Credentialing within a Clinically Integrated Network: Getting it Right

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Disclosure Statement

The speaker for this program DOES NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

Overview

Why the Concept of Clinical Integration Matters?
Clinical Integration – What is it?
Implementation/Success Challenges
Credentialing and Clinical Integration
  – Issues
  – Necessary Questions
  – Recommendations
National Trends
Mergers, acquisitions – consolidation of all types
Physician employment
Brand awareness
Continuum of care – not just acute care
Employers as payers/plan sponsors
Provider-driven: CINs, ACOs and similar arrangements that can begin to manage the health of certain populations
Payer driven: Payers seeking more relationships with coordinated groups of providers and different payment models that use cost control, shared savings, co-management, bundled payments, and patient-centered medical homes as components

Triple Aim
Less About Volume, More About VALUE
From Volume to Value

Hospital Value-Based Purchasing Program
Value-Based Purchasing for physicians and physician practice
Value-Based Purchasing for skilled nursing facilities, home health
agencies and ambulatory surgical centers
Medicare payment adjustments for conditions acquired in hospitals
Medicare Shared Savings Program
Bundled Payments for Care Initiative
BCBS
Cigna Collaborative Care and so on

All payers are introducing initiatives that require providers to reevaluate their reimbursement strategy.

All New Models Involve...

Alignment among care-givers around quality, cost, efficiency and patient satisfaction
Coordination within disease states: clinical integration:
- Evidence-based medicine driven by payment reform
- Integration of behavioral health and primary care
Physician leadership and design
Structured to intake and then allocate reimbursement
Strong reliance on HIT
The need to be flexible / adaptable

Clinical Integration/
Integrated Networks

Concept du jour
What is clinical integration or a clinically integrated network?
- “Eye of the beholder” - Federal Trade Commission, AMA, Consultants, Providers
- Many claim it!
What's driving this effort?
- Market-facing strategy of delivering high-quality, cost-effective care, that produces value for patients and payers
- Payer requirement/patient expectation?
- Merger, acquisition and affiliation activity driving antitrust scrutiny
- It may be the only way to move the needle
Common Elements of Clinical Integration

Clinical integration arrangements should include the following:

- Mechanisms to monitor and control utilization, control costs or improve quality of care;
- Significant investment in human and other capital for infrastructure to achieve efficiencies;
- Clinical protocols for most of the services provided by participating physicians;
- Establishment of efficiency goals for physician members and the organization;
- Selective inclusion of physicians who are likely to further efficiency goals;
- Methods to monitor physician compliance with protocols;
- Mechanisms to correct and improve performance of participating physicians; and
- Expulsion or other negative consequences for physicians who will not or cannot comply with protocols.

Source: Nathan Kaufman Strategic Advisors
Implementation/Success Challenges

Obvious:
– Reality, >PCPs, care coordination is hard, leakage, expertise, etc.
Dwindling market options
Viewing it as just another transaction
Cultural hurdles
– Lack of true “buy-in” with providers re quality, collaboration, concerns with loss of autonomy
Lack of real-time, transparent quality/performance incentives

Implementation/Success Challenges (cont.)
Lack of meaningful care coordination
– ½ effort patient navigation, poor care transition, no post-acute capability
Patient engagement shortcomings (poorly understood)
EMR wears no clothes
– Does not guarantee inter-operability, analytics, performance and risk management
Population costs: status quo re end-of-life care
Diluted cost and quality goals/quality focus apathy
Fraud and Abuse considerations

The focus on value-based reimbursement underscores that **credentialing is tied to reimbursement** and means much more than just getting a passing score during an accreditation or licensing survey

So what does it mean?
*It means money*
CINs and Credentialing

Credentialing, performance improvement and ongoing QA/PI are how CINs achieve cost containment and quality goals – improve both the experience and care for a given population.

Whether fully or partially integrated, a participant owned or subsidiary CIN, the goals and need to meaningfully credential and conduct QA/PI are pretty much the same.

- All require a structure that permits sharing data among participants and includes a meaningful QA/PI program to support, monitor and implement accountability.

Isn’t All Credentialing the Same?

<table>
<thead>
<tr>
<th>Hospital-based</th>
<th>CIN-focused</th>
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</thead>
<tbody>
<tr>
<td>Open membership</td>
<td>Selective membership (or open but filtered)</td>
</tr>
<tr>
<td>Minimum, general qualifications</td>
<td>Higher, payer specific qualifications</td>
</tr>
<tr>
<td>Something above malpractice</td>
<td>Performance-focused, high quality</td>
</tr>
<tr>
<td>Outcome driven</td>
<td>Metric driven</td>
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<tr>
<td>Inconsistent accountability</td>
<td>Contractual/financial accountability</td>
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Isn’t That Economic Credentialing?

Quality and economics are integral to CIN operations.

- Is the decision made on purely economic grounds and unrelated to quality of care?
- What is the CIN’s stated purpose, goals, etc.?
- Quality of care should be the cornerstone of credentialing activities.
- Consistency in implementation of objective, evidence-based metrics is strongest defense.

Remember?
CIN Credentialing: The New Frontier

Many open issues beyond antitrust analysis
Many traditional legal principles remain unsettled:
– Negligent Credentialing
– Corporate Negligence
– Confidentiality of “peer review” information
– Information sharing
– How is quality different for a CIN?

Initial Credentialing - Network Development

Network selection and maintenance may be the single greatest key to success
Two basic approaches:
– Inclusive and open – we can train/support you
– Selective, based on:
  • Strategic importance
  • Culturally compatible
  • Record of high-performance

Threshold Issues

Health Care Quality Improvement Act
– To be or not to be a “health care entity”
– Secures protections but imposes responsibilities re querying and reporting to the NPDB
– Immunity versus burden associated with due process, etc.

State Confidentiality and Immunity
– Primarily driven by statutory purposes, definitions of protected entities and required processes
– Most state peer review laws do not contemplate the role of a CIN/ACO, etc.
– Let’s look at Florida!
**Necessary Questions**

How will “peer review” differ for a CIN?

How will the sharing of peer review, credentialing and other protected information affect confidentiality?

Can we structure the CIN to maximize confidentiality protections?

Is there an appropriate balance between data transparency and risk-focused confidentiality?

For Hospital-affiliated CINs, what is the relationship between Medical Staff membership and CIN participation?

**Necessary Questions (cont.)**

How will quality standards, metrics and benchmarks be incorporated into CIN operations? (Remember, in a CIN, performance rather than malpractice avoidance matters)

How will so-called “data killers” be addressed?

Will you afford formal hearing or similar due process rights?

Should you use time-lapsed recredentialing processes or standards tied to participation agreements?

How might delegated credentialing be affected?

**Going Above and Beyond**

Do what traditional Medical Staffs have often struggled with:

- Implement a structured resource/function focused on clinical transformation
- Meaningful intervention/assistance – focused on overall CIN performance – “Lift all boats”

Select metrics that are:

- Limited
- Data recoverable
- Improve outcomes
- Are related to payer targets
- Are of interest to payer/employers
- Scalable
And Don’t Forget:

*Context is Everything:* You are in a position to "issue spot" and bring tremendous value because of your central role in your organization.

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