

Meeting the Challenge of Healthcare Reform: The Clinically Integrated Network

By Greg Montgomery
*Healthcare Attorney and Partner
Miller Nash LLP*



This Time Is Different

The baby-boomer generation is now turning 65 at the rate of 10,000 a day and will continue to do so for the next 18 years. According to the 2010 census, 40.3 million citizens are 65 or older, an increase of 5 million since the 2000 census. This segment of the population is growing faster than the population as a whole. The average 65-year-old spends approximately four times as much on healthcare services as the

average 40-year-old. These changing demographics, and the increasing healthcare costs associated with them, create a healthcare environment that differs from the past.

While "healthcare reform" may mean different things to different people, there is now fairly unanimous agreement that our current system of providing and paying for healthcare services is not financially sustainable. Regardless of what the Supreme Court may decide with respect to the 2010 healthcare legislation, "healthcare reform," directed at the manner in which we provide and pay for healthcare services, is already well underway.

Providers may escape the 27.4 percent Medicare reimbursement reduction that was scheduled for January 2012. But any escape from declining fee-for-service reimbursement, in which providers and facilities are paid based on volume of procedures and tests, is only temporary. The Medicare Payment Advisory Commission has recommended a freeze on primary-care-provider reimbursement rates, with a 5.9 percent annual reduction for all others for three years followed by a freeze

on these reimbursement rates.

In 2013, some Medicare payments will be subject to a further 2 percent cut as a result of the failed Joint Senate Committee effort to come up with a deficit-reduction proposal. One analysis suggests that hospitals and providers will absorb 32 percent and 12 percent, respectively, of this overall reimbursement cut.

In addition to absolute reimbursement reductions, Medicare reimbursement rates will increasingly be conditioned on meeting certain performance or value criteria. Over the next several years, providers and facilities may have reimbursement rates reduced up to 3 percent for failure to meet a variety of performance or value criteria. Commercial payers are also experimenting with outcome-based payment models.

In this environment of decreasing reimbursement amounts and changing criteria for calculating reimbursement amounts, the challenge for most healthcare facilities and providers is how best to continue making high-quality healthcare services accessible to all members of

the communities they serve.

The Responsive Healthcare Delivery Model

As the reimbursement model for healthcare services moves away from fee-for-service through reduction of reimbursement rates and conditioning of reimbursement on performance and outcomes, the healthcare services delivery model is going to have to adapt. Whatever delivery model ultimately emerges, it will have to be more efficient in delivering consistently higher quality healthcare services than the currently predominant model of separate independent providers, provider groups, and facilities.

Integrated networks of interdependent providers, provider groups, and facilities, in which healthcare services are coordinated within the network across the entire continuum of care, appear to represent the emerging delivery model for the new reimbursement environment. The Medicare Accountable Care Organization ("ACO") is only one example of an integrated healthcare network. Oregon intends to provide services to Medicaid and dually eligible Medicaid and Medicare beneficiaries through integrated networks referred to as Coordinated Care Organizations. Both Oregon and Washington are in the process of setting up health insurance exchanges under the federal healthcare reform legislation that, among other things, will require insurer-participants to provide a form of integrated network for their members.

Integrated networks have proved that they can reduce the overall cost of healthcare and improve its quality. For an integrated network to

succeed, however, it must successfully address cultural, financial, and legal issues. Since an integrated network often involves a combination of otherwise competing providers, provider groups, and facilities that intend to jointly negotiate reimbursement rates with healthcare plans and insurers, antitrust laws provide the predominant legal issue. Cultural issues arise from the necessary transformation of the delivery system from one of distinct, independent providers, provider groups, and facilities to an interdependent, coordinated system. Last but not least is the financial issue of what payment model will replace, in whole or in part, the current fee-for-service model. It is particularly on this issue that the clinically integrated network may offer some advantages over other integrated network models.

Under the recently adopted final rules, the Medicare ACO may offer advantages in addressing legal issues, but seemingly falls short on financial issues, except perhaps for the largest of networks. In addition to the initial cost of application and approval, a small ACO may have to achieve as much as a 3 percent saving from a historical cost benchmark for its assigned beneficiaries before it will share in the savings. Furthermore, an ACO must accomplish these savings with beneficiaries who have no incentive to limit their healthcare services to their assigned network. This is a significant disadvantage for achieving cost savings and quality improvement. In fact, in the antitrust analysis of integrated networks contracting with commercial payers, "leakage"(network patients obtaining healthcare outside the network) is sufficiently important that the networks must have

a plan to address it.

Since well before the introduction of the ACO, federal agencies responsible for antitrust enforcement have issued policy statements and advisory opinions describing the conditions under which networks of otherwise competing providers could jointly negotiate with commercial payers and still comply with federal antitrust laws under the rule-of-reason-approach. Generally, this required a network to demonstrate that its members were truly integrated, committed to and capable of providing the competitive benefits of reduced healthcare costs and improved quality for which joint price negotiation was a necessary but ancillary factor.

The necessary integration may be either financial or clinical. In a financially integrated network, all members share significant financial risk, as under a capitation or bundled payment model. Such risk-sharing ensures commitment of network members to cooperate in managing healthcare services to control costs and improve care.

In a clinically integrated network, commitment to and potential for the success of the network are typically provided through participation contracts under which each member agrees to devote significant personal time and effort to the network and its operational components, including such things as (1) assisting in the development of and adherence to evidence-based clinical protocols; (2) participating in systems to make patient treatment information readily available throughout the network; (3) assisting in the development of an agreed set of quality and performance measures; (4) par-

ticipating in the collection and sharing of data regarding outcomes and performance; (5) subjecting himself or herself to performance evaluation against the agreed measures; and (6) participating in and being subject to procedures for remediation and sanctions, including expulsion from the network.

While virtually all networks require the cultural shift from clinical independence to clinical interde-

pendence, the clinically integrated network retains the flexibility to negotiate reimbursement contracts that do not require the same degree of financial interdependence required in other network models. Thus, the clinically integrated network may provide the least challenging model for entry into the world of integrated, coordinated delivery of health-care services.

Greg Montgomery is a healthcare

attorney and partner at Miller Nash LLP. He can be reached at greg.montgomery@millernash.com or 206.622.8484. Miller Nash is a multispecialty law firm with over 115 attorneys in offices in Seattle and Vancouver, Washington, and Portland and central Oregon. To learn more about Miller Nash, visit www.millernash.com. To read about new or proposed healthcare legal developments, visit our blog at www.healthlawinsights.com

Reprinted with permission from the Washington Healthcare News. To learn more about the Washington Healthcare News visit wahcnews.com.