ongoing validity of "messenger model" fee-for-service contracting. This is because the FTC believes that any "messenger model" arrangement that in any way involves a discussion of fees or other economic terms on behalf of one or more physician practice is a *per se* violation of antitrust law. In contract, a clinically integrated network may negotiate with fee-for-service health plans as a network, thereby improving the opportunity for increased reimbursement in recognition of the efforts to improve performance.

Q: At St. Vincent's Health System, will physicians be involved in the development of clinical integration and the leadership of this endeavor?

A: Yes. St. Vincent's Health System and a number of physician leaders are now actively engaged in the process of developing a **new independent physician network** called the **St. Vincent's Physician Alliance**. This physician network will be governed by a board comprised predominately of physicians, and will operate for the explicit purpose of developing and implementing a **Population Health Solutions** program, on the basis of which the network would negotiate "pay-for-performance" arrangements and related provider contracts with PPOs and other fee-for-service health plans.

Q: What will physicians need to participate in the St. Vincent's Physician Alliance Population Health Solutions, empowering clinical integration?

- First, because membership in the St. Vincent's Physician Alliance Clinical Integration Program will be completely voluntary, physicians will need to choose whether they will participate in the St. Vincent's Physician Alliance Clinical Integration Program by signing a Network Participation Agreement.
- Second, physicians will be required to collaborate with their physician colleagues and St. Vincent's Physician Alliance in the development and adoption of a St. Vincent's Physician Alliance Clinical Integration Program – a collection of clinical initiatives that will enhance the quality, service, and cost-effectiveness of patient care.
- Third, physicians will need to hold themselves and their STVPA colleagues accountable for compliance with the initiatives of the St. Vincent's Physician Alliance Clinical Integration Program, including its disciplinary and improvement efforts should physicians fail to meet the benchmarks set by the St. Vincent's Physician Alliance Clinical Integration Program.

Q: By agreeing to participate in the St. Vincent's Physician Alliance Population Health Solutions, will physicians be required to abandon medical staff appointments at non-St. Vincent's Health System hospitals or admit patients only to St. Vincent's Health System hospitals and ambulatory care facilities?

A: No. The St. Vincent's Physician Alliance Population Health Solutions will be established as a non-exclusive organization, making no limitations whatsoever on a physician's ability to admit patients to non-St. Vincent's Hospital System sites of care or a physician's ability to maintain contracts with health plans on an individual basis or through another non-St. Vincent's Physician Alliance Clinical Integration Program or IPA affiliation. Shared savings are dependent upon 80% network utilization.

Q: What clinical initiatives will the St. Vincent's Physician Alliance Population Health Solutions include?

A: Although the St. Vincent's Physician Alliance Population Health Solutions is always evolving, it includes efforts designed by program managers to facilitate and improve:

- inpatient EMR and CPOE adoption
- ambulatory EMR adoption
- chronic disease management
- care episode management
- PQRI reporting
- communication among primary care physicians and specialists
- community case management
- quality-based credentialing
- inpatient practice efficiencies

Organizational structure provided on page 9.

The goal is that the St. Vincent's Physician Alliance Population Health Solutions will enhance the value of the services we provide the patient and payor communities, measuring compliance with the initiatives using data from various sources, including: claims processing and adjudication systems, practice management and scheduling systems, disease registries, pharmacy benefit systems, and hospital and ambulatory EMR systems.

Q: Will participation in the St. Vincent's Physician Alliance Population Health Solutions require physicians to change the way they practice medicine?

A: Yes. Participation in the quality and care management initiatives of the St. Vincent's Physician Alliance Population Health Solutions will require significant time and attention from their office staff. **But, in return, participating St. Vincent's Physician Alliance physicians will be eligible to obtain *financial rewards* for their achievements through the Population Health Solutions program, funded by contracted arrangements.** The amount of incentive payments will depend on both the physician's personal score and the overall score of the organization. This latter component highlights the importance of physicians working together to improve care. As an example, we distributed over $900,000 in 2018 for shared savings achieved in 2017.

Q: What if I do not choose to participate at the present time?

A: We currently manage over 10,000 lives. As we build, we plan to add additional contracts with other self-insured employers to also manage their health plans. If you are not a member of the STVPA, you will no longer be able to bill as a Tier 1 provider for these patients and will not participate in shared savings.

Q: What role does an EMR play in clinical integration?

A: An ambulatory EMR is *not a prerequisite* for the development of clinical integration. While a common ambulatory EMR across all participating physician practices can certainly accelerate and strengthen a clinical integration program, most (if not all) successful models of clinical integration nationwide do ***not*** depend on an ambulatory EMR for data on physician performance. Ultimately, a network of independent physicians may wish to implement an ambulatory EMR that is designed in a manner that assists in the capture an extraction of the data necessary to continue to operate their clinical integration program. However, the St. Vincent's Physician Alliance Population Health Solutions currently makes efforts to measure, analyze, and evaluate physician performance through claims data, existing hospital data, disease registries, and chart audits.

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Q: I have heard that the Federal Trade Commission (FTC) has not yet adequately clarified the meaning of clinical integration. Is this true?

A: No. Since 1996, the FTC has been very consistent in its definition of clinical integration as well as the analytical framework it applies when evaluating clinical integration among a network of independent physicians. As defined by the 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 the price or other terms or conditions of dealing entered into by or within the arrangement is reasonable 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.)*

The FTC has also indicated on numerous occasions that clinical integration programs may include:

> *…(1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.*

Q: Why are physicians across the country engaging in clinical integration?

A: Physicians have numerous and overlapping motivations for joining together in clinically-integrated networks, including: (1) to enhance the quality of the care provided to patients, (2) to legitimately negotiate with payors as a network, (3) to respond to health plans that are under tremendous pressure to use "report cards" that exclude "inefficient" physicians, (4) to provide access to technological and quality improvement infrastructure that will allow physicians to legitimately and appropriately contest against these "report cards", (5) to allow networks of physicians and hospitals to market themselves on the basis of quality, and (6) improve physician satisfaction with their practice.

Q: How is it lawful for a network of clinically-integrated physicians to collectively negotiate with health plans when the FTC is actively investigating and prosecuting physician networks for negotiating PPO contracts?

A: The FTC views clinically integrated physician networks as an opportunity to create efficiency and quality in care that outweighs any restraint on trade. However, the FTC will continue to prosecute those networks that fail to demonstrate the elements of true clinical integration.

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Q: In the process of developing clinical integration, is it advisable that networks of independent physicians seek an advisory opinion from the FTC?

A: Sometimes, but obtaining a formal advisory opinion from the FTC is not always the best course of action. The advisory opinion process can take a very long time, sometimes years, and even a good result does not actually provide any protection from future enforcement action. Nevertheless, there are other ways to get comfort in this process, including: (1) seeking advice and counsel from attorneys who have worked on these specific programs with the FTC, (2) embedding the well-established standards published by the FTC within the structure of your clinical integration program, and (3) engaging in discussions with the FTC once you are comfortable that your model exhibits the appropriate motivation, vision, structure, initiatives and compliance standards.

Q: What benefit does a health system provide in the development of clinical integration programs?

A: Partnering with a hospital can provide distinct advantages to a network of independent physicians in the development of clinical integration. In instances where the hospital shares the same quality vision as the physicians, the hospital can be a powerful ally in program development by: (1) collaborating with the physicians in the development of clinical integration initiatives based on existing inpatient quality measures, (2) providing additional resources, including personnel, financial, and IT in the implementation of inpatient and outpatient initiatives that provide true community benefit and are not tied to the volume or value of referrals, and (3) demonstrating to payors and the community as a whole that the clinical integration program is both legitimate and valuable.

Q: How is a clinical integration project typically organized?

A: There are a series of logical steps that physicians can take, with the assistance of competent legal counsel, in order to design, implement and operate a true clinical integration program, including:

1. Conducting a readiness assessment, whereby existing infrastructure, programs, and organizational structures (i.e., hospital technology, personnel, and other resources; the existence of current IPAs or PHOs) are evaluated to determine the preparedness of the physicians to engage in clinical integration;
2. Establishing an organizational framework, in order to create a flexible "joint venture" business entity through which the physicians can collaborate with each other and with their hospital to develop clinical quality and efficiency initiatives;
3. Developing commitment and consensus among all stakeholders – physicians, hospital administration, and even employers, health plans, and patients – that clinical integration is an ideal solution for the demands of improving health care quality, enhancing health care consumerism, and increasing health care efficiency;
4. Designing clinical integration programs and initiatives that (a) leverage existing data, technology, and human capital at the respective physician practice, physician network, and hospital levels; (b) provide the highest likelihood for accelerated implementation; (c) offer the greatest impact on health problems and disparities in the community; and (d) create the most probably case for overall health care cost reduction, based on better care rather than lowest unit price;
5. Engaging regulators, primarily the FTC but also relevant state and local officials, usually in the context of "informal" dialogue rather than a formal advisory opinion process, wherein the network of physicians is readily able to answer likely questions regarding program initiatives, the efficiencies anticipated from the CI program, and the reasonable necessity of joint negotiations to achieve efficiencies of the program;

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6. Implementing the clinical integration program through the execution of initiatives designed in step 4, the alignment of data collection and reporting systems to effectively measure physician performance, the delivery of feedback to network physicians about that performance, and the remediation of poor performance; and
7. Contracting with fee-for-service health plans as a network in a manner that adequately compensates for the "new product" developed by the physicians through clinical integration, and rewards physicians under "pay-for-performance" and other incentives.

Q: How can I receive more information regarding the details of the St. Vincent's Physician Alliance Population Health Solutions?

A: You or your representative may contact:

Dr. Jerry Kitchens, STVPA Executive Director at 205-542-5139

Dr. Jeff Clifton, STVPA Board Chairman at 205-595-5504

St. Vincent's Physician Alliance Population Health Solutions

Our goal is to provide personalized, care coordination support to assist physicians and patients in their time of need

When should my office contact a Program Manager for assistance?

- Assistance with social service needs
- Medication access
- Transportation barriers
- Frequent emergency department or inpatient visits
- Medically complex patients in need of additional care coordination
- Advanced stage of disease

For assistance with managing your patient / navigation support, call or email:

- Dana Meginniss, Clinical Integration Manager
  dana.meginniss@ascension.org; 205-790-3592
- Program Managers
  Casey Hamblin: billie.Hamblen@ascension.org; 205-838-5770
  Nathan Salter: nathan.salter@ascension.org; 205-838-5785
  Melissa Braden: melissa.braden@ascension.org;
  East: 205-838-5307
  Birmingham: 205-939-7998