INTEGRATED DELIVERY SYSTEMS

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As the health care industry changes, one of the responses has been the formation of integrated delivery systems (IDS). To create an IDS hospitals form linkages with other health care entities such as physicians, insurers and providers of all sorts.

Since the turn of the century, hospitals have developed or joined multi-institutional, multi-provider arrangements to adapt to a changing health care environment. Multi-institutional development has rapidly progressed as hospitals have responded to reimbursement constraints, internal management pressures, a changing demand for patient services and rising consumer expectations for health care.

Thus far, outcomes of integrated delivery systems have been mixed, at best. Drivers for the development of IDSs have been cost savings, competitive edge, improved quality of care, and wellness promotion. The jury is still out on whether or not these entities will live up to the expectations afforded them. Trustees need to carefully consider the complex issue of integration as they guide their organizations into the future.

In addition, to accomplish effective governance of an IDS, trustees are required to bring together diverse visions, missions, cultures and perspectives into a new relationship.

**INTEGRATED DELIVERY SYSTEM DEFINITION**
An integrated delivery system (IDS) is a network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served. An IDS may own or could be closely aligned with an insurance product.

Services provided by an IDS can include a fully-equipped community and/or tertiary hospital, home health care and hospice services, primary and specialty outpatient care and surgery, social services, rehabilitation, preventive care, health education and financing, usually using a form of managed care. An IDS can also be a training location for health professional students, including physicians, nurses and allied health professionals.

**OBJECTIVES OF INTEGRATED DELIVERY SYSTEMS**

Quality Improvement and Cost Reduction:

- Reducing administrative/overhead costs
- Sharing risk
- Eliminating cost-shifting
- Outcomes management and continuous quality improvement
- Reducing inappropriate and unnecessary resource use
- Efficient use of capital and technology

Consumer Responsiveness:
- Seamless continuum of care
- Focus on the health of enrollees

Community Benefit:
- Improvement of community health status
- Addressing the prevention of social issues which affect community health

CHARACTERISTICS OF A FULLY INTEGRATED DELIVERY SYSTEM
- Single, integrated entity: one organization is responsible for providing all services, including delivery of care, payment and risk management
- Seamless continuum of services: consumers are provided a consistent point of access to all services and their care is coordinated and managed
- Managed fixed resources: risk-adjusted capital payments to the network create incentives to avoid duplication, conserve resources and keep consumers healthy
- Community health focus and accountability: networks may focus on improving the health status of the entire community in which they serve, not just the enrolled population

STRENGTHS OF INTEGRATED DELIVERY SYSTEMS
The orientation, providers’ motives and missions of organizations involved in integrated delivery systems encourage economies of scale. At the hospital level, varying degrees of organizational consolidation may lead to improved utilization of resources, both capital and operating. Integration can enable the system, through coordinated activities, to meet the same level of demand with less capacity than that required by individual facilities. A larger scale of operations also allows for increased productivity, lower staffing requirements and reduced unit costs through joint activities.

ACCESS TO CAPITAL
An economic advantage of integrated provider arrangements is the ability to acquire capital more easily, more readily and with more consistent success. This is due to the larger asset base of the integrated organization, the stronger revenue
and income production from which borrowed capital can be repaid and the
greater frequency of contact with the knowledge of capital sources in the
marketplace.

LOWER COSTS
Better access to capital and economies of scale can lead to reduced operating
costs and lower prices to consumers. By coordinating the development of
programs and services multi-institutional and provider linkages may also
generate strategic planning at the community or regional level, rather than solely
on an institutional basis. This leads to ways of avoiding duplication of facilities
and services, improvements in the allocation of resources, a reduction in excess
capacity and an improvement in community health status.

PERSONNEL RECRUITMENT AND RETENTION
More effective recruitment and retention of clinical and administrative personnel
is a strength. For clinicians, there is generally a broader range of services and
programs, different levels of care and access to specialized personnel and
equipment. Availability of specialists allows for consultation and expanded
patient referral networks, and a stronger and more integrated clinical
organization can lead to improved quality of care throughout the system.

MAKING THE FIRST DECISIONS
The decision by a hospital to develop or affiliate with an integrated delivery
system should be made in the same context as any other business product line
decision. Successful development of any new delivery system will require a
thorough internal assessment of hospital operations (utilization and costs) and a
review of the external environment (demographics, employers and competitors).
The medical staff’s willingness to participate is crucial to determining the
feasibility of initiating any option.

In forming goals for developing or affiliating with an integrated delivery system,
the hospital will need to identify areas of relative importance, which may then
influence which strategy a hospital will choose. Areas that need to be put in
order of priority include: patient volume, medical staff, market share, financial
benefits and risks, quality, image, administration and governance. For example,
a Board that feels that control of the organization is essential may not want its
hospital to be one of many contracting providers with an integrated delivery
system.

After the information from the internal and external assessments has been
collected and summarized, forecasts should consider a variety of scenarios,
including no change in hospital market share, losses of significant levels of
patients and shifts of major employer group enrollees. These projections are
essential for determining the urgency of hospital involvement in new arrangements, as well as assisting in a realistic assessment of the opportunities.

ROLE OF THE GOVERNING BOARD
Hospital governing bodies will need to address the following considerations when thinking of creating or participating in an integrated delivery system:

- Are the trustees knowledgeable about the changes developing in the health care environment?
- Has the hospital explored all potential options?
- What level of control is important for the hospital?
- What are the responsibilities of the Board, CEO, physicians and insurers?
- What is the volume the hospital is seeking to achieve or maintain?
- Has a thorough financial analysis been conducted?
- Is there strong medical staff support to ensure success of the new arrangement?
- Does management have the necessary expertise to establish or affiliate with an integrated delivery system?
- How receptive are local employers to the offering of new plans?
- Have existing delivery systems demonstrated quality of care, competency of management and financial stability?
- What effect will a linkage with an integrated delivery system have on the hospital’s relationship with other hospitals?
- Will development of or affiliation with an integrated delivery system enhance or detract from the hospital’s reputation?
- Is sufficient capital available for startup costs?
- What will be the hospital’s investment and what is the expected return on that investment?
- Have all legal and tax implications been carefully examined?

ORGANIZATIONAL MODELS
There are several basic types of organizational models. Each represents varying degrees of integration and financing. The level and type of integration depends on the market, the ability of providers to cooperate, political factors, legal considerations, finances, needs of employers, resources available and the health care needs of the community.

THE PHYSICIAN–HOSPITAL ORGANIZATION
A physician-hospital organization (PHO) is a legal entity formed by a hospital and a group of physicians to further their mutual interests and achieve market objectives. The purpose of the PHO is to obtain payer contracts. The physicians still own their medical practices but agree to see managed care patients
according to the terms of a professional services agreement with the PHO. The PHO serves as a negotiating and contracting unit for the hospital and physicians.

The actual relationship between the physicians and the hospital remains relatively unchanged. The PHO loosely joins these two groups so that they can present a united front and exert greater bargaining leverage than they would alone. Contractors do not have to negotiate twice, however; federal and state antitrust laws create significant obstacles to accomplishing this goal. To be effective, this coalition must be viewed by prospective contractors as a potential cost-control strategy. The PHO therefore requires active utilization management, sophisticated information systems and intense involvement of physicians in developing standards of care and monitoring utilization.

A PHO is often the first step on the path to further integration. Hospitals and physicians in very competitive environments may set up a PHO to test the waters of collaboration. If the environment is favorable, they may find it in their best interests to collaborate further. For some, the PHO may be a transitory phase.

THE MANAGEMENT SERVICE ORGANIZATION
A management service organization (MSO) is a legal entity that provides administrative and practice management services to physicians. Physicians will contract with the MSO for such services as administrative, management and support services. An MSO is usually a direct subsidiary of a hospital, which typically owns 100% of it, although MSOs may also be jointly owned by the hospital and physicians.

The physicians still own their practices and contract out for management services. The MSO can provide sophisticated administrative systems that may be beyond the resources available to individual physicians comprising the professional corporation. They are not affiliated with any other groups who may have contracted with the same MSO.

THE GROUP PRACTICE WITHOUT WALLS
The group practice without walls (GPWW) is typically a network of physicians who have merged into one legal entity but maintain their individual practice locations. The assets of the individual practices have been acquired by a larger group, but some autonomy is maintained at each site. The group’s central management owns both the central facility and the equipment and provides administrative services.

Different sites are linked together and no longer compete with one another. The group entity makes equipment purchases and other managerial decisions. Links to a hospital can vary widely.
THE INTEGRATED PROVIDER
An integrated provider offers a comprehensive corporate umbrella for the management of a diversified health care delivery system. The system includes one or more hospitals, a large group practice, a health plan and other health care operations. It has the capacity to provide several levels of health care to patients in geographically contiguous areas. Physicians practice as employees of the system or in a tightly affiliated MD group.

The most important change is the addition of a health plan. With this addition, the word “integrated” can be used. In all of the other forms of collaboration, the entity seeks contracts from third-party payers. The integrated provider is both a provider and a payer. The entity enrolls patients in its own health plan, sets and collects premiums and provides the care. Therefore, all services are vertically integrated. Some of the other health care operations in the integrated system include nursing homes and pharmacies.

The high degree of integration affords physicians involvement in strategic planning activities at the Board level. Other advantages include enhanced collection and integration of operating statistics, enhancement of utilization review activities and cost control capacity. Duplication of services is greatly minimized at this level of integration.

An example of an integrated provider is the Health Maintenance Organization.

THE HEALTH MAINTENANCE ORGANIZATION
A health maintenance organization (HMO) is an organized system which combines the delivery and financing of health care and provides comprehensive health services to a voluntary enrolled population for a fixed, prepaid fee. HMOs are “at-risk” because their payments are limited to the prepaid premiums, thus establishing the HMO’s total budget for health care expenditures. As a result, HMOs use strong utilization controls for hospitalization and specialty referral.

There are four HMO models which can be distinguished by each HMO’s contractual relationships with physicians.

- **Staff Model** – an HMO that directly employs physicians and provides care through central offices. Some staff model HMOs own hospitals; others have affiliations with one or more independent hospitals.
- **Group Model** – an HMO which contracts with one independent, multi-specialty group practice to provide medical care. While some group model
HMOs own hospitals, most usually contact with a single hospital where the group’s physicians have staff privileges.

- Network Model – An HMO that contracts with two or more independent group practices to provide care. Network HMOs contract with the hospitals where members of the group practices have privileges.
- Individual Practice Association (IPA) Model – an HMO that either contracts with a physician’s association (which in turn contracts with individual physicians) or contracts directly with physicians from various settings (solo and group) to provide care. Because participating physicians are usually dispersed throughout an entire community, enrollees in an IPA model HMO receive inpatient care at a variety of hospitals.

FORMING AN INTEGRATED DELIVERY SYSTEM
Integrated delivery systems are forms of joint ventures. A joint venture is a legal arrangement between two or more entities to provide a new service, product or both. Participants in a joint venture usually share both the risks and the rewards of a venture.

A hospital can participate in a joint venture directly, through a subsidiary, through its parent corporation or through another subsidiary of the parent. Selecting the most appropriate structure depends on the objectives of the hospital and consideration of financial, legal, political and regulatory factors. Sometimes an arrangement other than a joint venture may best suit the circumstances.

Joint ventures may be accomplished by horizontal or vertical integration of facilities or services. Horizontal integration involves offering similar services across the same level of care, such as cardiology services. Vertical integration incorporates different levels of care, allowing a flow of patients from one level to another. For example, a vertical joint venture may formalize referrals from an ambulatory setting to an inpatient facility and then to home care or long-term care.

A leasing arrangement may allow the hospital to have control of a service without putting up a large capital investment or creating a new organization. An example of a leasing arrangement would be a group of physicians purchasing a diagnostic piece of equipment and then leasing it to a hospital, instead of the hospital purchasing the equipment or leasing it from a vendor.

PARTNERSHIPS
Partnerships are another way that integration may be pursued. There are two forms of partnerships. The first, a general partnership, is owned and controlled by the partners. The partners have equal control over management, and share in
any profits or losses. Each participant in a general partnership remains legally and financially liable.

The second form of partnership is a limited partnership. In this type of partnership, there must be at least one general partner and one limited partner. The general partner is responsible for the day-to-day management and is legally liable for the venture. The limited partners do not participate in the venture’s control and are only liable to the extent of their investment. The general partner can be the hospital, a corporation, such as a subsidiary of the hospital’s parent company or even a third party, which allows the hospital to participate as a limited partner and thus minimize its financial risk.

CORPORATIONS
Another model is a corporation, which offers centralized management and the benefit of limited liability. The corporation itself conducts the joint venture’s activity. A nonprofit corporation offers no potential for return on equity. A for-profit corporation could be capitalized by the selling of stock and it offers the potential for a return on equity.

The key in selecting the best organizational model for pursuing integration is to match the level of integration with the model that allows the hospital to achieve objectives consistent with its mission. Each model has benefits and limitations which the board must consider.

RANGE OF PARTNERS
A hospital may undertake integration with a wide range of partners. These partners might include other hospitals, physicians, HMOs, the hospital’s own employees, independent businesses, entrepreneurs, insurers and employers.

The most common integration activities have been those between a hospital and members of its medical staff. Trustees need to be aware of the following concerns regarding integration.

- Loss of control: successful integration requires trust and active interest by both the hospital and physicians.
- Violation of federal law: particular attention must be paid to the structuring of financial relationships between hospitals and physicians to prevent sanction and separation of the venture from traditional hospital/medical staff relationships.
- Quality management processes, such as credentialing and reappointment review, must not be influenced by a hospital’s financial relationship with a group of physicians.
ESSENTIAL ELEMENTS IN PLANNING INTEGRATION
The hospital’s decision-making team must determine whether to undertake integration through a strategic planning process. This process must include mechanisms for identifying opportunities, assessing joint venture efforts and deciding whether to reinvest in or divest from a joint venture. Creative entrepreneurial and management skills, including the business, legal and financial expertise of trustees, will enhance this process.

SCREENING CRITERIA
A Board should address the following key questions in screening potential integration opportunities:

- Is the joint venture consistent with the hospital’s values and mission? A hospital’s underlying value system should not be forgotten in an attempt to establish new services.
- Is the hospital compatible with the proposed joint venture partner? The partners in a joint venture must have a common mission, philosophy and goals. These must be clearly identified in initial deliberations to determine the compatibility of the organizations in pursuing the new venture.
- Is the joint venture within the resources and capabilities of the hospital? Insufficient capital and a lack of specialized staff are common hazards in hospital integration ventures.
- What are the alternatives to the joint venture? This assessment should include consideration of the risks of not venturing.
- Is the timing right for the joint venture? Sometimes opportunities present themselves rather suddenly and a decision must be made in a short amount of time. Flexibility and swiftness in making decisions in the planning stage are critical.
- Is there a market for the services provided by the joint venture? Before a hospital enters into a joint venture, it should determine whether a market exists for the proposed service or product. The market assessment should include an analysis of the venture’s potential competitors.
- Is the proposed operational plan sound? The operational plan should cover capital requirements, financial projections and contingency plans for what will be done if key objectives are not met.
- For nonprofit hospitals does the joint venture meet IRS requirements?

GOVERNANCE
Governance of an integrated delivery system involves:

- Uniting different visions, missions, organizational structures and cultures
Avoiding unnecessary and destructive competition between providers and hospitals
Creating a multi-disciplinary approach for decision making
Promoting a collaborative approach to the delivery of services
Providing cost-effective quality care

Governance must be shared and coordinated.

When two or more Boards exist, trustees may need to create a new Board. This new Board becomes responsible for governing the entire integrated organization. Some of the questions to answer in the creation of this new Board are:

- What should be the composition of the Board?
- What should be the size of the Board? How many physicians, how many hospital representatives should it have? What about patient/community representatives, insurers or employees?
- How should Board members be selected?
- What are the Board’s responsibilities? Powers?
- What committees should the Board have? What are their composition, purpose and duties?
- How is the CEO hired, evaluated and authority established?
- What legal requirements must the Board meet?
- How will bylaws be written, approved and changed?
- How will conflicts be resolved?

As the Governing Board moves from the old to the new, it is important to:

- Educate trustees on their new roles and responsibilities in an integrated delivery system
- Expect discomfort, confusion and fear
- Communicate plans and activities to the community, staff and all involved providers, hospitals and vendors
- Realize that the hospital and its services are changing
- Understand that the business of providers and hospitals is now integrated and that everyone needs to learn about the new business
- Accept that there will be some loss of control for everyone, including Board members and physicians
- Reach a consensus on vision, mission and goals for the IDS

LEGAL ISSUES
The Governing Board and hospital must obtain sound legal and financial advice in structuring and financing their integrated delivery systems. Legal issues vary depending on the integration activity, organizational model and range of
partners. The following list is in no way comprehensive, but does identify major issues to be considered by the Board.

CORPORATE LAWS
Compliance with state laws governing incorporation and creation of general and limited partnerships is important. Nonprofit corporations will need to be created under the provisions in Washington law.

TAX ISSUES
IDS activities between physicians, insurers and hospitals have prompted local, state and federal examination of the tax status of nonprofit health care organizations. Hospitals must demonstrate their community service missions. When considering new ventures, it is imperative to obtain current information on how a venture might affect a hospital’s tax-exempt status and whether the partners in the venture should be paying unrelated business income tax or property tax.

In order to obtain and keep an exemption from federal income tax, nonprofit hospitals must be operated only for a charitable purpose. A nonprofit hospital entering into a joint venture with a for-profit corporation needs to make sure that the venture benefits the community. Generally speaking, nonprofit and for-profit partners in a joint venture need to make equal contributions, bear equal risks, have shared control and receive equal benefits. IRS rulings suggest that the nonprofit entity should have the greater representation on the governing body and control of the venture.

THE INTERNAL REVENUE CODE
The Internal Revenue Code states that the earnings of a nonprofit institution cannot inure to the benefit of an individual or private shareholder. Private inurement is the acquisition of funds or other assets of a tax-exempt organization by a person with a private interest in the organization. Profit sharing and deferred compensation are permitted if the arrangement is for the purpose of achieving the hospital’s mission: patient care.

INSURANCE REGULATIONS
When the IDS involves an HMO or other third-party payer, insurance regulations may need to be addressed. In Washington, HMOs are regulated by the Office of the Insurance Commissioner. It may be necessary for an IDS entering into a contract with an HMO to first check with the Washington State Office of the Insurance Commissioner.

ANTITRUST ISSUES
Another area of concern is antitrust laws. Important antitrust issues include
price-fixing, division of markets, monopoly and restraint of trade. Policies creating “safety zones” for certain activities have been established. These policies address mergers of small hospitals, hospital joint ventures to purchase expensive equipment, collective provisions of medical information by physicians, hospital surveys of prices for services, salaries, wages or benefits of hospital personnel, hospital joint purchasing arrangements and certain physician network joint ventures.

FRAUD AND ABUSE PROHIBITIONS
The Medicare and Medicaid laws contain fraud and abuse provisions which prohibit hospitals from obligating physicians to refer patients exclusively to their facility. The Federal Medicare Fraud and Abuse Law (anti-kickback statute) also forbids the paying of any remuneration to induce a person to purchase, lease or order a good, facility, service or item that will be paid for with Medicare or Medicaid funds. This provision applies to a wide range of hospital agreements to obtain services, equipment or products. These hospital agreements may be considered legal under the Safe Harbor Regulations if certain standards are met.

The Washington Illegal Remuneration Statute, like the Federal Medicare Fraud and Abuse Law, prohibits physicians and all other licensed, registered or certified health professionals from accepting payment or paying anyone else for soliciting or securing patients. Arrangements and agreements which are legal under the Medicare Safe Harbor Regulations are legal under the Washington Illegal Remuneration Statute.

The federal Stark law prohibits patient referrals in certain situations involving physician ownership in or financial relationship to certain health care facilities. A “financial relationship” includes compensation arrangements and ownership. The possible effect of this law is also important to consider.

LICENSURE AND ACCREDITATION
Certain facilities or services may require separate licensure by the Washington State Department of Health. These include home health care and hospices. In addition, a separate license or accreditation may be required by some third-party payers for reimbursement purposes. In the case of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), when the parent organization is accredited, all facilities operated by the parent organization will also need to be accredited.

MALPRACTICE LIABILITY
Joint ventures with physicians may increase a hospital’s exposure to malpractice liability. In certain situations, courts have held hospitals liable for the actions of non-employed physicians. Legal review of the structure of IDS arrangements is
important so that the nature of the relationship between the venture partners and their responsibilities are clearly specified.

**HOSPITAL DISTRICTS**

Public hospitals may contract with physicians to ensure their availability. They may enter into contracts for hospital management. Public hospitals should be very familiar with their constitutional bases and the scope of their enabling legislation when structuring or organizing an IDS.

Public hospitals’ participation with nonprofit and for-profit entities in joint ventures is limited because of the constitutional prohibition on stock ownership in private companies. Public hospitals are also limited to activities that are authorized by statute or can be implied by their governing statutes.

**SUMMARY**

Boards need to be aware of the potential advantages and pitfalls of pursuing the formation of an integrated delivery system and thoughtfully guide their organization’s direction on this complex and important issue.
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