



**PYA**Leadership Briefing

# **Clinically Integrated Networks: Who, What, When, Where, Why, and How?**

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Healthcare reform in ten simple words: From *no output, no income* to *no outcome, no income*.

Today's volume-based, fee-for-service system is based on **independence**: each provider is paid for providing a discrete service, without regard to others' performance. Tomorrow's value-based payment systems, however, will demand **interdependence**: providers will be rewarded for quality and efficiency achieved through collaborative care.

The structure to develop and support such interdependence is the **clinically integrated**

**network**. Whatever specific form future reimbursement models may take - from shared savings to bundled payments to global budgets - they will demand providers be accountable to each other and the community they serve.

The development of a clinically integrated network is a journey, not an event. The first step in that journey is a common understanding of where we are headed.

## What is clinical integration?

Clinical integration is a new model for healthcare delivery. The model promotes collaboration among a community's independent providers to furnish high-quality care in a more efficient manner. Physicians, hospitals, and other providers share responsibility for, and information about, patients as they move from one setting to another over the entire course of their care.

Working together, clinically integrated providers develop and implement evidence-based clinical protocols, focusing on delivery of preventive care and coordinated management of high-cost, high-risk patients. Utilizing shared-information technology, these providers conduct ongoing clinical-care reviews to identify opportunities for improvement and ensure adherence to protocols.

While the antitrust laws generally prohibit joint contract negotiations among independent providers, those laws permit clinically integrated providers to engage in collective negotiations with health plans. Working together, these providers can more effectively compete for payor contracts because they demonstrate high quality and greater efficiency in care delivery.

**In short, clinically integrated providers are accountable to each other and to the communities they serve to deliver high-quality care in an efficient manner.** They accomplish this by: collectively establishing and enforcing standards of care; coordinating patient care (especially for high-risk, high-cost patients); and jointly negotiating and managing payor contracts.

**The following frequently asked questions provide additional information about clinically integrated networks and provide additional perspective about the future for those interested in developing a clinically integrated network.**

## **What is a Clinically Integrated Network or CIN?**

A clinically integrated network (“CIN”) is the lean infrastructure needed to support clinical integration among a community’s independent providers. The network develops a governance structure through which these providers come together to decide on protocol development and implementation, performance measurement and enforcement, and formulas for rewarding performance.

Other network activities include, for example, identifying, implementing, and maintaining supportive technologies

(including data analytics); analyzing care processes to identify efficiencies; encouraging patient engagement; negotiating pay-for-performance payor contracts; and distributing incentive payments to members.

While a hospital can provide administrative expertise for a CIN, network leadership is shared with physicians. Only physicians have the knowledge, skill, and experience needed to achieve improvements in clinical quality and efficiency.

## **How is it lawful for a CIN to collectively negotiate with payors when the Federal Trade Commission (“FTC”) is actively investigating and prosecuting providers for collusion?**

Provider worries about federal regulators are well-grounded. Since 2001, the FTC has prosecuted more than 30 independent practice associations and physician-hospital organizations alleging price-fixing arrangements.

The FTC, however, views provider collaboration through a CIN very differently than collusion among independent

providers. To the extent joint contracting is both necessary and subordinate to a CIN’s broader effort to improve quality and efficiency, the federal agencies view these arrangements as beneficial to consumers and pro-competitive. Thus, providers’ full commitment to achieving clinical integration is critical.

## **What are the key characteristics of a CIN?**

- Well-defined governance structure to promote organizational goals while protecting individual interests
- Relentless focus on improving the health of the population served
- Physician-driven, professional management
- Adherence to evidence-based medicine guidelines and clinical protocols
- Data-driven

## It seems everyone is talking about clinical integration lately. Why has interest in CINs grown so rapidly in the last several months?

The healthcare payment and delivery system is undergoing fundamental changes. Currently, a provider is paid for the individual services furnished by that provider. Such volume-based reimbursement offers no incentive for providers to work together in providing patient care.

However, payors now are shifting to value-based reimbursement, i.e., rewarding providers that deliver high-quality care in an efficient manner. The Centers for Medicare & Medicaid Services (“CMS”) is promoting this transition in the Medicare program through a number of initiatives authorized by the Affordable Care Act (“ACA”). These include the Medicare Shared Savings Program, hospital-physician value-based purchasing, and bundled payments. Following the Supreme Court’s decision on the

ACA and President Obama’s re-election, it appears these initiatives will move forward.

Commercial insurers, and employers, also are aggressively pursuing value-based purchasing arrangements. More and more payors are introducing pay-for-performance provisions in their standard provider agreements.

Achieving measurable improvements in quality and efficiency demanded under these new payment models requires coordination and collaboration among a community’s providers. **A CIN provides a vehicle for independent providers to work together for these purposes while protecting their individual interests.**

## How is a CIN different from an Accountable Care Organization (“ACO”)?

The term clinically integrated network dates back to the mid-1990s, when the Department of Justice and the Federal Trade Commission first acknowledged that independent providers working together to improve quality and efficiency could engage in joint-payor negotiations.

The term accountable care organization (“ACO”) was first used about a decade later in reference to a group of providers that assumes responsibility to provide care for an assigned patient population. Typically, an ACO bears some financial risk associated with providing such care.

Generally speaking, an ACO is a more formal arrangement, structured to satisfy specific payor requirements. For example, only an ACO that meets certain regulatory requirements is eligible to participate in the Medicare Shared Savings Program.

A CIN may elect to form an ACO for purposes of contracting with a particular payor. That decision, however, may be deferred until the CIN is fully operational.

## How do the fraud and abuse laws impact a CIN?

The federal Anti-Kickback Statute, the Stark Law, and the Civil Monetary Penalties Act (collectively referred to as the fraud and abuse laws) place restrictions on relationships among healthcare providers. For example, any financial relationship between providers must be based on fair market value for the goods or services provided.

Any financial relationship created as part of a CIN will have to be structured in a manner to comply with the fraud and abuse laws. A CIN does not provide any special protection from the civil and criminal penalties associated with violations of these laws.

## What is the Medicare Shares Savings Program (“MSSP”)?

An ACO that participates in the MSSP and meets certain quality standards is eligible to receive a portion of any savings generated through improved efficiencies in care delivery. CMS measures these savings by its annual expenditure per beneficiary assigned to the ACO as compared to a historical benchmark. Beneficiaries are assigned to an ACO based on their primary care physician.

In addition to eligibility for shared savings, an ACO participating in the MSSP enjoys certain waivers from the Anti-Kickback Statute, the Stark Law, and the prohibitions on gain sharing and beneficiary inducements, all of which now serve as barriers to provider collaboration. (Groups of providers organizing for purposes of participating in the MSSP also benefit from these waivers.) As a result, ACO participants may enter into financial arrangements

otherwise prohibited by law. Any CIN or ACO planning to participate in the MSSP should consult qualified legal counsel to ensure appropriate application of the MSSP waivers.

If a CIN elects to pursue participation in the Medicare Shared Savings program as an ACO, it will enjoy significantly greater flexibility in structuring relationships among its member providers.

CMS accepts applications for participation in the MSSP once a year. The next application deadline is July 31, 2013 (for a January 1, 2014, start date). Providers organizing to participate in the MSSP may take advantage of a pre-participation waiver starting one year prior to the application deadline.

## How do pay-for-performance contracts and shared savings programs work?

Under a pay-for-performance contract (often referred to as a P4P contract), an individual provider continues to submit claims and receive fee-for-service reimbursement. If the provider achieves a certain goal specified in the contract, the provider receives an additional incentive payment. A P4P contract may provide for a penalty if a provider fails to meet a specified target.

The Medicare Physician Quality Reporting System (“PQRS”) is an example of a P4P program. Under PQRS, a physician will receive a 0.5% bonus payment if he or she submits a report on specified quality measures in 2013. If, however, a physician does not submit such a report in 2013, that physician will be penalized 1.5% on Medicare payments in 2015.

Many commercial payors are looking to include P4P provisions in their contracts with individual providers. Generally speaking, a CIN can negotiate more favorable P4P terms. Also, a CIN supports an infrastructure that enables its members to achieve P4P measures.

Under a shared savings program, a network of providers is eligible to receive a portion of a payor’s savings generated by improved quality and efficiency. This is accomplished through a multi-step process:

1. The payor assigns a specific patient population to the CIN, usually based on the patients’ primary care provider.
2. Providers in the CIN continue to receive fee-for-service reimbursement for all services, including services for patients in the assigned population. The payor calculates a benchmark rate based on the payor’s historical cost of providing care for that population.
3. At the end of the year, the payor calculates the actual cost of providing care for the patient population. (This includes the costs of care furnished by providers not included in the CIN. Patients in the assigned population are not limited to providers in the CIN).

4. If the actual costs of care are less than the benchmark and if specified quality measures are met, the CIN will receive a percentage of the savings based on a predetermined formula (e.g., the parties split the savings 50/50). If the CIN does not achieve the quality measures, the payor will not share any savings with the CIN.
5. A CIN may opt for a “two-sided” shared savings program. Under this model, the CIN and the payor agree

to share losses, i.e., the CIN agrees to repay a portion of the difference if actual expenditures exceed the benchmark. In exchange for the CIN accepting this risk, the payor agrees to pay a larger percentage of any savings to the CIN.

6. The CIN is responsible for deciding how the shared savings (or losses) are to be distributed among its members. Typically, a portion of any shared savings payment is retained by the CIN to pay its expenses.

## Have other CINs been successful in improving quality and efficiency in healthcare delivery while protecting physician incomes?

Early adopters have achieved impressive results. For example, you can find success stories at Advocate Health Care in Chicago, Billings Clinic in Montana, and Mesa IPA in Grand Junction, Colorado. Advocate Health

Care publishes an annual Value Report (available at <http://www.advocatehealth.com/2012valuereport>), which clearly demonstrates the value of a high-functioning CIN to providers, payors, and patients.

## What types of protocols have other CINs adopted?

Typically, a CIN develops its initial set of protocols around delivery of preventive care and management of patients with chronic diseases (e.g., diabetes, COPD, asthma, heart failure). CINs have utilized well-recognized quality standards as a basis for protocol development including, for example, National Quality Forum-endorsed standards. Other sources include CMS’ Physician Quality Reporting System measures, the Medicare Shared Savings Program

performance standards, and Stage 1 and 2 meaningful-use quality reporting requirements.

To view an example of CIN-developed protocols, please visit the website for Integris Health Partners, a CIN in Oklahoma City. The web address is <http://integrisok.com/health-partners/metrics>.

## What role does technology play in a CIN?

A CIN can employ technological solutions in several ways to advance its goal of improved population health:

- Technology can assist a physician in adhering to clinical protocols, such as tracking whether a patient has received certain preventive services.
- Reporting on quality measures to the CIN (or to payors directly) may be accomplished using IT solutions.
- Data analytics can identify those patients for whom certain interventions are appropriate, thus allowing providers to manage those patients more effectively.

- Technology can assist the CIN in tracking care costs to identify opportunities for improvement.
- Electronic health information exchange permits CIN members to effectively coordinate patient care (especially for high-cost, high-risk patients), thus improving outcomes and reducing costs.
- Patient and family member access to electronic records enables them to be more active and engaged participants in the care process.

## How does a CIN make decisions? How are the interests of a hospital balanced against those of physicians?

A CIN's governance structure must further its members' common goals while protecting their individual interests. This is achieved through the selection of governing board members, balancing voting rights among participants, reserving certain fundamental decisions to the respective parties, delegating organizational functions through carefully drafted committee charters, and other organizational processes.

## What types of services do CINs offer to physician members?

There are significant differences between types of services CINs offer their physician members. Some limit their operations to quality improvement and care coordination, while others offer an expanded range of services to support physician members.

The following is a nonexclusive list of services a CIN might provide for its members. Keep in mind a CIN does not necessarily have to provide all services directly; a CIN may contract with third parties (including, for example, the hospital) for specific services. Also, in the future, a CIN may contract to provide services to third parties. This may be a way for a CIN to generate revenue to support its operations.

1. Operate disease registries/data analytics.
2. Implement evidence-based medicine practices/population health improvement strategies.
  - a. Identify and develop practice protocols (e.g., align with payor-required measures).
  - b. Support protocol implementation and adherence (e.g., education, technology solutions).
  - c. Monitor protocol compliance (reporting on quality measures).
  - d. Implement corrective action for protocol noncompliance.
3. Establish chronic disease management/patient navigator programs.
4. Develop transitional care management program (based on new Medicare Physician Fee Schedule payment for post-discharge transitional care management).
5. Implement medication therapy management programs.
6. Provide Physician Quality Reporting System support for physician members (e.g., education, abstracting, technology solutions).
7. Provide CMS Maintenance of Certification program support for physician members (e.g., CME opportunities, practice assessment, attestations).
8. Develop patient education and engagement strategies and tools (e.g., shared decision-making).
9. Explore clinical co-management arrangements and/or gain-sharing opportunities (hospital service line quality and efficiency improvement programs with financial rewards to physicians if program meets specified targets).

Before deciding on a particular structure, however, there should be consensus around common goals, i.e., identification of the functions the CIN will perform. **Stated another way, the form the CIN takes should follow from the functions it will perform, not vice versa.**



- 10.** Develop bundled payments for specific episodes of care (e.g., surgical procedures, maternity).
- 11.** Develop Centers of Excellence (by service line).
- 12.** Participate in Medicare Shared Savings Program (accountable care organization).
- 13.** Pursue preferred network contracts with private payors.
- 14.** Pursue shared savings and/or global budget contracts with private payors (including employers).
- 15.** Develop and market health plan (e.g., hospital employee health plan, Medicare Advantage).
- 16.** Provide EHR/meaningful use technical support for physician members.
- 17.** Furnish support for primary care providers in implementing patient-centered medical home models.
- 18.** Form or contract with group-purchasing organizations.
- 19.** Perform back-office functions for physician offices (e.g., coding, billing, collecting, accounts payable).
- 20.** Provide support for ICD-10 transition and compliance.
- 21.** Provide HIPAA Privacy and Security Rule compliance support.

### **How are CINs' operations funded?**

Exploring funding sources will be part of the decision-making process for identifying the specific functions a CIN will perform. Other CINs fund their operations in a number of different ways including, for example,

contributions from the participating hospital, physician dues, the sale of investment interests, revenue generated by selling services, and withholdings from payor reimbursement and/or pay-for-performance payments.

### **Do CINs typically restrict membership opportunities for physicians?**

To ensure compliance with the antitrust laws, CIN participation should be open to any physician who satisfies established minimum requirements for membership and who maintains compliance with specified performance

standards. Part of the CIN planning process involves identifying reasonable and appropriate requirements and standards.

### **How do physicians join a CIN? What will be expected of physicians as CIN members?**

Typically, a CIN's governing body develops a network participation agreement which specifies the rights and duties of CIN members. Community providers are given the opportunity to review this agreement prior to making a formal commitment to CIN participation.

At a minimum, a physician member of a CIN is expected to adhere to CIN-approved protocols and otherwise participate in and support CIN operations. Depending on decisions made by the CIN's governing body, a participant's ability to contract with payors independently or through another network may be subject to restrictions.



## What will Happen to CIN Participants Who Do Not Meet Established Standards?

The implementation of clinical protocols and performance measures will be an ongoing process of education and continuous quality improvement. No provider will be expected to perform at a certain level without adequate support to achieve that goal. While the intent is to improve quality and outcome metrics, successful CINs

demonstrate the will to cull an outlier if all attempts, such as peer review and education, fail. To protect individual's rights, the CIN may establish a review process to afford a physician the opportunity to challenge an adverse decision. No participant will be excluded based solely on subjective criteria.

### Still more questions about CINs?

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