COVER STORY

Katherine A. Cwiek
Meredith C. Inniger
Daniel K. Zismer

REPRINT April 2014

hfm
healthcare financial management association hfma.org

setting the right path and pace for integration

No single path to or pace for achieving integration exists for all healthcare organizations. Each must pursue its own strategy based on unique circumstances and characteristics.

Initiatives aimed at advancing integration in health care have surged in recent years, driven in large part by the advent and implementation of alternative payment models by both government and commercial payers. A key premise underlying these initiatives is that clinical, financial, and structural integration are effective means by which healthcare organizations can affect both the quality and cost components of the healthcare value equation. Given this assumption, it follows that integration can promote success under alternative payment methodologies. Efforts that test this premise and related assumptions will continue to gain favor as healthcare systems look to evolve and innovate in this uncertain industry transition period.

For many of these organizations, integration may not be the end goal, but rather what results when otherwise unaligned entities try to achieve mutually beneficial interdependence and share financial responsibility for better quality and cost outcomes. For example, accountable care organizations (ACOs), while not mandated to achieve a specified level of formal integration, represent a systematic framework for collaboration and coordination that is grounded by integrative infrastructure and care models. Over time, and to achieve desired benefits, ACO participants become more integrated to maximize value-based performance, share savings, and minimize financial risk. Here, integration may be a byproduct of trying to bridge the delivery and financing of care.

However, for some organizations, advancing integration is a fundamental, deliberate, and proactive strategy to ensure future viability and differentiate. Indeed, the term *integration* is often

AT A GLANCE

- Far from being a monolithic trend, integration in health care today is progressing in various forms, and at different rates in different markets within and across the range of healthcare organizations.
- Each organization should develop a tailored strategy that delineates the level and type of integration it will pursue and at what pace to pursue it.
- This effort will require evaluation of external market conditions with respect to integration and competition and a candid assessment of intraorganizational integration. The compared results of the two analyses will provide the basis for formulating strategy.

used in reference to integrated delivery systems (IDSs) that often exemplify this latter approach—for example, Kaiser Permanente in Oakland, Calif., Geisinger Health System in Danville, Pa., and HealthPartners in Bloomington, Minn.

It is important to note, however, that these very large and vertically integrated systems represent an extreme subset in terms of scale, structural configuration, and degree of integration. Although each of these IDSs has strategically fostered integration and achieved success as a result, optimal integration strategy varies by market and must account for current performance and position. Further, although these notable IDSs have delivered higher quality and lower cost by present standards, disruptive innovation in coming years will undoubtedly recalibrate the meaning of high-value health care and redefine the set of required capacities and competencies to achieve it. Successful IDSs in the future may provide higher-value care than we can imagine today, shifting from refining and replicating existing methods to rethinking and redefining assumptions, advantages, and approaches.

Defining Integration

There is no standard, commonly accepted definition of *integration* or even an *IDS*, and many in the field struggle with crystallizing what constitute the essential components of an integrated healthcare organization. Some focus on the most tangible aspect of structural integration, or an organizational form that centralizes oversight and ownership of the entire healthcare enterprise—including, in the case of vertical integration, the financing component. Other organizations may consider care coordination—across providers, settings, and time—to be the defining characteristic, emphasizing the importance of collaboration, communication and connectivity. Each year, *Becker's Hospital Review* lists the top "100 Integrated Health Systems to Know" using criteria that include continuum of care; innovation through participation in care and payment reform initiatives; and financial, clinical, and operational strength.

Perhaps the best way to conceptualize integration on a broad scale is that it represents the opposite of fragmentation, with key assumptions being that less fragmentation results in higher quality

MATCHING MARKET PACE AND DEMANDS WITH INTEGRATION STRATEGIES

Significant change required to meet value-based demands	**Significant** change required to meet value-based demands
Significant market innovation and integration	**Significant** market innovation and integration
Insignificant and Insufficient organizational innovation and integration	**Significant and Sufficient** organizational innovation and integration
Out-of-sync with market	**In-sync** with market
Insignificant change required to meet value-based demands	**Insignificant** change required to meet value-based demands
Insignificant market innovation and integration	**Insignificant** market innovation and integration
Insignificant but Sufficient organizational innovation and integration	**Significant but Unnecessary** organizational innovation and integration
In-sync with market	**Out-of-sync** with market

LEGEND

Orange quadrants = out of sync with market; financial risk
Green = in sync with market; financial sustainability

of care at lower costs, and that the integrated entity is held, at least in part, fiscally responsible for achieving these outcomes.

Even with a conceptual definition and growing consensus that integration can be a useful vehicle to improve value-based performance, significant uncertainty exists about the types and degree of integration to be pursued, and even what integration looks like when achieved. Further, most are unsure about the sequencing and speed at which they should undertake integration initiatives. All of this uncertainty is compounded by the fact that there is no universally successful integration strategy, as unique organizational and market characteristics necessitate customized approaches.

To craft the right approach with the right timing, each organization should evaluate and account for market conditions and existing internal integration, assess current and projected financial capacity, and define the role of integration within the broader context of its strategic priorities.

Finding the Integration Sweet Spot

The sweet spot of integration is achieved when organizations synchronize the investment of resources and development of competencies with the pace and demands of their market, as is illustrated in the green quadrants of the exhibit on page 2.

As noted previously, more effectively integrating within the care delivery component and across the delivery and financing mechanisms is likely to correlate with sustainability and growth potential. However, success with integration hinges on strategic and appropriately timed decisions and investments. Pitfalls exist for provider organizations that believe they are in a unique position to survive new pressures and address external mandates by relying upon the strategies and degree of risk assumption that enabled historic success. Likewise, real risks exist for organizations that misread market signals and invest too broadly or aggressively in integration-related infrastructure and tactics. These organizations could find themselves overextended in the short- to mid-term, having overinvested or misallocated resources to place too much emphasis on long-term payoff.

In fact, emerging evidence indicates that investments associated with integration are weighing on health system free cash flow productivity and balance sheet liquidity, and interviews with health system financial leadership suggest that miscalculation or underestimation of the full costs of integration may be more common than not.[a]

In addition to accurately estimating the costs of integration, organizations should carefully weigh current financial realities against anticipated returns. A stronger balance sheet provides a cushion for experimentation and greater capacity to misjudge and correct course without significant risk, and should, in part, drive an organization's willingness and ability to take on integration and the associated challenges. However, financially sound healthcare organizations that have achieved success and sustained a strong position by avoiding risk may find it particularly difficult to stray from this risk-averse posture. Although it may be true that many large and successful systems—even those that own or operate most components of the care delivery continuum—do not demonstrate real integration, the majority of highly integrated health systems are financially strong and growing stronger. This latter correlation may indicate that the right amount of risk propensity is a future critical success factor.

Determining the Appropriate Level and Pace of Integration

Understanding the defining characteristics and differentiating features of an organization's mar-

a. Zismer, D.K., and Beith, C., *Free Cash Flow Productivity and Its Connections to U.S. Health System Financial Performance and Strategy in Current and Future Markets—A Macro View of a Potentially Systemic Problem*, Governance Institute, Boardroom Press (in-press).

ASSESSMENT: UNDERSTANDING YOUR MARKET*

General Characteristics†	Population size and description (nearest MSA)	250K; low density; < non-metro or rural small-metro	250K-650K; moderate density; suburban or or urban	Nearest MSA > 650,000; high-density; large metro
	Point Allocation	1	3	5
Consolidation	**Payers** (market leader or top two leaders in % total commercial enrollment)	Leader < 40% or combined leaders < 60%	Leader 40%-60% or combined leaders 60%-75%	Leader > 65% or combined leaders > 75%
	Hospitals and systems	More independent than system-owned hospitals	Mix of independent and system-owned hospitals	More system-owned than independent hospitals
	Physician employment (% system-employed physicians)	< 40%	40%-55%	> 55%
	Physician group practice characteristics (nonemployed)	Small to midsized single-specialty groups; solo practices remain viable	Few solo practices; midsized or large practices, mostly single and some multispecialty	Nearly all large or "mega"-sized groups; blend of single and multispecialty
Partnerships	**Provider + provider**	Narrow and referral-driven affiliations with many partners; primarily acute care focused	Exclusive acute care clinical affiliations; loose alliances for care continuum coverage	Exclusive and tight affiliations; strategic alliances support population health management
	Provider + payer	Shared-savings pilots	Cobranded private label products	Full vertically integrated networks
	Provider/payer + employers	Marginally lower employee copayment for 'preferred' providers	Narrow network employer contracts	Self-funded employer bundled and other value-based contracts
Pricing and Plans	**Average per member per month** (individual market)	> $350	$200-$350	< $200
	Managed care penetration‡	< 15%	15%-30%	> 30%
	High-deductible plan enrollment§	< 10%	10%-25%	> 25%
Value-Based Contracts and Performance	**Value-based contracts**	Pay-for-performance and one-sided shared-savings	Two-sided shared-savings and case-rate (bundled)	Fully capitated and/or global budget
	Competitive care outcomes (composite average of 30-day Medicare readmission and mortality rates [by HRR])	Mortality > 13% Readmissions > 21%	Mortality 11%-13% Readmissions 19%-21%	Mortality < 11% Readmissions < 19%
	Competitive cost (adjusted expenditure/Medicare beneficiary)	> $9,500	$8,800-$9,500	< $8,800
	Appropriate utilization (ED visits/1,000 population—all ages/payers)	> 700/1,000	600-700/1,000	< 600/1,000
'New Era Readiness'	**Regional care philosophy**	> Reactive, ad hoc, volume versus value > Minimizing readmission penalties and managing referrals	> Proactive, targeted, narrow scope > Improving management/ reducing care variability for select chronic physical disease	> Standardized, systematic, holistic > Risk-stratified application of interdisciplinary models; prevention; physical and behavioral
	Population health management infrastructure (people, analytics, EHR, care models)	Mostly basic but a priority	"Soft" capacity (people, models) and investments in hardware	"Soft" skill expertise and best-in-class hardware/tools
	Change agents	No clear innovator or first mover; reactive and weary of risk	Multiple potential innovators; focus on cutting costs vs. transformation	Strong early adopters drive market sophistication and integration

* Assessment results intended to be directional only. Scoring indicates relative magnitude of market competition and integration on select factors. All data required to populate quantitative indicators is publicly available at the metropolitan statistical area (MSA), hospital referral region (HRR), county, zip code, and organization-specific levels. Scoring cut-off points are estimated based on ranges, which are intentionally broad. National measure of central tendency used to estimate midpoint, with maximum and minimum values providing the high and low ends of each range.

† Not scored; for contextual and strategy framing purposes only. Additional contextual indicators to consider include demographics (aging), socioeconomic factors, and the degree to which state (versus federal) intervention and regulation will impact market integration.

‡ Includes enrollees in both traditional HMOs and HMO point-of-service (POS) plans—commercial, government , and direct-pay products.

§ Deductible >$1,000 for adults ages 19-64.

ket is the appropriate first step for determining three key aspects of an integration strategy:

> The level of integration that an organization should pursue for the next two to three years
> The strategic priorities of integration
> The pace at which to pursue integration

The assessment in the exhibit on page 4 can be used to initiate discussions and frame strategy development, ensuring that integration decisions are founded on a comprehensive understanding of the environment. It is important to note that the diagnostic does not take into account the rate of change in a market and focuses exclusively on current position as per today's standards. As such, although the assessment is relevant and useful, movement on certain leading indicators—including consolidation, innovative partnerships, and substantial investments in 'new era readiness'—would significantly alter the landscape and possibly cause benchmarks associated with even the most integrated systems today to appear

RUBRIC: UNDERSTANDING YOUR CURRENT INTEGRATION LEVEL

Key Attributes of Effective Integrated Delivery Systems	Not at All Accurate	Somewhat Accurate	Accurate	Very Accurate
1. A central and unified physician enterprise entity manages all physician relationships with the system.				
2. The majority of physicians have tight financial and strategic ties to the organization (clinically integrated, employed); compensation and incentive systems are value based.				
3. The primary care and ambulatory network is sufficiently sized and distributed.				
4. Management of the full physical and behavioral healthcare continuum is coordinated and geographically distributed.				
5. There is systematic deployment of team-based, interdisciplinary, person-centered care models supported by centralized care management/coordination resources.				
6. Consumers and caregivers are highly satisfied with the ability to transition across care sites and along the continuum.				
7. All sites and providers leverage a common electronic health record and data management platform.				
8. Evidence-based clinical pathways are fully adopted systemwide.				
9. There is demonstrated willingness and ability to manage value-based contracts and assume financial risk.				
10. The totality of the system is not in competition with its component parts.				
11. There is adequate capital to invest and reinvest in population health management infrastructure.				

It is important to challenge the assumption that integration follows a linear path. The reality is that progress toward integration tends to be highly dynamic.

outdated. The assessment is coupled with a discussion of how poised the market is to shift to the right, both in specific categories and in general.

Here is how to use and score the assessment: Circle or shade the column description that best fits your market in each row. Allocate points using the values indicated in the column head (1, 3, or 5). Point totals exceeding 70 signify that conditions in your market are highly competitive and indicative of existing and advanced integration. Higher scores indicate a greater likelihood of resource-intensive investments, more organizationally complex integration plans, and a strategically sequenced but quicker pace.

Determining the Organization's Integration Profile

The next step for determining the level of integration an organization should pursue, identifying strategic priorities and pacing implementation tactics is to examine your organization's current internal integration level. The rubric on page 5 can be used to qualitatively gauge the extent to which an organization possesses key attributes of an effective integrated system.

The 11 descriptors along the left characterize select dimensions of integration. The scale along the top provides a framework to indicate the extent to which each of the attributes listed accurately describes your organization. The rubric provides a basis for focused comparison on important integration characteristics, helping to pinpoint specific strengths and weaknesses as well as providing more global insight on overall position.

The gap between results from the previously described assessment and conclusions drawn using this rubric should facilitate productive discussion and conclusions about key challenges and priorities. Together, the assessments should paint a high-level picture of where your organization stands relative to best-in-class integration and relative to the degree of competition and integration present in your market.

In addition, as introduced above, it is necessary to layer in a future-oriented perspective and keep in mind that even today's highest-functioning integrated systems must evolve. The following attributes might characterize the ideal for a high-performing integrated system in the next three to five years:

> Assume financial risk for a defined population with a single signature.
> Effectively manage total quality of care and total costs of care to acceptable year-over-year financial inflation rates.
> Engage patients and health plan members as accountable and active participants in their health, modifying behaviors and care-seeking patterns that link most closely to demand for health services.
> Ensure effective interaction and collaboration of clinical providers and provider teams to actively manage and enhance care delivery.
> Deliver uniform care from clinical service lines across multiple geographic sites with effective coordinators of care at and between locations.

Matching External and Internal Realities to Guide Strategy

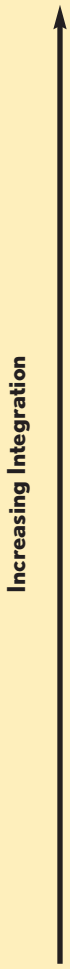
Leveraging the collective value of external and internal assessment findings will inform strategic decisions about how quickly and aggressively, and in what ways, an organization should act. For example, an organization with significant internal fragmentation operating in a highly competitive, integrated marketplace should consider prioritizing and disproportionately allocating time and resources to transformative integration over the next one to two years. Alternatively, an organization that has made considerable

progress on integration internally but operates in a moderately competitive, somewhat integrated market is likely better off pursuing a more incremental and highly targeted pace of investment.

The organization also should compare its level of integration internally with that of its market not only overall, but also for each area of integration. Any areas where gaps exist (e.g., in physician relationships, financial accountability, or payer relationships) represent possible areas in which the organization should prioritize investing in greater integration. For example, in a market characterized by high levels of physician employment and large group sizes, the lack of a reasonable proportion of employed physicians supported by a well-developed physician enterprise platform would constitute a critical gap. However, in a market with a fair number of independent physicians organized in smaller groups, a more incremental approach to engaging physicians in clinically integrated contracts would make sense.

It also is important to challenge common assumptions about integration. Although it may seem logical to assume that integration

A TALE OF THREE CITIES: HOW MARKET CONDITIONS DIFFER IN THREE U.S. METROPOLITAN AREAS



Boston

In perhaps the most academically renowned and competitive healthcare market nationally, the innovation and integration continues to unfold and evolve. There is rapid movement toward significant provider-risk assumption with commercial payers. The market is a hotbed of accountable care organization (ACO) activity and the home of several original ACO Pioneers. Significant state-based regulation and antitrust scrutiny have moderated but not mitigated merger and affiliation activity among hospitals and between hospitals and physician groups. Real quality, cost, and price transparency is emerging, also due to state-based initiatives, though highly concentrated provider and payer segments continue to leverage size and scale in their favor. Massachusetts has the lowest uninsurance rates but some of the highest premiums and prices nationally. Price competition and efforts to reduce overall healthcare expenditures are the next frontier. Several health systems have entered or are entering the provider-sponsored health plan business to have a more direct impact on cost and drive payment for value. Fundamental changes to and integration of the care delivery and financing components are anticipated as a result of innovative payer-provider-employer partnerships and the emergence of stronger suburban-based systems that offer lower cost and price options and that are focused on retaining patients locally.

Chicago

This market is quickly moving from its historically moderate integration with rapid consolidation in the provider sector, including hospital/system mergers and increasing health system employment of physicians. An interesting blend of highly scaled national and regional systems—including Catholic and for-profit organizations—make merger and affiliation activity particularly impactful. Cutting costs and competing on value are growing areas of focus, and will be sources of competitive advantage. Capitalizing on cost-savings for reinvestment in population health management infrastructure will be critical. A highly concentrated commercial payer segment has resulted in slower uptake of Medicare ACOs, although some market providers are national success stories for performance on commercial-shared savings contracts.

Los Angeles

This market is characterized by a high degree of fragmentation (minimal consolidation) on the hospital side and a moderately consolidated health plan sector. Some large health systems have initiated integration of community hospitals, and the largely independent physician groups are seeking health system affiliations. Ongoing challenges are a significant need for safety-net providers, low Medicaid rates, and physician shortages. Although unconsolidated, this market has a high and increasing number of ACOs, and value-based competencies are recognized as competitive advantages. A proliferation of narrow network products (both provider and payer) is likely and will further the emphasis on more cost-effective prescription drug utilization. Competing on cost and demonstrating objective quality outcomes are critical success factors.

follows a linear path and that movement along all dimensions at equal rates is appropriate, the reality is that progress toward integration tends to be highly dynamic. It is more likely to be rapid along a few dimensions and to lag in others based on the organization's capacities and market conditions. Approaches to integration also require a fair amount of customization, as every organization faces different market realities and possesses a unique platform from which to integrate faster or slower.

Finally, the price tag and level of cultural transformation required will determine integration capacity and priorities. Today's environment of short-term uncertainty and rapid change creates a sense of urgency to move forward quickly, yet no one would expect an effective integration strategy to be cheap or easy. This situation poses a major challenge for providers taking a long-term perspective on the time and resources required for a measured approach. Each organization should objectively compare its integration position with that of its market if it is to make a compelling case for change—both how much and how fast. ●

About the authors

Katherine A. Cwiek
is a manager, Veralon, Philadelphia (kcwiek@veralon.com).

Meredith C. Inniger
is a senior consultant, Veralon, Philadelphia (minniger@Veralon.com).

Daniel K. Zismer, PhD,
is Wegmiller Professor and program chair, masters in health administration and executive studies programs, School of Public Health, University of Minnesota, Minneapolis (zisme006@umn.edu).

VERALON™

HEALTHCARE MANAGEMENT ADVISORS

- Strategy and Planning
- Mergers and Transactions
- Valuation and Physician Compensation
- Clinical Transformation and Value-Based Payment

PHILADELPHIA CHICAGO NEW YORK WASHINGTON DC

www.veralon.com | 877.676.3600