Clinically Integrated Networks: Should You Form One or Join One?

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Background: Healthcare Organizational Structures

- Driven by payor policy.
- Medicare is the largest purchaser of healthcare services
- Medicare reductions in hospital cost reporting drove horizonal integration -- economies of scale
- Medicare reductions in physician reimbursements drove vertical integrations
- Medicare innovations in payment (Medicare Center for Innovation) driving Integrated Care Models

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For an in depth look at organizational structures

- Heeringa, J., Mutti, A., Furukawa, M. F., Lechner, A., Maurer, K. A., & Rich, E. (2020). Horizontal and vertical integration of health care providers: a framework for understanding various provider organizational structures. International journal of integrated care, 20(1).
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6978994/

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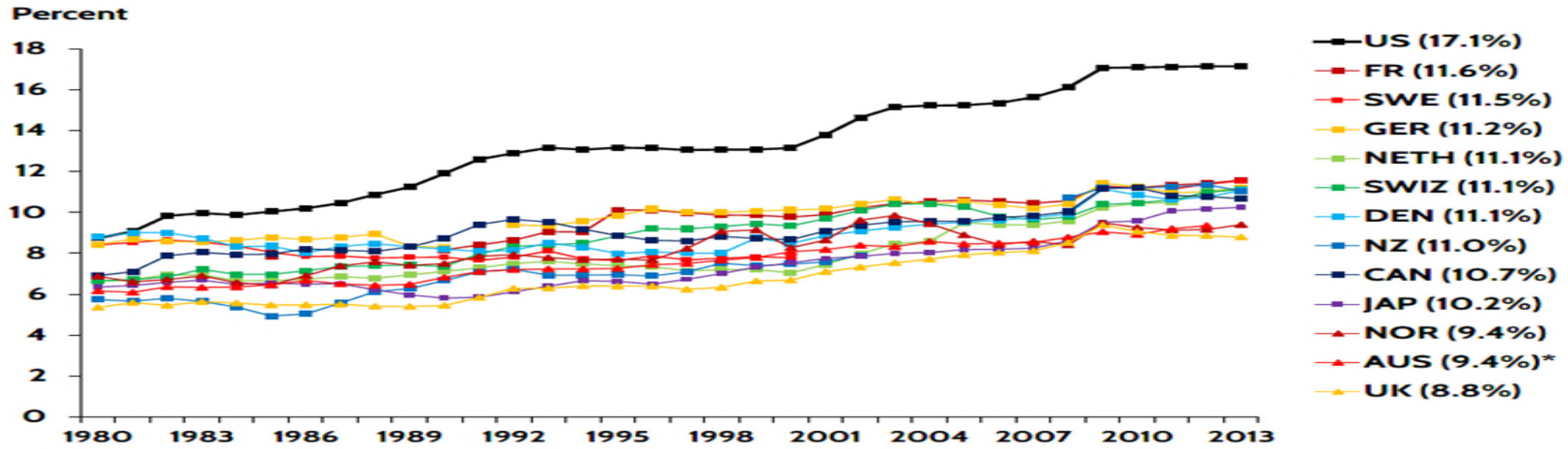
Making the Case for CINs

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.
Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.
Source: OECD Health Data 2015.

*Squires, D, Anderson, C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries New York: The Commonwealth Fund; 2015. [Cited 2018 Nov 26].

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Exhibit 2. Health Care Spending, 2013

	Total health care spending per capita[e]	Real average annual growth rate per capita		Current health care spending per capita, by source of financing[e,f]		
					Private	
		2003–2009	2009–2013	Public	Out-of-pocket	Other
Australia	$4,115[a]	2.70%	2.42%[c]	$2,614[a]	$771[a]	$480[a]
Canada	$4,569	3.15%	0.22%	$3,074	$623	$654
Denmark	$4,847	3.32%	-0.17%	$3,841	$625	$88
France	$4,361	1.72%	1.35%	$3,247	$277	$600
Germany	$4,920	2.01%	1.95%	$3,677	$649	$492
Japan	$3,713	3.08%	3.83%	$2,965[a]	$503[a]	$124[a]
Netherlands	$5,131[d]	4.75%[d]	1.73%[d]	$4,495	$270	$366
New Zealand	$3,855	6.11%[b]	0.82%	$2,656	$420	$251
Norway	$6,170	1.59%	1.40%	$4,981	$855	$26
Sweden	$5,153	1.82%[d]	6.95%[d]	$4,126	$726	$53
Switzerland	$6,325[d]	1.42%[d]	2.54%[d]	$4,178	$1,630	$454
United Kingdom	$3,364	4.00%	-0.88%	$2,802	$321	$240
United States[e]	$9,086	2.47%	1.50%	$4,197	$1,074	$3,442
OECD median	$3,661	3.10%	1.24%	$2,598	$625	$181

[a] 2012. [b] 2002–2009. [c] 2009–2012.
[d] Current spending only; excludes spending on capital formation of health care providers.
[e] Adjusted for differences in the cost of living.
[f] Numbers may not sum to total health care spending per capita due to excluding capital formation of health care providers, and some uncategorized spending.
Source: OECD Health Data 2015.

*Squires, D, Anderson, C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries New York: The Commonwealth Fund; 2015. [Cited 2018 Nov 26].

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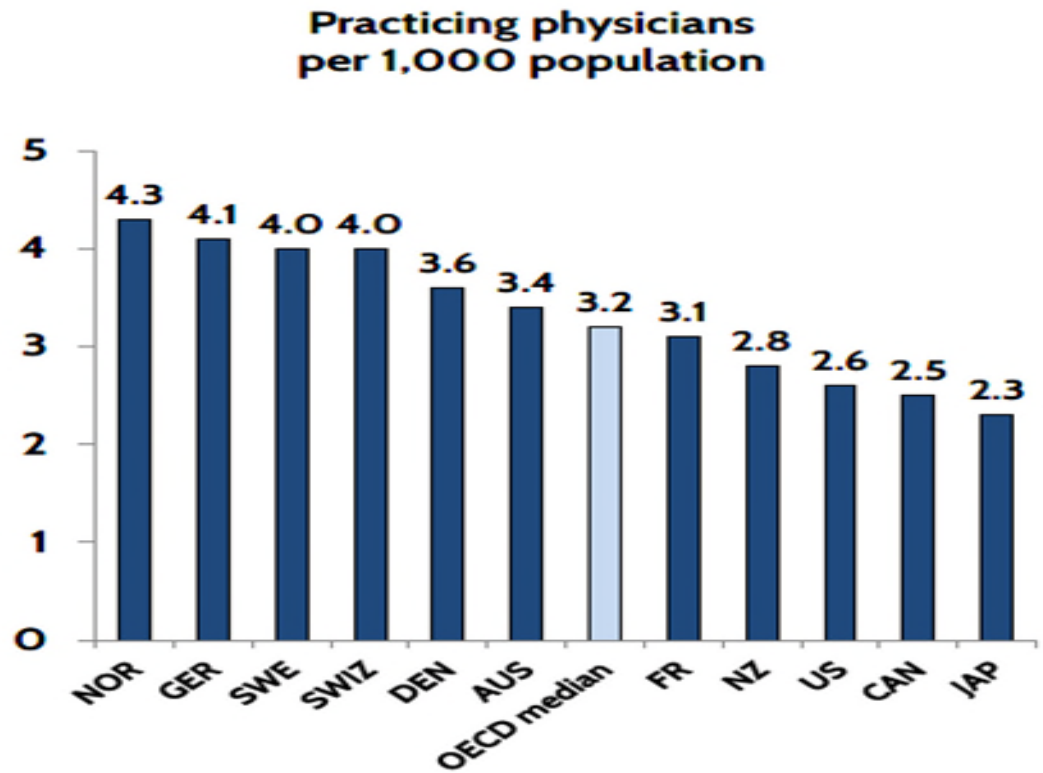
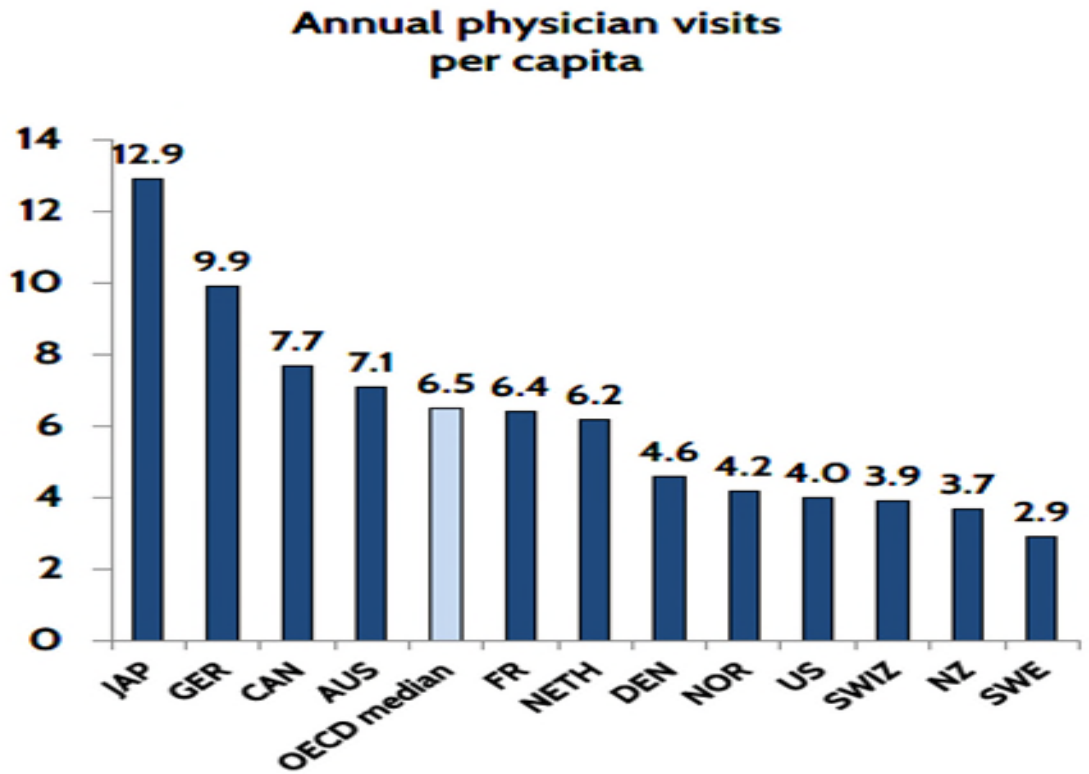
Exhibit 3. Physician Supply and Use, 2013 or Nearest Year



Note: Data from 2012 in Canada, Denmark, Japan, and Sweden.



Note: Data from 2012 in Canada, Japan, Sweden, and Switzerland; and 2010 in the U.S.

Source: OECD Health Data 2015.

*Squires, D, Anderson, C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries New York: The Commonwealth Fund; 2015. [Cited 2018 Nov 26].

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Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013[a]	Infant mortality, per 1,000 live births, 2013[a]	Percent of pop. age 65+ with two or more chronic conditions, 2014[b]	Obesity rate (BMI>30), 2013[a,c]	Percent of pop. (age 15+) who are daily smokers, 2013[a]	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3[e]	12.8	14.4
Canada	81.5[e]	4.8[e]	56	25.8	14.9	15.2
Denmark	80.4	3.5	–	14.2	17.0	17.8
France	82.3	3.6	43	14.5[d]	24.1[d]	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	–	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2[e]	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0[d]	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3[d]	20.4[d]	17.3
United Kingdom	81.1	3.8	33	24.9	20.0[d]	17.1
United States	78.8	6.1[e]	68	35.3[d]	13.7	14.1
OECD median	81.2	3.5	–	28.3	18.9	17.0

[a] Source: OECD Health Data 2015.
[b] Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.
[c] DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.
[d] 2012. [e] 2011.

*Squires, D, Anderson, C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries New York: The Commonwealth Fund; 2015. [Cited 2018 Nov 26].

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Making the case for CINs

"One potential consequence of high health spending is that it may crowd out other forms of social spending that support health. In the U.S., health care spending substantially outweighs spending on social services. This imbalance may contribute to the country's poor health outcomes. A growing body of evidence suggests that social services play an important role in shaping health trajectories and mitigating health disparities."

*Squires, D, Anderson, C. U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries New York: The Commonwealth Fund; 2015. [Cited 2018 Nov 26].

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What is a CIN?

- A clinically integrated network is a way for providers to collaborate for the purpose of increasing quality, improving outcomes all while decreasing utilization and the overall spend for consumers. It is not full financial integration. A goal is to remain organizationally and operationally separate. Many form CINs to maintain their own independence, mission and corporate culture while leveraging relationships with other providers to gain market strength, particularly when negotiating with payors. CINs can be formed as freestanding corporations to which provider organizations belong or virtual organizations through a series of agreements.

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History

- Department of Justice and FTC Antitrust Enforcement Policy Statements in the Health Care Area (Sept. 15. 1993)
- Statements of Antitrust Enforcement Policy in Health Care (Aug 1, 1996)
- Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (Oct. 20 2011)

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History

- Feb. 3, 2023 DOJ Withdrew all 3 Enforcement Policy Statements
- Statements are overly permissive…
- No longer provide guidance on relevant competition issues.
- AHA statement: “[w]ithdrawing all the guidance without consultation with the field is both unnecessary and reckless.”

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What is the commitment like?

- Membership in a CIN is a big commitment.
- Members are required to contribute time and resources toward achieving the agreed to objectives.
- Participation does not require any change in ownership, change in tax identification numbers for billing purposes or any other material change in the corporate structure of member organizations.

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What actually is asked of participants?

- Participants must:
  - actively participate in the CIN's clinical and quality improvement initiatives;
  - exchange data within the CIN;
  - implement best practices & comply with them;
  - agree to policies and practices of the CIN which promote efficiencies;
  - participate in all payor agreements negotiated by the CIN.
- Not asking for full financial integration.

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Why Form a CIN?

- Rapidly changing payor systems (public & commercial)
- Providers are being ask to bear risk
- Larger the population served, broader the services covered, greater the leverage & market position to negotiate best contractual terms.

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Why Form a CIN?

- It is predicted that over one half of providers in the behavioral health space will merge, be acquired or simply close their doors in the next 10 years.
- Two BH focused CINs in Michigan. 10 provider organizations to start. Two mergers already.
- Horizonal Integration: Look at physical health delivery system. Hospital acquisition wars. Horizonal Integration to the point that mergers are being challenged.
- Vertical Integration: We are also seeing hospitals gobble up primary care practices and specialty practices as reimbursement rates drop and small practices are squeezed out with the utilization of narrow networks.
- Narrow networks – big threat to BH providers.
- Health systems will figure out integrated care delivery and will begin to search out BH providers for acquisition.
- The private equity market knows the above risks and the value created by them which in part is driving record setting private equity acquisition of BH providers.

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Why Form a CIN?

- If a BH provider is to survive, it must gain market power through size. There are only two ways to do this: financially integrate through merger or acquisition; or remain independent and collaborate via clinical integration.

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Are They Successful?

- Some CINs are flailing and some are very successful. The difference between success and failure comes down to who is calling the shots in the Boardroom. CINs run by large health systems without significant provider ownership and control typically fail. The Hospitals are making all the decisions which alienates the very providers who can make a CIN successful.
- We have formed successful BH CINs in many states in order to gain market share and negotiating leverage as the state is establishing fully integrated MCO contracts. CINs get providers noticed, get meetings with payors and get prime contracts with prime terms.

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What Are the Critical Steps to Formation of a CIN?

1. Gather Interested Parties. Consider who the founding partners should be and in doing so, consider factors such as market position, organizational leadership, reputation regarding quality, commitment to data gathering and analytics.
2. Create a Value Proposition a/k/a Design the Model. While it is inevitable that each member of the CIN will have ideas about the design and value proposition, it is important that all members decide on and support the ultimate design and value proposition of the CIN.

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What Are the Critical Steps to Formation of a CIN?

3. Structure Organizational Documents and Participation Documents. As with any organization, members need to decide how decisions will be made within the CIN, how governance will be handled, how payor contracts will be negotiated, how capital contributions will be handled and at what level, and how the proceeds of the CIN's efforts will be distributed.

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What Are the Critical Steps to Formation of a CIN?

4. Design Quality Indicators and Best Practices. The CIN will need to determine the measures which best demonstrate the design model and/or value proposition and also decide what best practices need to be followed in order to achieve desired outcomes. Technology is a critical tool that must be utilized not only to measure necessary metrics but also to report out to providers in real time their efforts toward achieving the stated goals.

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What Are the Critical Steps to Formation of a CIN?

5. Recruit Participating Organizations beyond the Founder Organizations. The CIN must identify the types of providers the network needs. It is important to spend a lot of time building a high level of trust among the founding providers so they can communicate the business case to joining the CIN to other providers. The strength of the CIN will be dependent not only on selecting a meaningful design but also selecting the correct organizations to demonstrate commitment to quality and adequate market power to make a meaningful difference in covered populations.

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What Are the Critical Steps to Formation of a CIN?

6. Gather Data, Measure It and Demonstrate Effectiveness. Again, the role technology plays in a successful CIN cannot be emphasized enough. Equally important to the success of the CIN will be the correct application of measures to the data and the convincing reporting of those metrics.
7. Approach and Negotiate with Payors. After establishing that the necessary antitrust protections are in place, the CIN armed with the effectiveness of its value proposition and design as evidenced by the underlying data and metrics will be able to engage in meaningful payment reforms and innovation with payors.

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What Doesn't Work

- Co location of services with nothing more – Merely increases access
- Status Quo contracting with PCP connector incentive – Fails to control run a way costs like hospitalization & lacks "Team-Driven" care
- Basically any system of care or set of relationships which doesn't
  - Incentivize multidisciplinary coordination;
  - Focus compensation on outcomes (FFS and PMPM / PEPM are dinosaurs)
  - Focus on measurement of outcomes
  - Focus on best practices with proven health improvement outcomes

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What Does Work – Collaborative Care

- Washington State's Mental Health Integration Program (MHIP) – a Collaborative Care Model (2009 start)
  - Funders – State Legislature, Community Health Plan of Washington, and Public Health – Seattle & King County
  - Target Conditions – ADHD, Anxiety, PTSD, Depression, SMI, SUD, Medical Conditions
  - Practice Type – Primary Care, safety net clinics, rural
  - Target Population – Children, Moms, Older Adults, Ethnic Minority, Low-Income
  - Wealth of resources on AIMS Center website

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What Does Work – MHIP Results

- 17% fewer inpatient medical admissions and smaller increases in inpatient psychiatric costs (21% vs. 167%) over the review period.
- 24% decline in the number of arrests
- Smaller increase in those living in homeless shelters or outdoors (50% vs. 100%)
- Smaller increase in days spent in state hospitals (33% vs. 500%)

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What Does Work – Value Based Payment

- New York started a statewide grant in 2012. Following its success, the State turned on a Medicaid code to reimburse a limited number of practices in the model in 2015.
- Legislature allocated over $11 million annually for depression treatment in a primary care setting. Now over 100 PCPs participating including hospital-affiliated clinics, FQHCs, and independent practices.
- Innovative value-based model with monthly case rate payment to help sustain practices. This allows practices to provide necessary services flexibly without being limited by fee-for-service billing. The monthly payment also helps to support crucial infrastructure such as the addition of behavioral health care management staff to provide counseling and care coordination.
- Process and outcome data reported quarterly. Providers accountable so that patients do not remain in ineffective treatment.

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What Does Work – Value Based Payment

- The value-based payment model emphasizes frequent telephone contact with the patient, recurring in-person sessions, and virtual consultation with an off-site psychiatrist for caseload support focused on patients who are not improving. Monthly payment conditioned on contact and completed a PHQ-9 to track the depression symptoms.
- 25% of the payment is withheld each month, but can be paid retroactively after 6 months if the practice can attest that the patient has improved, or that they have intervened and made adjustments to the patient's treatment plan to address the lack of improvement.

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What Does Work – Value Based Payment

- Colorado Children's Hospital – Pediatric Care Network (PCN)
- Rated top network in region for 11 straight years (as of 2021)
- One payor started National Pilot with PCN and ranked PCN top in country
- In-depth study of differences between adult population focused CIN and pediatric care focused CIN
  - Pediatric Value Based Care focuses on prevention with longer period of payoff in proving absence of disease vs. more immediate outcome measures for more chronically ill elderly populations.
- Schwartz, R., & Leishman, T. (2021). The evolution of value-based care for pediatrics. Current Problems in Pediatric and Adolescent Health Care, 51(8), 101067.
- https://www.sciencedirect.com/science/article/pii/S153854422100122X

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What Does Work

Locking Arms with colleagues through

- Clinical Integration
- Financial Integration

So that you can accomplish together what is not possible alone.

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A Deeper Dive - Antitrust Law Primer

Antitrust law condemns as per se illegal naked agreements among competitors that fix prices or allocate markets.

Multiprovider networks will not be viewed as per se illegal if *clinical integration* through the network produces significant efficiencies and improves quality that benefit consumers, and any price agreements are reasonably necessary to realize those efficiencies.

***Statements of Antitrust Enforcement Policy in Health Care issued by U.S. Department of Justice and the Federal Trade Commission, August 1996**

- Rule of reason standard applied on case by case basis in the absence of enforcement policy statement

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Under old Policy Statement - A Clinically Integrated Network Must . . .

- Show improved quality and efficiency
- Deploy consistent clinical protocols across CIN
- Have as a goal achieving measurable targets
- Monitor network performance
- Have a collective financial investment in a reporting system

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In the end . . .

- Combining several smaller systems of care into one larger one will greatly increase the efficiency and quality of care offered

- Sharing patient clinical and financial data across CIN creates a more holistic view of patient than siloed approach

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What Might a Purpose Statement Look Like?

We are a clinically integrated alliance of behavioral health providers who have aligned themselves to preserve the principles of exceptional patient care, all the while investing in the culture of practice independence and expansion.

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If We Don’t Act – Integration will be Forced

- Arizona is a Prime Example

- Discussion of the Arizona Model

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Integrated Contractor Anticipated Procurement Timeline

Activity	Target Date
Issue Request for Proposal	November 1, 2017
Prospective Offerors' Conference and Technical Interface Meeting	November 8, 2017
Proposals Due	January 25, 2018
Contracts Awarded	By March 8, 2018
Transition Activities Begin	March 9, 2018
Contract Start	October 1, 2018

Note: *Dates are subject to change*

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Reaching across Arizona to provide comprehensive quality health care for those in need

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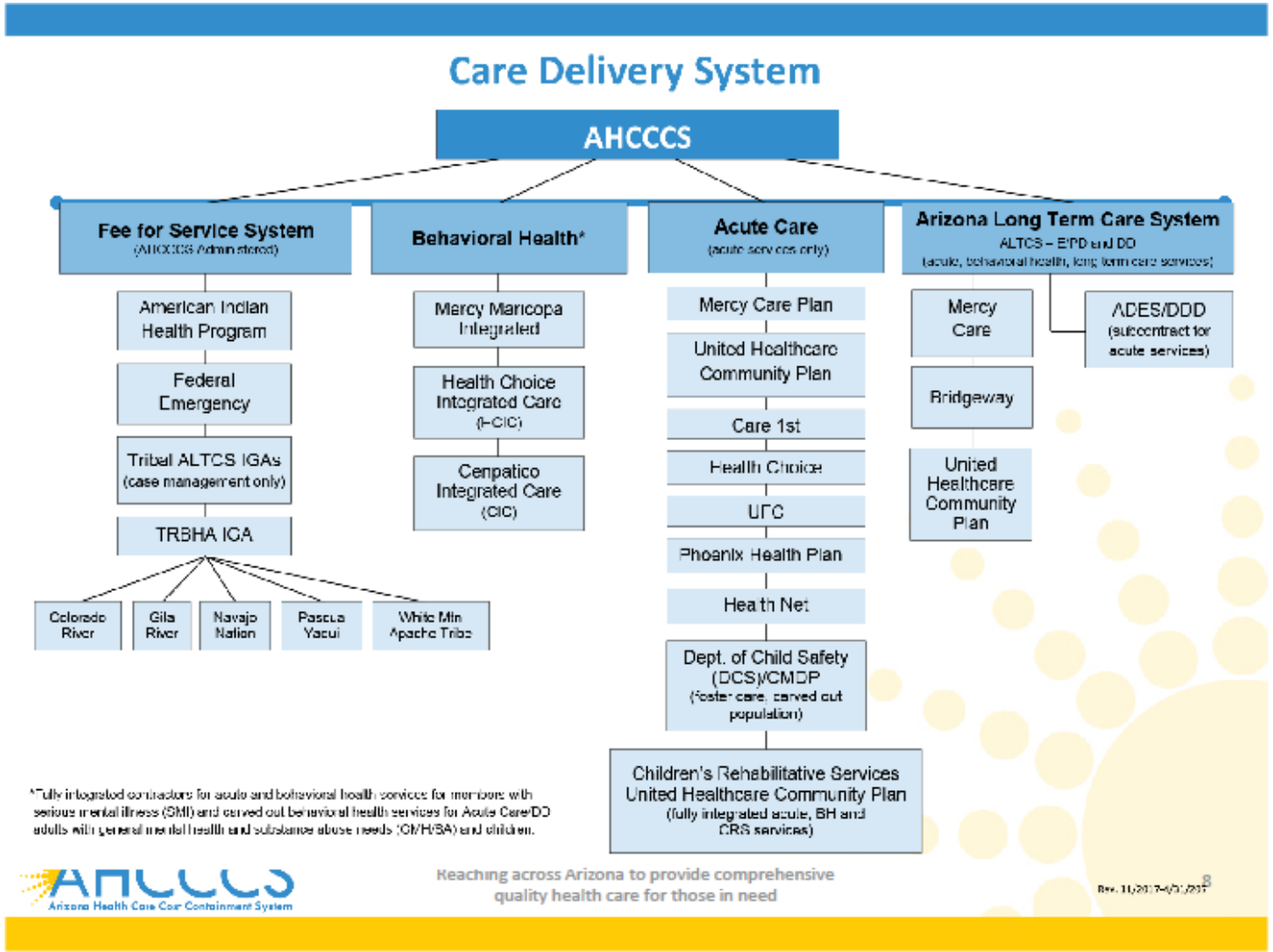
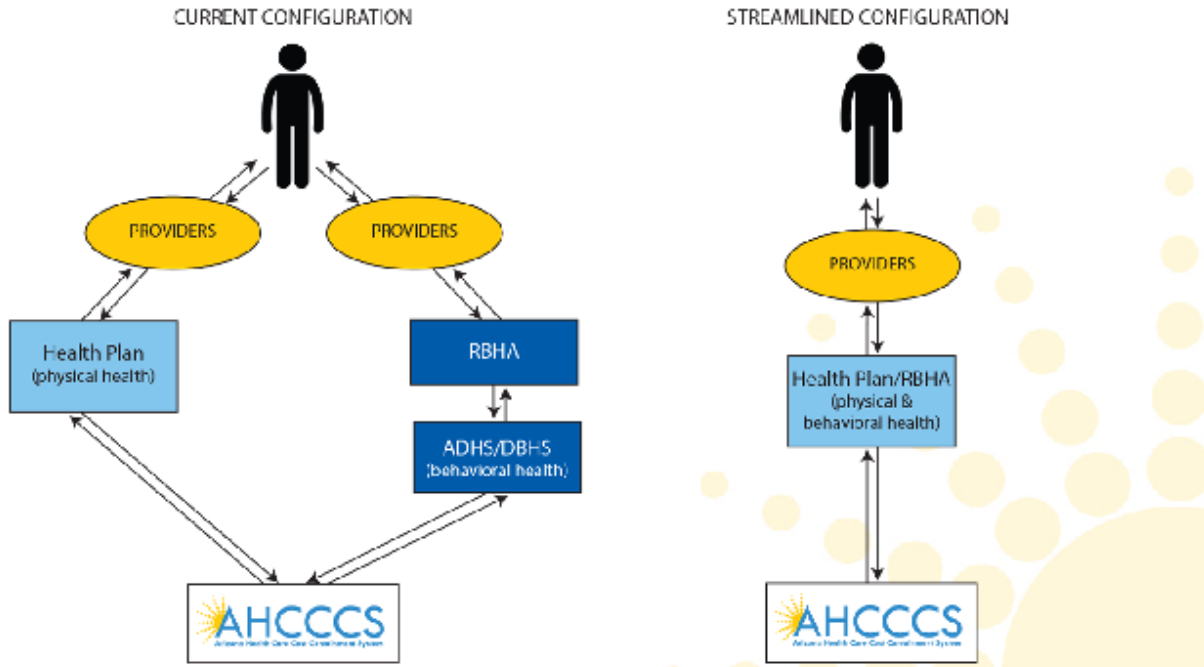

Care Delivery System
AHCCCS
Fee for Service System
(AHCCCS Administered)
Behavioral Health*
Acute Care
(acute services only)
Arizona Long Term Care System
ALTCS – EPD and DD
(acute, behavioral health, long term care services)
American Indian Health Program
Federal Emergency
Tribal ALTCS IGAs
(case management only)
TRBHA IGA
Colorado River
Gila River
Navajo Nation
Pascua Yaqui
White Mtn Apache Tribe
Mercy Maricopa Integrated
Health Choice Integrated Care
(HCIC)
Cenpatico Integrated Care
(CIC)
Mercy Care Plan
United Healthcare Community Plan
Care 1st
Health Choice
UHC
Phoenix Health Plan
Health Net
Dept. of Child Safety (DCS)/CMDP
(foster care, carved out population)
Children's Rehabilitative Services
United Healthcare Community Plan
(fully integrated acute, BH and CRS services)
Mercy Care
Bridgeway
United Healthcare Community Plan
ADES/DDD
(subcontract for acute services)
*Fully integrated contractors for acute and behavioral health services for members with serious mental illness (SMI) and carved out behavioral health services for Acute Care/DD adults with general mental health and substance abuse needs (GMH/SA) and children.
Arizona Health Care Cost Containment System
Reaching across Arizona to provide comprehensive quality health care for those in need

Vision - Integration at all 3 Levels



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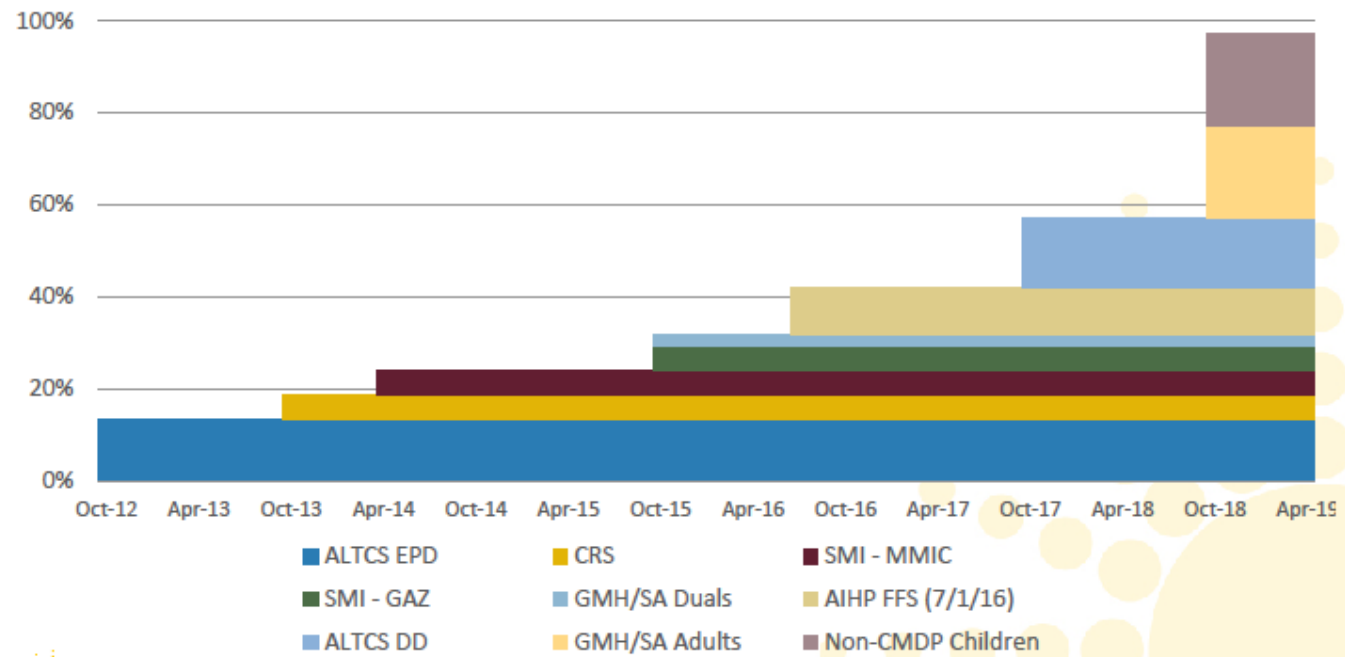
Integration Efforts



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Current Program Highlights

- "Acute Plans" provide physical health (PH) services to Medicaid enrolled individuals not in another integrated program and also behavioral health (BH) services for individuals who have not been determined to have a serious mental illness (SMI) who are dually enrolled in Medicare
- Regional Behavioral Health Authorities (RBHAs)
  - Carved out BH services for children
  - Carved out BH services for adults not served by an integrated plan
  - Integrated services for individuals with a serious mental illness (SMI)
  - Crisis services all populations
  - Grant and other non-TXIX funded services
- Members have access to a robust network of health care providers

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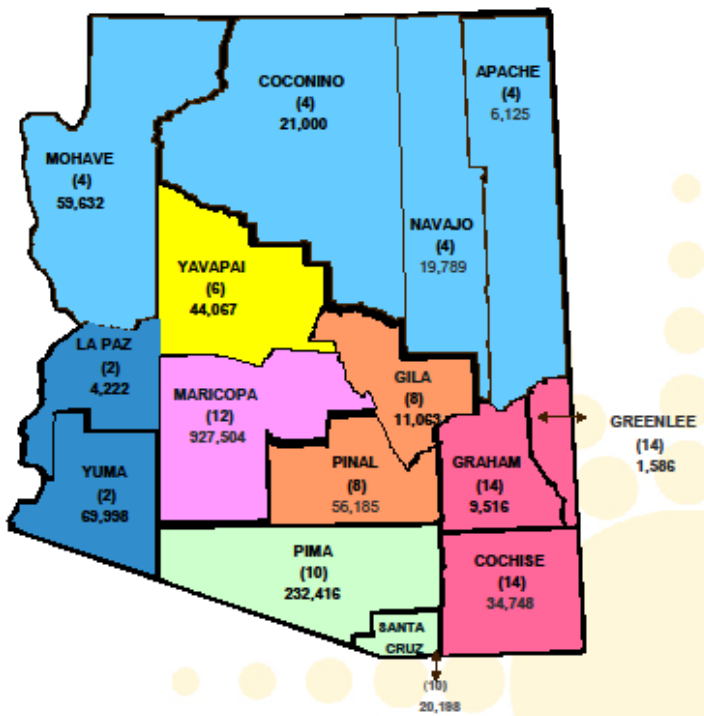
Acute Geographic Service Areas

Acute Enrollment As of January 1, 2017

GSA Number	Acute Health Plan Enrollment	
2	75,562	UHC, UFC
4	110,968	UHC, HCA
6	46,463	UHC, UFC
8	69,443	HCA, UFC
10	266,933	UHC, HCA, UFC, Care1st, MCP
12	927,504	UHC, Care 1st, HCA, MHP, MCP, PHP, HNA
14	46,914	UHC, UFC



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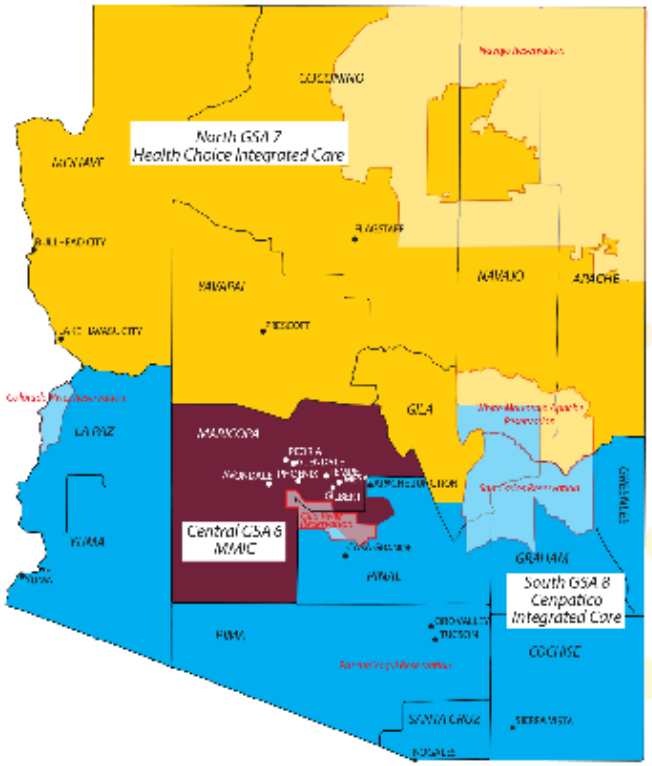
Current RBHA GSAs



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