



## The Value of Provider Integration

A new era in care delivery has been emerging as providers focus on improving the patient care experience, enhancing care quality and lowering the cost of patient care. An emphasis on population health has provided the foundation for greater collaboration among providers and the development of coordinated care models. These new

models often are “value-based” and providers are at financial risk if quality and cost goals are not achieved.

The need to transform health care delivery has stimulated hospitals and hospital systems to integrate among themselves and with other providers across the care continuum by unifying patient information, better coordinating

transitions and follow-up care, sharing financial risk and streamlining management services. Even as regulatory barriers continue to constrain the pace of innovation, these efforts are expanding and are achieving promising results in terms of improving the patient care experience, quality and efficiency.

## Provider Integration Takes Many Forms

Health care provider integration can take a number of different forms – hospitals, physicians and post-acute care providers can integrate clinically or financially, horizontally or vertically, and the rela-

tionships can range from loose affiliations to complete mergers. As such, it is important to understand that the term “integration” can be inclusive of many different types of organizational models.

Clinical integration enables greater collaboration on care delivery within and across settings of care, which in turn improves the patient experience. Clinically integrated hospitals and other

Integration efforts are evolving to change and improve patient care delivery.

Chart 1: Stages of Clinical Integration

	Historic Model	Transitional	Advanced	Breakthrough
Clinical Integration Approach	Provide care within a given operating unit (e.g., orthopedics) for a specific condition; protocols and pathways exist within unit with little coordination	Coordinate care across operating units within a given stage of illness; protocols and pathways continue to be based within a given setting of care, such as a hospital or inpatient rehabilitation facility	Seamless transition across all relevant settings of care for a given episode of illness; protocols and care pathways based on service lines across providers, instead of within a single setting of care	Disease prevention and population health management across the full continuum of care
Management Model	Individual operating units	Horizontal alignment based on clusters of consolidated operating units within a setting (e.g., Vice President for Acute Care, Vice President for Physician Groups)	Horizontal or vertical alignment focused on clinical service lines (e.g., cardiovascular, oncology, behavioral health, women’s health) across settings of care	Dynamic processes and capabilities created to serve the diverse and multiple care needs of a given population

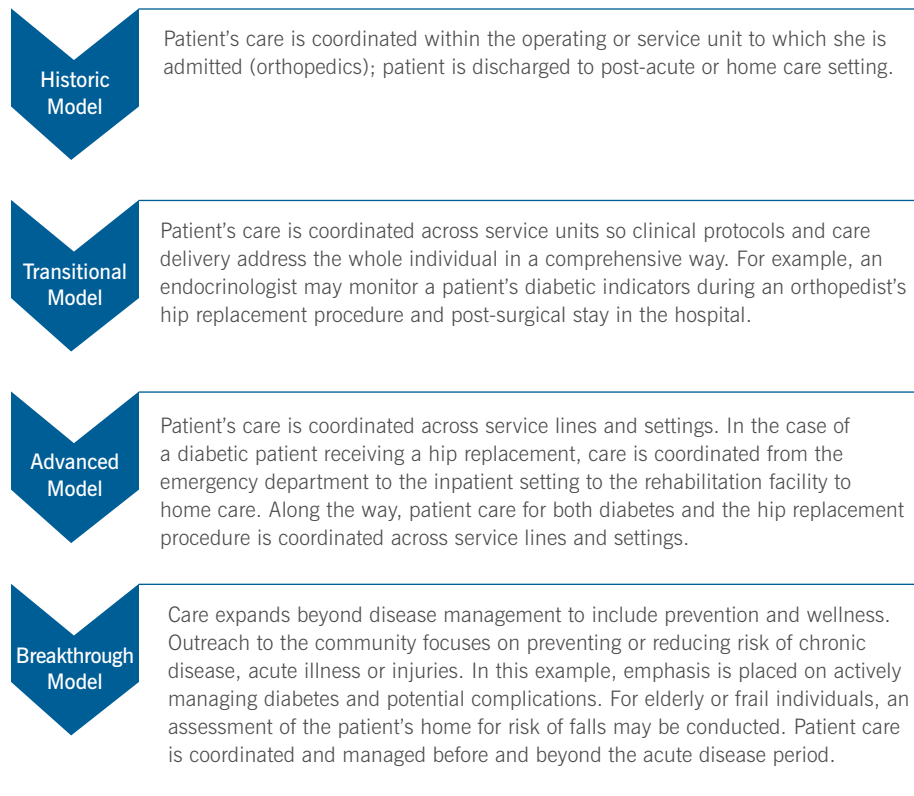
providers work together across settings of care to establish consistent practices in areas such as quality assurance, utilization review, guidelines and protocols, as well as coordination of patient services and shared access to medical records.<sup>1</sup>

Financial integration means that facilities share income and expenses.<sup>2</sup> This allows for greater access to resources and an ability to spread costs over larger populations, leading to efficiencies in overhead, administrative expenses and infrastructure.\* However, efforts to integrate are complex and in many cases, the absence of antitrust guidelines is a barrier.

Health care organizations can integrate horizontally or vertically. Horizontal integration occurs when two or more like providers, such as two hospitals, join forces.<sup>3</sup> Horizontal integration helps groups of like providers gain economies of scale by purchasing supplies and drugs at lower costs, eliminating inefficiencies, removing duplicative service lines and technologies, and consolidating common services and functions, including revenue cycle management and human resources.<sup>4</sup> Vertical integration refers to integration of providers at different points along the continuum of care, such as a hospital partnering with a skilled nursing facility (SNF) or a physician group.<sup>5</sup> Vertical integration can facilitate lower costs and, ultimately, better patient outcomes. Specifically, better communication and information sharing among providers across the continuum of care provides the foundation for care coordination, with benefits such as reducing readmissions or minimizing redundant testing. While care coordination can occur

**The experience of patient care will transform as care systems become increasingly integrated.**

Chart 2: Example of Patient Care in Stages of Provider Integration for Elderly Patient with Diabetes Requiring Hip Replacement



through a variety of organizational structures, vertically integrated organizations can manage a patient's care throughout a care episode, support transitions from one level of care to another and, thereby, improve outcomes at lower costs.

Relationships also vary in the strength of the ties among the organizations. Less formal initiatives include those aimed at a single service, preferred partnerships or

non-binding affiliations. Other forms of integration are more formal, such as joint ventures. More formal integration models may permit increased operational efficiencies or access to resources that would otherwise not be attainable. Highly integrated models are likely to include providers across multiple settings of care and to provide preventive and coordinated care for the populations they serve.

“ ”  
*from the field*

“[The Clinical Integration Program] brings together what would otherwise be a fragmented group of employed and independently practicing physicians into a single comprehensive care management program.”

— Advocate Physician Partners, *The 2013 Value Report*.

\*Some audiences define financial integration as a provider that also administers a health plan.

## Advocate Physician Partners: Maximizing Value through Accountable Care<sup>6</sup>

Based in the Chicago area, Advocate Physician Partners (APP) represents one of the largest clinically integrated networks in the country, joining 10 hospitals and 4,000 physicians in a partnership that has created value for patients, payers and employers by improving quality and lowering costs. The organization grew out of a “super physician hospital organization (PHO)” formed in 1995 to manage the care of its commercially insured Health Maintenance Organization (HMO) population. Following an extensive antitrust investigation requiring Advocate Health Care, APP’s parent organization, to enter into a consent decree, APP further developed and transferred its competencies in care coordination to a broader population through its Clinical Integration Program and is now pursuing innovative value-driven contracts with the state’s Blue Cross Blue Shield plan as well as participating in the Medicare Shared Savings Program. Advocate Health Care has succeeded in building a sizable integrated delivery system largely composed of small practices and physicians who are not employed by APP.

The Clinical Integration Program aligns the entire organization around a comprehensive program of tools and resources used to drive improved clinical performance across the care continuum. For example, embedded care managers focus on the management of complex, high-risk patients in primary care offices, developing individualized care plans based on medical needs, patient preferences,

### ADVOCATE’S INTEGRATION EFFORTS HAVE RESULTED IN:

- In 2012, admission rates were down 6 percent while length of stay dropped 2.9 percent in Advocate’s commercial shared savings population
- APP’s asthma control rate exceeds the national average by 16 percentage points, saving an estimated \$6.2 million annually in direct and indirect costs
- APP advances in diabetes management extended life expectancy, reduced morbidity and saved an estimated \$6 million annually through improvements related to better control of HbA1c
- Lowered rate of elective inductions from 11.7 percent to 5.7 percent
- Reduced use of blood products by 20 percent

values and capabilities. Practice Operation Coaches work alongside physicians using data-driven strategies to identify opportunities to perform better. Protocol-driven chronic disease clinics, staffed by an array of health care professionals, focus on patients with poorly controlled chronic conditions including diabetes, heart failure, chronic obstructive pulmonary disease and asthma. The transition coach program educates patients at high risk for readmission, identified through a risk stratification tool, on medication reconciliation, physician follow-up care and actions to take given various signs and symptoms.

Technology forms a critical backbone for many of the system’s initiatives. APP physicians are required to adopt certain technologies that drive up performance including computerized physician order entry, the electronic intensive care unit, web-based patient registries, e-prescribing, an APP e-learning program, a patient portal, an electronic medical records

system and tools for tracking patients across the continuum.

Central to the success of the Clinical Integration Program is a unique physician incentive structure that rewards high performance related to technology adoption, quality, value, patient safety and patient experience. APP combines funds across all of the system’s commercial and Medicare accountable care organization contracts to build a meaningful incentive pool. Rigorous membership criteria ensure physicians are fully committed to the program and non-performance can result in loss of incentive payments, enrollment in corrective action programs or removal from the network. Physicians also receive a monthly report card comparing their performance on such indicators as admissions, length of stay and total cost of care to their local PHO and the organization as a whole. These data are transparent across the network.

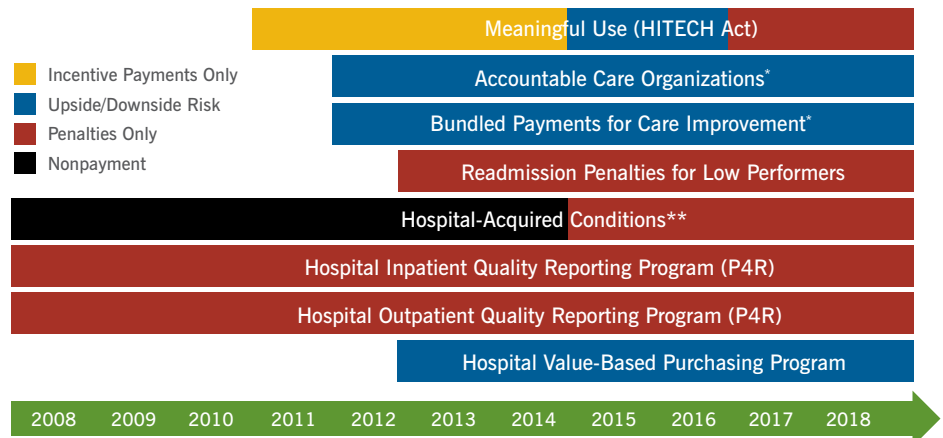
## Policy and Market Forces are Driving Integration

Before Congress began considering the most recent round of health reform proposals in the late-2000s, leaders in the hospital field already were pursuing integration, aware of the need to improve patient outcomes, curb the growing financial burden of health care and respond to downward pressure on reimbursement from public and private payers. The Affordable Care Act’s (ACA) focus on enhanced quality and accountability in care delivery has provided an even greater impetus to restructure. New voluntary payment models, such as bundled payments and shared savings via accountable care organizations (ACOs), establish payment and quality improvement targets for patients for a pre-defined patient population for either an episode of care or for all care provided over a specific time period.

Other Medicare programs, such as quality reporting and value-based purchasing, on top of payment penalties for readmissions and hospital-acquired conditions, create additional incentives to better manage care across the

### CMS quality and accountability initiatives provide additional impetus to hospitals’ integration efforts.

Chart 3: Timeline of CMS Value-driven Payment Initiatives



P4R: Pay-for-reporting. HITECH: Health Information Technology for Economic and Clinical Health.  
 \* Program is voluntary  
 \*\* In 2008, Medicare stopped paying for select hospital-acquired conditions (HAC). In FY 2015, Medicare will begin penalizing hospitals in the top quartile of Medicare HACs.  
 Source: Centers for Medicare & Medicaid Services

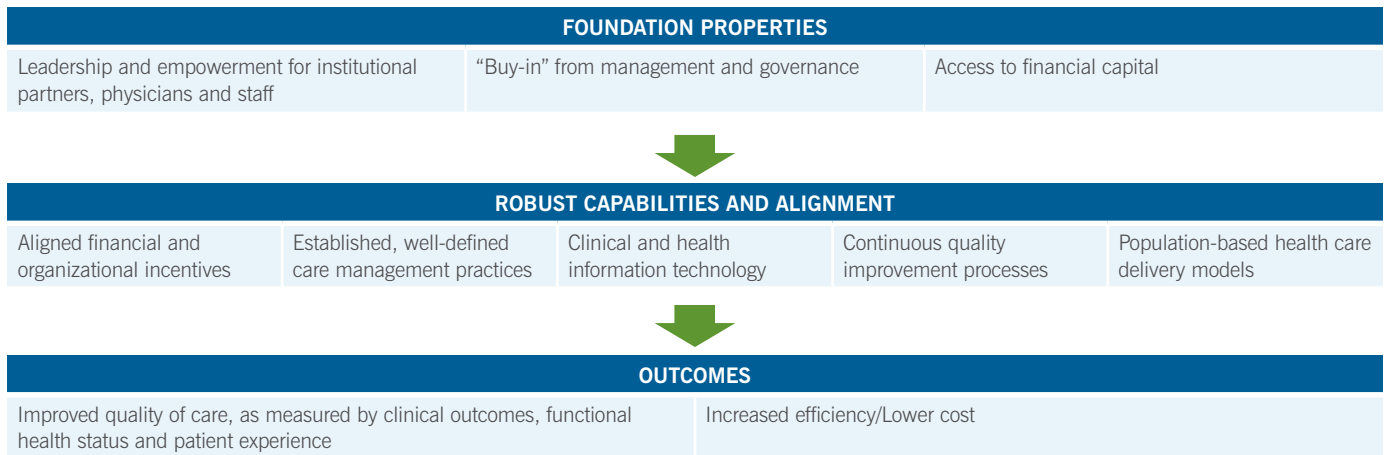
continuum. Many private payers are moving in this direction as well.

The changing reimbursement environment requires hospitals to develop and enhance core competencies to ensure that a patient’s care is

well-managed, even after a hospital discharge. These capabilities include, but are not limited to, the alignment of financial and organizational incentives, well-defined care management practices, and robust utilization of

### As care delivery systems are developed, enhanced core competencies are necessary to achieve integration.

Chart 4: Core Competencies Needed for Development of Integrated Care Systems



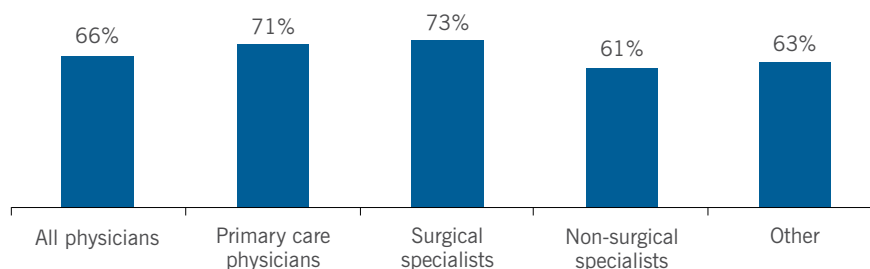
Source: Adapted from work of Steven M. Shortell, Ph.D., etc. (2000) in *Remaking Health Care in America: The Evolution of Organized Delivery Systems*, 2nd edition and American Hospital Association, Committee on Performance Improvement (2011). *Hospitals and Health Systems of the Future*.

clinical data and health information technologies. These skills are necessary to enable hospitals to collaborate with physicians and post-acute care providers on patient care delivered outside of the “four walls” of a hospital. Experts stress the importance of integration to be successful under value-driven, risk-based models,<sup>7</sup> as integrated models have achieved improvements in quality and patient satisfaction while at the same time reducing cost. High performance on these metrics is essential to improve patient care and to mitigate financial risk as payment shifts from volume-based to value-based reimbursement.<sup>8,9</sup>

Early efforts show the potential of ACOs and other care integration efforts—Advocate Health Care experienced a reduction of 26 percent in readmission rates for patients with chronic conditions in the first year of its ACO program, while a state-wide Medicaid ACO in Colorado decreased the length

### Physicians widely anticipate increased levels of integration with partner hospitals.

Chart 5: Percent of Physicians who Believe Physicians and Hospitals are Likely or Very Likely to become More Integrated in the Next 3 Years, by Medical Specialty, 2013<sup>13</sup>



Source: Deloitte Center for Health Solutions (2013). Deloitte 2013 Survey of U.S. Physicians.

of inpatient stays by 8.6 percent, on average.<sup>10,11</sup> Preliminary data on Medicare ACOs has found that all participants showed improvements in quality, but only half had lower expenditures than projected.<sup>12</sup> Collectively, these results show that clinical integration efforts often provide an immediate improvement in patient

quality of care, but financial savings may be harder to achieve. Integration efforts are expected to continue expanding—as these models mature, more information will become available about the specific innovations in care delivery that yield the best outcomes in terms of quality, patient experience of care and cost.

“ ”  
*from the field*

“Our initial interest in integration was a result of health care trends. Patient outcomes demanded improvement and, in a larger sense, there was a need to lower the burden of expensive employee premiums on corporate America.”

— Dan Wolterman, president and CEO, Memorial Hermann Health System, Houston, TX

### Memorial Hermann Health System: Foundations for an Integrated Delivery System

As hospitals seek to promote care coordination, they are increasingly engaging their physician partners to coordinate care and ensure care is provided in the right setting at the right time. Memorial Hermann Health System, Houston, TX, is a multi-hospital system complemented by specialty outpatient centers for patients with cardiac, neurological, rehabilitation and cancer care needs. More than a decade ago, Memorial

Hermann’s system leadership recognized the future health care environment would focus on value and evidence-based payment, instead of traditional fee-for-service (FFS) reimbursement. In response, the health system began efforts to integrate care across settings.

A major building block for Memorial Hermann was the transition, starting in 2006, of its affiliated association of indepen-

dent physicians into an integrated delivery system. Memorial Hermann Physician Network (MHMD) offered all 4,000 physicians the opportunity to integrate; 1,100 physicians initially accepted. The integrated physicians agreed to develop and follow certain evidence-based protocols, report their quality data monthly, share clinical information, and move toward a common electronic health record (EHR).

In order to build the number of

participating physicians, MHMD had to establish trust and prove that the integration efforts would be beneficial to patients. A critical structural component of MHMD's integration strategy was the creation of nearly 30 clinical program councils comprised of MHMD physicians. This approach continues to serve an essential role in involving physicians as key stakeholders in the advancement of integration efforts, as doctors review the latest evidence-based medicine to create and update the clinical standards by which their performance will be ultimately measured.

Health IT is also a key priority for Memorial Hermann as continued growth in integration requires greater information sharing across settings. All Memorial Hermann hospitals now share a common EHR vendor, while at the same time enhancements to the health system's data warehouse and management information systems have been prioritized to create linkages among facilities. MHMD assists private practice physicians in making the transition to a common EHR through subsidies; more than 1,000 physicians have migrated to preferred EHR platforms, to date. Memorial Hermann quickly found that the appetite for outcomes data for the clinical program councils had outstripped the health system's ability to provide appropriate metrics. As a result, the health system has invested in clinical informatics to create data that drive cost management and quality improvement. The organization recognizes that it is funding the acquisition of tools that are specifically designed to take utilization—and revenues—out of the system. However, health system leadership believes the strategy ultimately creates better outcomes for patients and will create

MEMORIAL HERMANN'S INTEGRATION EFFORTS HAVE RESULTED IN:

- Reduction of nearly a half day in the average patient length of stay
- 15-33 percent (depending on condition) decrease in cost of care, per patient
- \$70 million in savings in one year due to reductions in readmissions and hospital-acquired conditions
- Over 1,000 physicians have migrated to Memorial Hermann's preferred EHR vendor

competitive benefits for the health system over the long term.

MHMD's positive experience with its early integration efforts has provided the foundation for additional innovation. Memorial Hermann's ability to approach the market with a lower cost structure, partially due to integration, and pass savings back to employers and insurers has made the health system an attractive partner. However, the health system and payer partners often need to work to overcome potential barriers to collaboration before designing an initiative. For example, as Memorial Hermann and Aetna prepared to create an ACO in April 2013, both organizations noted the importance of addressing past relationship challenges and cited increased transparency as a key to establishing trust and moving forward with the ACO. This ongoing transparency is enabled by sharing and collaboratively reviewing claims data, which is a foundational request that Memorial Hermann asks of all payer partners in order to support clinical informatics. Data sharing, along with predictive modeling tools, also helps physicians and care managers understand patient care patterns in order to target when in a patient's care episode interventions may be most effective.

Already, Memorial Hermann's internal efforts to integrate care have

created dramatic savings, including a reduction of nearly a half day in average length of stay and a 15-33 percent (depending on condition) decrease in cost of care per patient. The health system's internal metrics also have shown improvements on quality indicators, including fewer hospital-acquired conditions (HACs) and a reduction of nearly half of hospital readmissions (5.92 percent vs. 10.38 percent for non-integrated physicians). Memorial Hermann created savings of \$70 million in one year alone from reductions in readmissions and HACs.

While Memorial Hermann has experienced exceptional results, leaders at the health system noted that it took six to eight years to achieve success, including building infrastructure, securing buy-in from staff and implementing an integrated care system. These positive results have helped create momentum among physicians—over 2,100 doctors are now part of integration efforts—as the positive impact of Memorial Hermann's efforts has been proven by patient outcomes data. Furthermore, integrated physicians began receiving bonuses in 2010 to reward performance on key indicators in the areas of quality and safety, patient experience and operational excellence.

“ ”  
from the field

“Physicians are developing the standards to which they are ultimately held accountable, and the standards are driven by evidence-based medicine to improve outcomes.”

– Christopher Lloyd, CEO, MHMD, Houston, TX

## Integrated Care Models Produce Benefits in Terms of Quality, Cost and Access

When hospitals choose to pursue an integrated strategy, there are often key benefits that the hospital hopes to create for its patients and for the hospital’s long-term sustainability. The most common benefits of integration are improved coordination across the care continuum, increased operational efficiencies, greater access to capital for smaller or financially distressed hospitals and support of risk assumption and innovation.

### Enhanced Care Coordination

Integration of providers across the care continuum strengthens care coordination by facilitating better communication and information sharing among providers. Such improvements minimize redundant testing and ensure patients receive the appropriate care in a timely manner, thereby improving outcomes at lower costs and enhancing the patient’s overall experience.

One example of efforts to improve information sharing and reduce redundancies among providers is transitional care models.<sup>14</sup> These programs provide patients and caregivers with tools and coaching around the transition in care from the acute care setting to post-acute care and/or the community. The care models typically utilize a specially trained nurse to coordinate care and track the patient through the transition. The nurse educates the patient and family caregivers regarding the patient’s condition, rehabilitation, and medications and continues with periodic patient check-ins. In one study of these interventions,

enrolled patients experienced lower readmission rates and spending per patient was reduced by \$800 to \$1,200 per year.<sup>15, 16</sup>

### Efficiencies from Economies of Scale

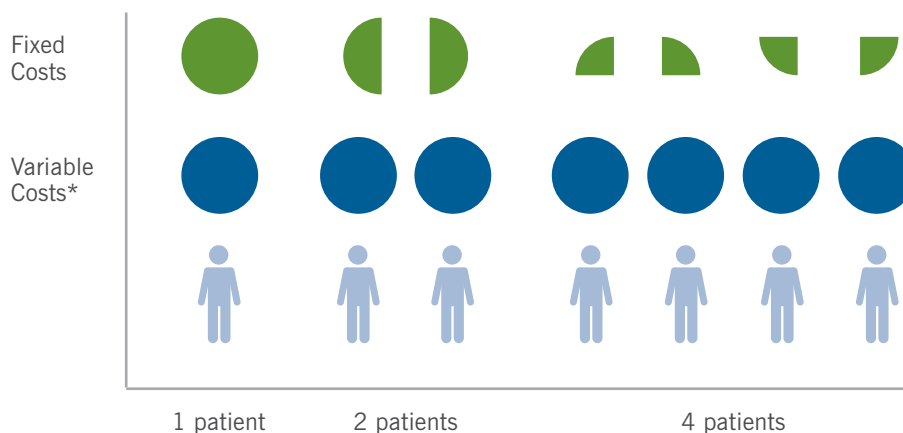
Greater organization size and scope can lead to increased economies of scale. Larger organizations spread the fixed costs associated with running a health care system over a greater number of patients. In particular, health care systems are able to consolidate administrative functions including revenue cycle

management and human resources and reduce redundant administrative staff. Health care systems also can combine service offerings across facilities, which can both reduce costs and improve quality. Additionally, greater size allows health care organizations to purchase supplies and drugs at lower costs.

Financial integration also can provide organizations with the scale necessary to enhance service offerings. For example, multiple facilities can share specialists, such as intensivists, cardiologists or neurologists. This is

### Integration helps hospitals gain efficiencies through economies of scale.

Chart 6: Economies of Scale with Increasing Patient Population



**Fixed costs**, such as medical technologies, are spread across each patient. The more patients that need the technology, the lower the cost per patient.

**Variable costs**, such as labor costs, scale with the number of patients.

Source: Bond, R. (2012). American Healthcare Industrial Revolution: Economies of Scale and the Accountable Care Organization (ACO). ACODatabase.com.

especially valuable when one or more of the hospitals, by themselves, would not have the patient volume or financial resources to employ a specialist. Offering additional specialist services locally not only improves access but can also create savings, as fewer patients need to be relocated by medical air

transport or ambulance when emergency specialty care is necessary.

**Integration Supports Development of Innovative Payment and Care Delivery Models**

Combining resources and patient volume under an integrated arrangement

provides an environment conducive to innovation in patient care, as additional resources and patient volume beyond a single hospital's scope are often necessary to field test new clinical or reimbursement models.

Integration allows hospitals to spread the risks inherent in global payment

**Scripps Health: Cross-system Sharing Fosters Best Practices Adoption<sup>18,19,20,21</sup>**

Hospital systems often can take advantage of opportunities for cross-organization sharing that can lead to improved quality and efficiency. Scripps Health in San Diego is one such example. In 2010, Scripps pulled its chief operating officers out of its five hospital campuses and instead gave each system-wide responsibility for a specific function (e.g., nursing, radiology). These individuals were then charged with identifying and rooting out non-value added variation in operational practices across the organization.

Initial analysis found significant variation in practices such as staffing, process flow, use of supplies and quality. By standardizing to match the best practices across the system, Scripps was able to reduce costs by more than \$190 million over a three-year period. For example, Scripps redesigned its emergency departments (ED) to create an urgent care path to better serve the large number of people with non-emergent conditions that were contributing to ED overcrowding and diversions. Scripps also altered

**SCRIPPS HEALTH'S INTEGRATION EFFORTS HAVE RESULTED IN:**

- \$190 million in reduced costs due to standardization of best practices
- Lowered ED wait times and virtual elimination of ambulance diversion
- Enhanced physician engagement in organizational improvement efforts

patient flow such that patients were seen by both the nurse and the doctor simultaneously, reducing the need for the patients to repeat information and lowering the overall length of stay in the ED. These changes brought the waiting times down to 30 minutes and virtually eliminated ambulance diversion, at the same time resulting in decreased costs and improved revenue.

Scripps examined patterns of supply use to identify opportunities for standardization as well. For example, Scripps found that some facilities were routinely administering nitric oxide to patients after cardiac valve and coronary artery bypass graft procedures while others were not. This practice was found to have no clinical benefit and eliminating it saved \$400,000 per year.

Scripps began its efforts by focusing on operational issues, but has since moved on to examine physician practice patterns. Clinical care lines now operate as horizontal structures as well, crossing the five hospital campuses and 23 outpatient clinics. Each area is co-managed by a physician. Scripps has created a cross-organizational physician leadership cabinet elected by peers as well. While this group is informal in nature, its recommendations for change have been adopted uniformly. These structures help to uncover variation but also ensure physician engagement in decision-making and facilitate getting buy-in from Scripps' 600 employed and 2,000 independent physicians in making needed changes.



“By definition there is only one best practice.”

– Chris Van Gorder, CEO, Scripps Health, San Diego, CA



mechanisms over a larger population, thereby lessening actuarial risk—that is, the risk that a group of people will incur more costs than predicted.<sup>17</sup> For example, an ACO accepting risk for cost and quality of care for its patient population could be adversely affected if in any given year, it has a spike in volume of very sick patients, or if it serves patients in an area that is known to have a higher incidence rate of certain conditions. While risk-adjustment mechanisms can partially protect providers, forming an ACO with other providers, some of whom may be in other geographic areas, gives the ACO

a larger patient population for spreading the costs and risks associated with pockets of high utilization.

### Preserve Access to Capital and Care

Some providers find that clinical or financial integration is necessary to make the investments required to deliver quality care in a value-based payment environment. Many technologies that are central to care coordination, such as EHRs, require substantial capital and personnel investments in order to implement. For some hospitals and physician practices, adding these

capabilities can be cost-prohibitive, unless they engage in a partnership or financially integrate with hospitals that have greater access to capital.

One example of this type of integration is the partnership of Adventist HealthCare and nine safety-net clinics in Montgomery County, MD, to implement a health information exchange system. Adventist has provided financial and technical support to the clinics, which in turn are able to provide EHRs and e-prescribing services to their patient population, resulting in safer and better care.

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## Integration Poses Challenges and Risks

Hospitals face a number of hurdles when seeking to integrate. Regulatory barriers include the civil monetary penalty, antitrust, Stark, anti-kickback laws and the Internal Revenue Service (IRS) prohibition on private inurement for not-for-profit hospitals.<sup>22</sup> These laws are intended to restrict financial incentives to providers that could result in over-utilization, under-utilization, or referrals that are not in the best interest of the patient. Unfortunately, the statutes are broadly written and/or interpreted, bringing confusion and uncertainty to arrangements that are ultimately meant to better align hospitals and physicians. For example, if a clinically integrated hospital wishes to reward a physician for following evidence-based clinical protocols under one of its programs, the reward could violate the anti-kickback law.<sup>23</sup>

In limited circumstances, regulatory agencies have worked with providers and physicians to reduce barriers, such as in the case of exceptions to the Stark Law and anti-kickback laws created in

2006, to support health IT implementation. This exception allows for greater clinical integration when the specific terms of the protections are met by providers. To continue the acceleration of the adoption of health IT, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator (ONC) recently consented to extend the duration of the exception for an additional eight years from the original sunset date, to December 2021. However, outside of this limited exception, providers integrating clinically are required in most circumstances to integrate financially to avoid violating the current legal and regulatory framework. As a result, hospitals and physicians often are deterred from forming innovative clinical integration structures.

The current Medicare fee-for-service (FFS) payment system does not align very well with clinical integration objectives. Providers are currently paid for the volume of services provided, with no additional payment

for coordinating care or keeping beneficiaries well. As a result, hospitals on the leading edge of care delivery redesign could experience undue financial risk unless payment incentives are modified to provide compensation for effective population health management. Myriad legal, regulatory and financial challenges thwart many efforts to integrate care.

Efforts to integrate also may spur concerns from regulators, payers and other stakeholders that integration will reduce competition, leading to higher health care costs. Yet, evidence suggests that hospital prices are directly related to costs associated with labor and capital, the level and type of care received by patients in the hospital and the severity of patient illness.<sup>24</sup> Additionally, many ACA-initiated care coordination programs, such as the Hospital Readmissions Reduction Program, transfer greater risk to providers and promote the types of efficiencies that can be gained through integrated care models.

**Current legal and regulatory barriers are a deterrent to innovative clinical integration efforts.**

Chart 7: Legal Barriers to Integrated Care Delivery

Historic Model	What is Prohibited?	The Concern Behind the Law	Unintended Consequences	How to Address?
<b>Antitrust (Sherman Act)</b>	Joint negotiations by providers unless ancillary to financial or clinical integration; agreements that give health care provider market power	Providers may enter into agreements that either are nothing more than price-fixing, or which give them market power so they can raise prices above competitive levels	Deters providers from entering into procompetitive, innovative arrangements because they are uncertain about antitrust consequences	Additional guidance from antitrust enforcers to clarify when arrangements will raise serious issues; guidance is currently available for federally-designated accountable care organizations (ACOs)
<b>Ethics in Patient Referral Act (“Stark Law”)</b>	Referrals of Medicare patients by physicians for certain designated health services to entities with which the physician has a financial relationship (ownership or compensation)	Physicians may have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient’s best interest	Arrangements to improve patient care are banned when payments tied to achievements in quality and efficiency vary based on services ordered instead of tied to hours worked	Congress should remove compensation arrangements from the definition of “financial relationships” subject to the law. Arrangement would continue to be regulated by other laws
<b>Anti-kickback Law</b>	Payments to induce Medicare or Medicaid patient referrals or ordering covered goods or services	Physicians may have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient’s best interest	Creates uncertainty concerning arrangements where physicians are rewarded for treating patients using evidence-based clinical protocols	Congress should create a safe harbor for clinical integration programs
<b>Civil Monetary Penalty (CMP)</b>	Payments from a hospital that directly or indirectly induce a physician to reduce or limit services to Medicare or Medicaid patients	Physician may have incentive to reduce the provision of necessary medical services	As interpreted by the Office of the Inspector General, the law prohibits any incentive that may result in a reduction of care, even if the result is an improvement in the quality of care	The CMP law should be changed to make clear it applies only to the reduction or withholding of medically necessary services
<b>IRS Tax-exempt Laws</b>	Use of charitable assets for the private benefit of any individual or entity	Assets that are intended for the public benefit are used to benefit any private individual (e.g., a physician)	Uncertainty about how IRS will view payments to physicians in a clinical integration program is a significant deterrent to the teamwork needed for clinical integration	IRS should issue guidance providing explicit examples of how it would apply the rules to physician payments in clinical integration programs

**Conclusion**

Hospitals are deploying a variety of clinical and financial integration strategies that increase coordination across the care continuum, improve care outcomes, reduce costs, enhance the availability of health care in underserved areas and improve the care experience for patients and their families. In addition to the

clinical and financial benefits, integration has become an attractive strategy as hospitals work to remain solvent, reimbursement is increasingly constrained and new payment mechanisms shift risk to providers. These relationships ultimately can keep hospital doors open and preserve access to care by allowing hospitals

to streamline administrative and other expenditures. Hospitals, through these integrated relationships, are field testing clinical and financial innovations to ensure health care is patient-centered, accessible and sustainable for the future.

## POLICY QUESTIONS

- How can barriers to change in the current regulatory environment be overcome as payment systems transition from volume-based to value-based reimbursement?
- How can payers ensure that providers pursuing integration are properly compensated for care coordination efforts that lead to increased value?
- How can we combine the findings from private and public sector integration efforts, such as ACOs, to help accelerate the pace of change?
- Other than removing legal and regulatory barriers, what else can policymakers do to encourage and speed the transition to a less fragmented, more coordinated care environment?

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