Clinical Integration and Payer Contracts: A Balancing Act

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The passage of the Patient Protection and Affordable Care Act (PPACA) means changes for health care and those who pay for it. As these changes include an increase in the insured population and increased eligibility for Medicaid, United States employers, government entitlement programs, and private insurers will have more healthcare costs to manage.1 To manage these costs, it is imperative that healthcare providers and payers minimize excess costs and align incentives to maximize efficiency and value.2 One way to do this is through the creation of clinically integrated care networks, where healthcare providers work together to share best practices and various resources in order to provide higher quality care.3 Clinical integration is strengthened further when payers recognize the value in these systems and coordinate with healthcare providers in order to deliver superior insurance coverage for consumers.4 Finance and quality generally go hand in hand when it comes to transitioning successful clinically integrated networks to

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systems participating in value-based payments. However, to fully develop clinically integrated networks, it is crucial that those at the forefront carefully consider ways to attract providers and patients to adapt to changing attitudes in healthcare today. Vanderbilt University Medical Center has considered some of these strategies, but its course of action is not without flaws.

This article examines the characteristics of the Vanderbilt Health Affiliate Network and the delivery of care through the clinically integrated network itself, as well as through partnerships with payers. This article advocates for a careful balance between past characteristic flaws of traditional managed care and necessary measures for future successful value-based payments. In doing so, Part I explains background information on the PPACA’s emphasis on efficiency in health care, detailing clinical integration and capitation. Part II details the Vanderbilt Health Affiliate Network and its popularity with insurers. Parts III and IV then note some of the strengths of the clinically integrated network for purposes of patient satisfaction, while arguing that these may present challenges if not monitored or strategically implemented. Finally, Part V describes some of the successes of the Vanderbilt network in terms of physician satisfaction compared to historical weaknesses from managed care.

I. BACKGROUND ON CLINICAL INTEGRATION AND PPACA

The Federal Trade Commission defines clinical integration as “a group of

5. JASON GOLDWATER & LARRY YUHASZ, CONSIDERATIONS FOR CLINICAL INTEGRATION, TRUVEN HEALTH ANALYTICS 1, 4-5 (2011) (describing how clinical integration helps lay the groundwork for working relationships necessary for coordinated care, such as value based payments like risk-adjusted reimbursement, pay-for-performance, and economic credentialing).
6. Id.
7. See infra notes 27-34 and accompanying text (discussing the background of Vanderbilt University Medical Center’s clinically integrated network).
8. See infra Part I.
9. See infra Part II.
10. See infra Parts III and IV.
11. See infra Part V.
providers who mutually choose to work together and commit to a united cause: to improve outcomes and reduce costs through the employment of evidence-based medicine and continuous process improvement.” The importance of this movement stems from initiatives to alleviate historical issues in healthcare delivery and payment. The PPACA encourages efficiency in health care, responding to crippling healthcare spending as a result of misaligned financial incentives. The financial incentives of clinically integrated networks do not function the same as an accountable care organization (ACO), which encourages value in healthcare for Medicare beneficiaries. This is because ACOs assume financial risk for efficiency of care where clinically integrated networks do not. However, the networks still function as a cost saving mechanism, particularly for intellectual capital and coordination, cutting down on unnecessary or duplicative treatment. Key components of clinically integrated networks tend to feature measures like shared electronic health record databases, best practices, guidelines for care, and hospital-physician coordination. Nonetheless, clinically integrated networks are, at times, merely a means for providers to lay the groundwork for bundled payments and other payment methods requiring financial risk.

Capitation and bundled payments are one way for providers to limit

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13. See GOLDWATER & YUHASZ, supra note 5, at 4; see also The Economic Case for Health Reform, WHITEHOUSE.GOV (last visited Apr. 24, 2015) (“Some of the strongest evidence of such inefficiencies comes from the tremendous variation across states in Medicare spending per enrollee, with no evidence of corresponding variations in either medical needs or outcomes. These large variations in spending suggest that up to 30 percent of health care costs (or about 5 percent of GDP) could be saved without compromising health outcomes.”).
14. See Berwick & Hackbarth, supra note 2.
16. Id.
17. Id.
18. Id.
healthcare spending through value creation and efficiency in care. By providing a set amount of money per patient regardless of labor or supplies, capitation and bundled payments place financial responsibility on providers to provide effective and efficient care. This contrasts with traditional reimbursement where providers are reimbursed on a fee-for-service basis through receipt of reimbursement per service provided. Fee-for-service reimbursement incentivizes providers to increase service volume and not necessarily spend healthcare dollars wisely. Due to the traditional excess spending resulting from fee-for-service reimbursement, recent healthcare payment trends indicate a shift towards value-based payment methods like capitation and bundled payments. These payments were traditionally utilized by managed care organizations, but may become more widespread for other health insurance organizations. This shift in payment makes provider adaptation to coordination and efficiency even more important, and clinically integrated networks seek to address these aims.

II. VANDERBILT HEALTH AFFILIATE NETWORK

One clinical integration success story is the Vanderbilt Health Affiliate Network (VHAN) developed by Vanderbilt University Medical Center in

21. *Id.*
22. *Id.*
Nashville, Tennessee.\(^{27}\) Vanderbilt University Medical Center has accomplished clinical integration through its creation of the VHAN.\(^{28}\) In doing so, Vanderbilt created a strategy that enabled it to form the largest clinically integrated network in the country.\(^{29}\) Vanderbilt began its initiative to form a clinically integrated network by creating collaborative relationships with other hospitals and physician practices.\(^{30}\) These relationships are centered on sharing infrastructure in order to coordinate care and cut down on administrative waste.\(^{31}\) Further, VHAN network participants interact through communication, governance, organization, and the development of novel medical record forms.\(^{32}\) The success of these measures allowed VHAN to demonstrate its efficiency and value to other providers to expand its network.\(^{33}\) Through this initiative, Vanderbilt successfully formed a system of 3,200 physicians and other providers caring for two million patients under VHAN.\(^{34}\)

### III. VHAN Successes in Insurance

Clinically integrated networks as a means to encourage healthcare efficiency will also heavily depend on attractiveness to payers.\(^{35}\) Coordination between payers and providers is paramount.\(^{36}\) Patients will be further incen-
tivized to utilize providers within a clinically integrated network if they ensure that they have low-cost access to quality care through their health insurance.\textsuperscript{37}

Vanderbilt has already begun to successfully market its clinically integrated network by partnering with health insurance providers to deliver insurance plans based upon networks of physicians.\textsuperscript{38} Although assumption of financial risk is not normally included in clinical integration, successful clinical integration attracts payers wishing to efficiently manage healthcare costs.\textsuperscript{39} In the case of VHAN, those assuming costs for health care utilized the network in two ways.\textsuperscript{40} First, VHAN providers self-insure their employees, offering employees the network from which to choose providers.\textsuperscript{41} Second, Aetna offers the network as an insurance product.\textsuperscript{42}

Vanderbilt’s method of offering its clinically integrated network as an insurance product was a low-risk way to test a provider-insurer relationship.\textsuperscript{43} To create a stable base for its network, Vanderbilt made strides by keeping an eye on the movement to value-based payments but not alienating providers and patients.\textsuperscript{44} In doing so, Vanderbilt began providing its network as self-

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\item \textsuperscript{38} \textit{FAQ, Vanderbilt Health Affiliated Network}, http://vhan.com/providers/faq.
\item \textsuperscript{39} See Goldwater & Yuhasz, supra note 5, at 6.
\item \textsuperscript{40} David R. Posch & John A. Lutz, \textit{The Vanderbilt Experience: An Expanding Clinically Integrated Network}, \textit{Navigant Pulse} 18, 20 (2013).
\item \textsuperscript{41} Id.
\item \textsuperscript{43} Id.
\item \textsuperscript{44} See infra notes 45-51 and accompanying text.
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insurance by managing the healthcare of the 70,000 employees and dependents of the network.\textsuperscript{45} In January 2013, under the VHAN health plan, Vanderbilt employees could be treated at any VHAN participating facility.\textsuperscript{46} By starting with its own employees, Vanderbilt and Aetna had access to a preexisting pool of insured individuals, which enabled them to market the product without having to start from scratch.\textsuperscript{47} After offering the network only to its employees and their families, Vanderbilt worked with large employers to design similar programs offering the network as an insurance product.\textsuperscript{48}

In January 2014, Aetna began offering VHAN as an insurance plan, expanding the network’s reach to Tennessee employers.\textsuperscript{49} The 2014 health plan for Vanderbilt faculty and staff included two “tiers” of coverage administered by Aetna.\textsuperscript{50} Tier one included a range of affiliated providers at a lower cost compared to non-affiliated Aetna providers while tier two included access to Aetna’s national network of providers.\textsuperscript{51}

Although VHAN’s success has evolved due to its attractiveness to payers and employers, it appears as though the system is making gradual movements towards capitation and bundled payments in order to attract providers who may be slow to change.\textsuperscript{52} This is an effective way to align independent physicians with a system without acquiring their physician practices.\textsuperscript{53} It allows physicians to remain independent but benefit from intellectual capital and technology that otherwise may be difficult to obtain.\textsuperscript{54} In order to participate

\textsuperscript{45} See Posch & Lutz, supra note 40.
\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Id.
\textsuperscript{49} Id.
\textsuperscript{50} See Vanderbilt Health Affiliated Network to Offer Expanded Options, supra note 12.
\textsuperscript{51} Id.
\textsuperscript{52} See FAQ, supra note 38.
\textsuperscript{53} See Knowledge Hub, supra note 3.
\textsuperscript{54} Id.
in VHAN, providers are not required to contract with VHAN-Aetna exclusively; therefore, providers can maintain financial flexibility and assume lower risks. Additionally, providers participating in VHAN maintain base payer contracts when they become a part of VHAN. After the network becomes fully integrated, the VHAN system may enter comprehensive contracts that include reimbursement rates tied to value achieved through clinical initiatives. Once risk capabilities increase, contracts may progress to bundled payments, global payments, and capitation.

VHAN-Aetna’s tier program is one way to provide care within a clinically integrated network as a variation on a narrow network insurance product. Tier one providers offered by the VHAN-administered health plan provide enrollees with lower co-pays and deductibles. While consumers are financially incentivized to go to these providers, they are not prohibited from going elsewhere. Enrollees in the VHAN-Aetna plan may choose to seek care from within the tier two level, which includes any other Aetna provider. This is positive for purposes of facilitating consumer choice and preference. For example, a VHAN enrollee may have the option to continue to see his or her primary care physician (provided he or she is an Aetna physician) outside

55. See FAQ, supra note 38.
56. Id.
57. Id.
58. Id.
59. A narrow network insurance product is one where enrollees receive care within a network of providers, where the insurance covers costs. David Blumenthal, Narrow Networks: Boon or Bane?, THE COMMONWEALTH FUND (Feb. 24, 2014), http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane. Generally, insurance companies are able to negotiate lower prices within these networks, leading to lower co-pays and deductibles. Id.
60. See FAQ, supra note 38.
61. Id.
62. Id.
If a patient has a particularly good relationship with a physician and does not mind paying the extra expense, the patient is still covered by the insurance.\(^{65}\)

**IV. POTENTIAL CHALLENGES PRESENTED BY VHAN’S INSURANCE MODEL**

VHAN’s initiative of synching a clinically integrated network with Aetna in order to provide high quality, low cost care is a progressive movement towards capitation and bundled payments. However, in doing so, the organization must balance initiatives to appease physicians and patients with lessons from past managed care models.\(^{66}\) One risk VHAN-Aetna takes when allowing its enrollees to seek care outside of the integrated network is reduced efficiency in care.\(^{67}\) By allowing enrollees to leave the clinically integrated network, VHAN may perpetuate some of the measures its clinically integrated network attempts to combat.\(^{68}\) For example, patients may be subject to repeat diagnostic tests, conflicting treatment plans, or adverse prescription drug reactions due to non-streamlined practices or medical records.\(^{69}\)

A managed care model of note is the health maintenance organization (HMO). The United States Department of Health and Human Services defines HMOs as insurance plans that limit coverage from care by doctors who work for or contract with the HMO (excluding out-of-network coverage except in cases of emergency), focus on integration, and promote prevention

\(^{64}\) See FAQ, supra note 38.

\(^{65}\) See id.

\(^{66}\) See Knowledge Hub, supra note 3.


\(^{68}\) See GOLDWATER & YUHASZ, supra note 5, at 2-3.

\(^{69}\) See Knowledge Hub, supra note 3.
and wellness.\textsuperscript{70} Although the VHAN-Aetna product is \textit{not} an HMO,\textsuperscript{71} its movement toward managed care may cause the health plan offered by Aetna and VHAN to more closely resemble an HMO as the organization moves towards risk-based payments.\textsuperscript{72}

The reality and potential range of issues arising from allowing consumers a diluted form of a managed care product are evident in the history of HMOs.\textsuperscript{73} Organizations administering HMOs experienced and continue to experience less success when they do not have as much control over costs, often arising with weakened integration.\textsuperscript{74} Physician-hospital organizations (PHOs) were one aspect of HMOs where physicians contracted with an HMO to form integrated delivery systems.\textsuperscript{75} Most of these arrangements featured fee-for-service payments, while some featured capitated payments.\textsuperscript{76} These arrangements generally did not manage risk well because most allowed all physicians with hospital privileges to participate instead of limiting participation to only efficient physicians suited for patient value.\textsuperscript{77} PHOs also commonly lacked organization, infrastructure, management, and other resources that are imperative to successful coordinated care.\textsuperscript{78} Further, open-ended HMO products that employers sought in the 1980s and 1990s allowed enrollees to self-refer outside the network with traditional cost sharing.\textsuperscript{79} By al-

\begin{thebibliography}{99}
\bibitem{FAQ} \textit{See FAQ, supra} note 38.
\bibitem{Id} \textit{Id.}
\bibitem{Clayton} \textit{See C\textsc{layton M.克里斯滕森 et al.}, The Innovator’s Prescription, 228-230 (McGraw Hill, 2009)}.
\bibitem{Origins} \textit{See Origins, supra} note 63, at 8
\bibitem{Id} \textit{Id.}
\bibitem{Id} \textit{Id.}
\bibitem{Id} \textit{Id.}
\bibitem{Gold} \textit{Marsha R. Gold, HMOs and Managed Care}, 10 \textsc{Health Aff.} 189, 202 (1991).
\end{thebibliography}
allowing patients to receive de-centralized care, healthcare expenditures become more costly.\textsuperscript{80} Additionally, carve-out companies (i.e., provider networks specializing in the management of a specific disease or condition) weakened efficiency and coordination efforts.\textsuperscript{81} This inefficiency drove reintegration of the carved out networks back into HMOs in order to coordinate in-network and out-of-network patient care.\textsuperscript{82}

With this background in mind, VHAN system must carefully weigh the risk of allowing enrollees to receive care at out-of-network providers. Some of the previous issues associated with HMOs can arise from a tiered approach to insurance in and outside of a clinically integrated network.\textsuperscript{83} If patients do not stay within a managed care network, the financial incentive is significantly weakened, and the goal of holistic health will be less certain to occur.\textsuperscript{84} In order for VHAN to efficiently equip itself to address value-based payments, it should be aware of this history. The option for a fragmented network of providers must be alleviated when capitation and bundled payments become more imminent.\textsuperscript{85} When provider incentives are not aligned, patient care is less efficient because different providers do not have an incentive to provide the utmost quality of care if someone else will assume that cost.\textsuperscript{86}

V. VHAN PHYSICIAN INCENTIVES

As opposed to its patient incentives, VHAN incentivizes physicians to join the network in ways that have fewer drawbacks.\textsuperscript{87} VHAN is merely laying

\begin{itemize}
\item \textsuperscript{80} Id. at 203.
\item \textsuperscript{81} Origins, supra note 63, at 8.
\item \textsuperscript{82} Id.
\item \textsuperscript{83} See infra notes 84-86 and accompanying text.
\item \textsuperscript{84} See Wood, supra note 74, at 325-26.
\item \textsuperscript{85} See Goldwater & Yuhasz, supra note 5, at 2-3.
\item \textsuperscript{87} See infra notes 84- 88 and accompanying text.
\end{itemize}
the groundwork for managed care arrangements of the future; therefore, certain features characteristic of traditional managed care programs are appropriately absent from its system.\textsuperscript{88} Previous managed care arrangements featured physician alienations, like requiring authorizations, excluding them from networks, and bargaining for lower prices.\textsuperscript{89}

These typical features are all but present from VHAN.\textsuperscript{90} Physicians have minimal costs required to join the network, but gain a plethora of intellectual capital and access to patients in the VHAN network, as well as goodwill associated with the Vanderbilt Health System.\textsuperscript{91} Further, physicians do not have to exclusively treat patients who have a certain kind of health insurance or are in the VHAN network.\textsuperscript{92} As a member of the network, physicians are enabled to accept other methods of payment in addition to the Aetna-VHAN plan.\textsuperscript{93} Additionally, no service needs approval, like in an HMO.\textsuperscript{94} These measures all present a low-risk option for physicians who want to align with a large system to prepare for value-based payments, yet are not comfortable with giving up all control by becoming a part of a large health system through a merger or acquisition.\textsuperscript{95}

VI. CONCLUSION

Clinically integrated networks are clearly utilized by healthcare providers to prepare for the value-based payments necessary to cut excess and remain attractive in the healthcare market.\textsuperscript{96} It is important, however, for providers

\textsuperscript{88} See FAQ, supra note 38.
\textsuperscript{89} Ezekiel J. Emanuel, Why Accountable Care Organizations Are Not 1990s Managed Care Redux, 307 JAMA 2263, 2263 (2012).
\textsuperscript{90} See infra notes 84-88 and accompanying text.
\textsuperscript{91} See FAQ, supra note 38.
\textsuperscript{92} Id.
\textsuperscript{93} Id.
\textsuperscript{94} Id.
\textsuperscript{95} Id.
\textsuperscript{96} See Pizzo & Grube, supra note 15, at 4.
to remember the recent past and keep a careful eye on how networks are effectively utilized by payers, patients, and physicians. This requires careful balancing of concerns related to consumers, patient-quality, and physician satisfaction.

Measures taken by those initiating the networks clearly have addressed these factors, but as payment makes a shift to value-based payments, further change may be necessary in order to ensure health care remains efficient. VHAN’s insurance initiatives wisely facilitate some degree of consumer choice, but the history of managed care reveals that too much flexibility may result in drawbacks elsewhere.97 The strategies VHAN used to attract physicians to the network seem to present fewer areas for concern, especially considering how they contrast with unpopular managed care requirements and procedures.98 As health care continues to evolve, clinically integrated providers should utilize this information in order to best respond to the demands of the industry.

97. See supra Sections III-IV.
98. See supra Section V.