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Developing an Effective Clinically Integrated Network

Part One

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I. Overview of Clinical Integration

Clinical Integration is a widely-used term in the healthcare industry, but what is it? Why is it moving from simply a good idea to a business imperative?

Although the concept of clinical integration has been around for a number of years, the applications have evolved over time. The growth of managed care during the 1980s and 1990s gave physicians very strong incentives to negotiate jointly with health plans. Earliest models centered on competing physicians organizing through independent practice associations (IPAs) and physician hospital organizations (PHOs) to negotiate jointly with health plans in response to health plans' initiatives to control payment rates. For leverage, health plans used the threat of selective contracting—that is, excluding them from their provider networks. Through risk sharing, physicians tried to gain leverage, as well as the size or volume to manage financial risk.

Healthcare organizations define clinical integration differently, each with its own variations and nuances. Basically, clinical integration of providers encompasses the following:

1. Working together across multiple entities to share clinical data to ensure the greatest care possible to patients
2. Establishing best practices and processes in patient care
3. Deploying an integrated information technology (IT) infrastructure

The push for the accountable care model, as is being driven strongly by the recent passage of the Accountable Care Act, is rooted in a changing reimbursement paradigm which rewards providers for consistent delivery of high-quality and cost effective care. This is only achievable through alignment among providers and facilities. Clinical integration in its newest dimension eliminates the competition factor previously held among physicians by integrating them into one accountable care unit. Clinical integration can be an effective approach for improving patient healthcare, reducing costs, and saving lives. Figure I-1 identifies the benefits of clinical integration.

The push for the accountable care model is rooted in a changing reimbursement paradigm which rewards providers for consistent delivery of high-quality and cost effective care.

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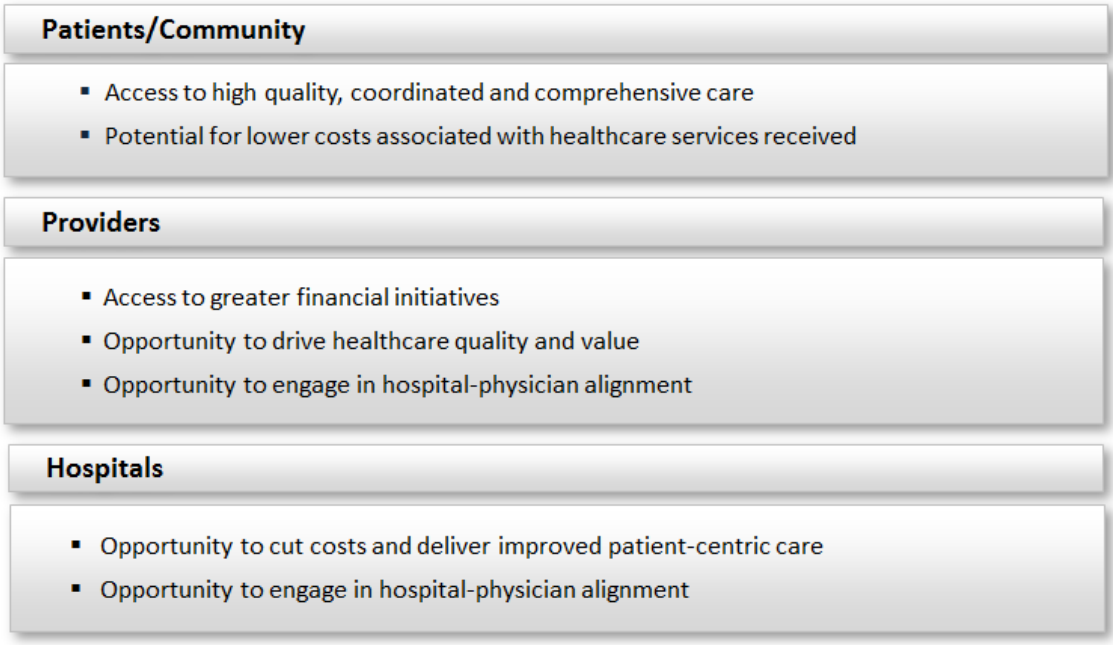
Figure I-1 -- Benefits of Clinical Integration



Clinical Integration as a Response to the Changing Reimbursement Paradigm

While many current patient care and reimbursement models center on separate, independent provider groups and facilities, the increasing costs and decreasing reimbursement rates compel the healthcare services delivery model to respond differently to the changing environment. Simply stated, the legislative measures enacted by the Patient Protection and Affordable Care for America Act, including the Centers for Medicare and Medicaid Service's (CMS's) requirements for participating in the Medicare ACO Shared Savings Program (effective January 2012), are moving physicians away from working in silos to integrated systems of interdependent provider groups and facilities and coordinated care. Physicians must look for ways to align their practices with other entities, with a focus on efficiency and the consistent delivery of high-quality and cost-effective care. With an eye on accountable care, alignment offers providers and healthcare facilities a viable option for achieving cost savings while increasing both the quality and efficiency of patient care. Realistically, alignment is key to the provider for remaining competitive in the marketplace.

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Clinical integration is essential for physicians and healthcare facilities to remain viable for their future delivery of patient care.

Summary

The concept of clinical integration is that hospitals and physicians share responsibility for and information about patients as they move from one setting to another over the entire course of their care—and maybe even beyond. The following sections in this paper will address various aspects of creating clinically integrated organizations, including getting from physician/hospital alignment to CINs, presenting an overview and purpose of CINs, and describing CIN structural models. The final section will present studies on actual functional CIN organizations.

II. Building Upon a Foundation of Alignment

Alignment between health systems and physicians is now seen as one of the most effective ways to respond to the changing reimbursement paradigm. In addition, alignment has been shown as a viable way to stabilize service lines, increase market share, and improve an organization's bottom line. As a result, many systems are presently focusing significantly on alignment efforts. Clinically integrated networks definitely fall within the overall realm of "alignment," but there are myriad other alignment models that also create effective partnerships between health systems and physicians. These models and their relationship to clinically integrated networks are explored in detail in this section.

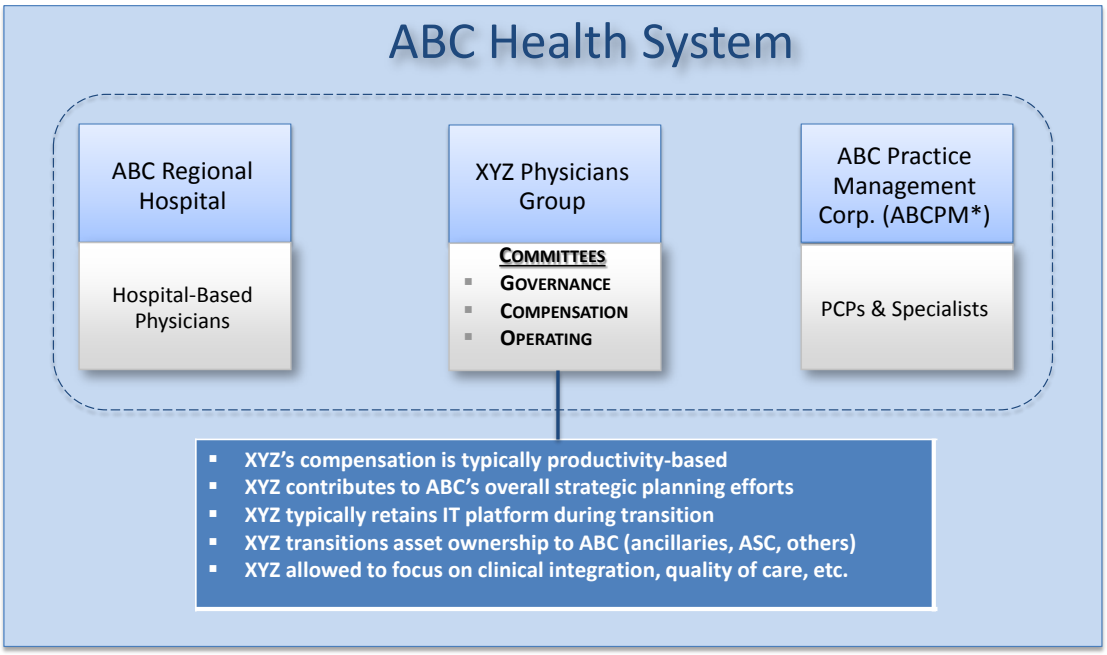
Current Forms of Alignment

Alignment is certainly not a new concept, but it is one that has assumed a more expansive meaning in recent years. For example, in the 1990s, alignment was nearly synonymous with employment. The pay-for-call relationships, joint ventures, and other contractual arrangements that exist in abundance today were less prevalent during that period, and as result, most alignment structures centered on employment. In addition, even the employment models in effect during that time are dissimilar to employment structures that are currently being implemented. Rather than a "top down" model where the health system sees itself as the "owner" of the physician practice and exerts significant influence over the operations and governance of the practice (even when unwanted or unnecessary), more contemporary employment models have a greater sense of partnership. In these

arrangements, the contributions of the physicians to the practice and the overall health system are seen as an important component of the overall transaction.

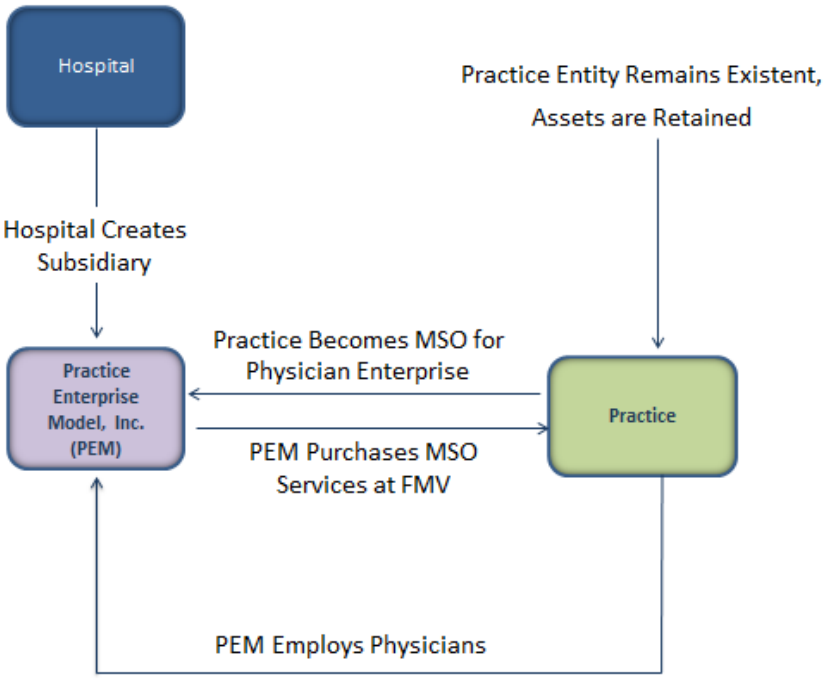
Several alternative employment structures that are being utilized in the market today are detailed in Figures II-1 and II-2, below. For example, the Group Practice Subsidiary (GPS) Model is a model applicable to larger group practices (often multi-specialty groups) that are interested in becoming aligned with a system. However, they want to retain their group practice mentality rather than working as individual physicians within the system's existent employed physician network. Within the GPS model, the aligned group continues to operate with significant autonomy, in stark contrast to the employment models of the 1990s where this was not the case.

Figure II-1 – Group Practice Subsidiary Model



Another employment structure in use today and not seen in the 1990s is the physician enterprise model. In this model, a new organization (often a wholly owned subsidiary of the hospital/health system) employs physicians yet allows the physician practice entity to remain intact. The system then contracts with the existent practice entity for ongoing management services.

Figure II-2 – Physician Enterprise Model



In addition to these newer forms of employment, a host of other alignment structures are available to bring health systems and physicians into closer working relationships. For example, professional services agreements (PSAs) are growing in popularity.[1] Often referred to as "employment lite," these relationships stop short of full employment but create a close (and in some cases, exclusive) relationship between physicians and a system. Under the PSA, the system contracts with a physician (through his or her existing practice entity) for professional services; in exchange, the system provides fair market value based compensation to the physician. There are a number of variants on the PSA model, including models wherein the physician is or is not employed, and models where the practice staff continues to be employed by the practice, or they transition to employment by the health system. Subject to legal and regulatory compliance, there are many options for the structure of these contractual arrangements.

In summary, the number of potential alignment structures that exist today is significantly greater than the number available 20 years ago. One of the key benefits is that there are now more ways than ever to meet the needs of the health system and the

[1] Note: For additional information on PSAs, download a complimentary copy of Coker's whitepaper, "Employment Lite: One Option for Integration and Alignment," accessible at www.cokergroup.com.

physician, rather than using employment (or nothing) as the sole medium for alignment. As a result, in recent years, physician-hospital alignment has become more palatable and more popular for a greater number of organizations.

Importance of Alignment as a Foundation for Clinical Integration

While many current patient care and reimbursement models center on separate, independent roles between physician practices and hospitals, there is movement within the healthcare industry to transition to a system that will require greater interconnectedness between parties. One recent example is the CMS Bundled Payments for Care Improvement (BPCI) initiative. Several of the proposed models of care include payment for an entire episode of care, which will require hospitals and physicians to work together to not only provide comprehensive and coordinated care, but also to share in the reimbursement for such services. Clearly, this will require more extensive integration between the parties than has ever occurred. Thus, as initiatives such as BPCI become more pervasive within the industry, the relationships between physicians and hospitals will continue to transition to adapt to this need for interconnectedness.

Likewise, clinical integration requires the same type of close-knit relationship between physicians and hospitals that is necessary under initiatives such as a bundled payment program. And, given the various alignment structures that currently exist in the industry, organizations are now in a solid position to realize success in their clinical integration efforts by building upon a foundation of alignment. As will be discussed in subsequent sections, CIN structures rely on physicians and hospitals working together effectively. This level of interaction may not be possible for many organizations without their first having some initial forays into alignment. This does not mean that hospitals need to employ their entire medical staff, nor that physicians should feel compelled to rush to hospitals requesting employment. Rather, it means that the *entire spectrum* of alignment options should be considered as part of an organization's accountable care readiness assessment process. For some organizations, contractual relationships with key physician groups can help create a solid working relationship, building trust between the parties and working out any operational issues, before additional layers of involvedness (such as the execution of a CIN) are added. In

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particular, this sort of preparation is of substantial benefit to organizations that meet some or all of these criteria:

- **Health systems that do not currently have alignment relationships with their medical staff**. If an organization does not already have alignment relationships, it may be because they have not considered the need for such historically. As a result, education regarding viable models and their benefits (for both parties) should occur to ensure an organization has considered the merits of alignment fully.
- **Health systems that currently only have one form of alignment with their medical staff.** If an organization is currently only pursuing one form of alignment, they may need to consider other forms of alignment. For example, if a system is primarily aligned with its medical staff through pay-for-call programs and medical directorships, it may need to consider more "full" forms of alignment (such as PSAs or employment), where warranted.
- **Health systems that have an animus relationship with their medical staff (or key factions thereof).** The type of trust that must be inherent within close working relationships (such as that of a CIN) does not happen overnight, and may require organizations to build this trust with physicians through smaller more manageable steps, including precursor alignment transactions
- **Health systems that are unsure of the infrastructure needs necessary to support a new initiative.** By forging alignment relationships, health systems will quickly learn what support systems they have in place and what they are missing to support physician relationships. These support systems include not only human resources, but technology platforms, equipment and space considerations, capital needs, and even established processes and protocols.

Overall, pursuing alignment relationships as a precursor to clinical integration can help replace misunderstandings. This will ensure that the CIN will begin with the support of physician participants and with appropriate resources in place from an operational and support perspective. Thus, the pursuit of alignment relationships is a highly advisable first step in the entire process.

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Summary

Structures focused on clinical integration, achievement of quality outcomes, and reductions in healthcare expenditures require strong relationships between health systems and physicians. For many organizations, developing a foundation through a spectrum of alignment options builds the trust and confidence necessary between the parties to engage in more collaborative, risk-based relationships.

III. Overview and Purpose of CINs

What is the reason for developing clinically integrated networks and what is the overarching principle that drives them? CINs are a response to the accountable care era at the commercial payer level. Just as ACOs are designed to meet the requirements for reimbursement as set by Medicare/CMS, CINs also address the commercial payers' movement toward reimbursement based on improved quality and efficiency of care, utilization of evidence-based data for substantiated performance improvement, and ultimately a written agreement with payers that aligns financial and clinical incentives. Although both CINs and ACOs meet this criteria, they also have notable differences in what governs them. As Medicare/CMS models, ACOs are subject to regulatory guidelines, which can bear extreme ramifications, while CINs relate to the private marketplace and are more flexible and less regulated.

This section provides an overview of CINs and explains how they fit into the accountable care era of healthcare. While they are complex and challenging to develop, they are well on their way to becoming the standard for healthcare delivery and can offer great benefits.

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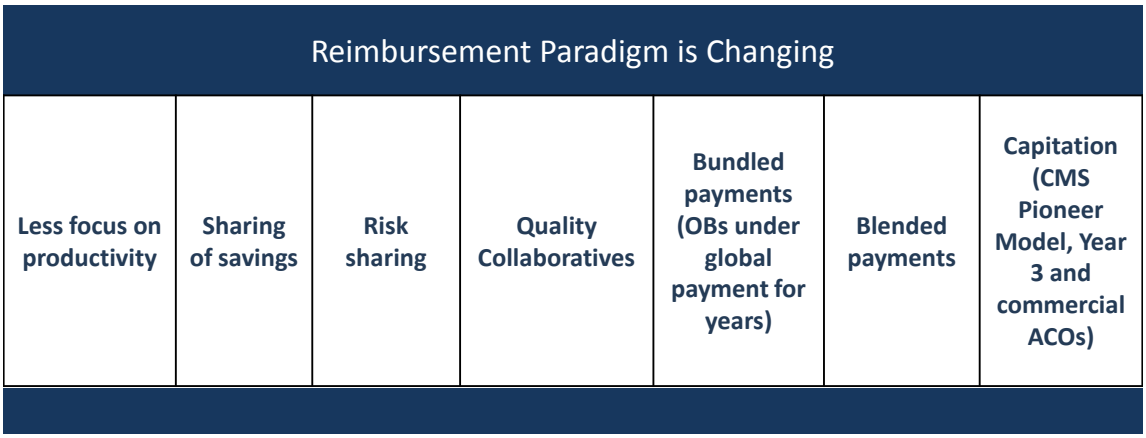
Reimbursement Paradigm

The reimbursement paradigm is indeed changing, as Figure III-1 illustrates.

Figure III-1 – Accountable Care Paradigm



Reading from left to right, this chart illustrates that while we are still in a productivity based reimbursement (i.e., fee for service) model, the paradigm is moving at a fast pace toward reimbursement tied to quality, cost savings, and ultimately taking the shape of blended and/or bundled payments. Thus, it is essential for physician/hospital and other providers to collaborate if not to fully integrate. Every hospital/health system in the United States should have an alignment strategy, which entails various forms of collaboration/affiliation with physician groups. In many instances, this has taken the form of full (W-2) employment, but it also can be an independent contractor (i.e., 1099) relationship, usually memorialized through PSAs and/or management services agreements (MSAs). Regardless of the level and form of alignment, CIN/CIOs must exhibit the characteristics of physicians and hospitals working together through an affiliated model. The changing reimbursement paradigm will accommodate such structures, wherein a bundled and/or blended payment structure would find it very difficult to accommodate reimbursing physicians, for example, that are not aligned with hospitals.[2]

[2]Note: In this instance, by alignment we are referring to some form of contractual agreement such as an employment contract, PSA, and/or MSA.

Clinical Integration Focus

Another very prominent characteristic of CINs is the focus upon clinical integration.[3] Although certain precursors of CINs are being formed without clinical integration of those entities, ultimately they will need those characteristics to reap the greatest benefit and respond best to the changing reimbursement models.

A key component of successful clinical integration is an integrated technology infrastructure.

In the purest sense, clinical integration entails providers working together to share clinical data, with the goal of rendering the greatest care possible to patients at an efficient level of cost. A key component of successful clinical integration is an integrated technology infrastructure. Many physician groups and virtually all health systems (including smaller hospitals, both rural and suburban) have converted their manual medical records and other information gathering of clinical data to electronic based systems. Further, many have adopted dashboard reporting that includes much more sophisticated analytics, relative to performance and coordination of data. However, having this ability to generate an electronic record does not in and of itself make one clinically integrated. This information has to be assimilated, stored, and easily retrieved across a number of providers and often over several information systems. This is true particularly if those providers are not a part of the same integrated health care delivery system. Thus, clinical integration may require extensive interfacing, including storage and developing a data repository which ultimately will effectuate the ability to share the clinical information. In concept, clinical integration helps bridge the gap between office-based physician practices, hospital/health systems, and other providers. The benefits of clinical integration are illustrated via Figure I-1, (see Section I). Ideally, once clinical integration is achieved, virtually everybody within the continuum of care and receipt of care is affected.

Thus, clinical integration is not only a key characteristic of ACOs, they are likewise extremely important relative to the formation and operation of CIN/CIOs.

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[3] Clinical Integration (FTC Definition), a "qualified clinically integrated arrangement" is a*n arrangement to provide physician services in which: 1. all physicians who participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of, interdependence and cooperation among these physicians in order to control costs and ensure the quality of services provided through the arrangement; and, 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.* (Statements of Antitrust Enforcement Policy in Health Care by the FTC and the U.S. Department of Justice, Statement 8, http://www.ftc.gov/reports/hlth3s.htm#8.)

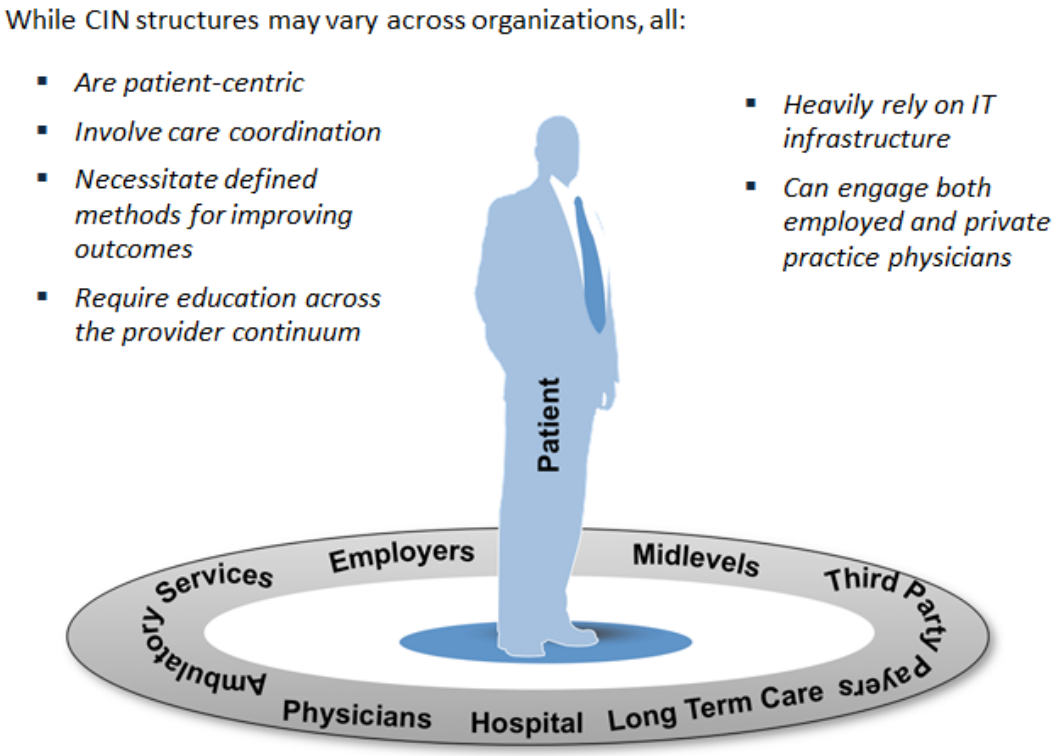
Developing a Clinically Integrated Network

The CIN is a network of interdependent healthcare facilities and providers that work collaboratively to develop and sustain clinical initiatives. All participants (ideally, all types and forms of providers within a continuum of care) must commit to several key overarching tenants. First they must adhere to evidence based clinical protocols. They must ensure patient treatment information is readily available throughout the network. They must collaborate in the development of a prescribed set of quality and performance measures. The participants must agree to participate in the collection and sharing of data specifically related to their clinical performance and outcomes. This performance will be evaluated against agreed upon standards and participants must be willing to be subject to remediation directives (even sanctions and ultimately expulsion from the network), if their quality and performance standards are not up to par. Also, the ability to participate within a payer contracting network is a key prerequisite of being within the CIN.

…clinical integration may require extensive interfacing, including storage and developing a data repository which ultimately will effectuate the ability to share the clinical information.

CIN structures, which we address in greater detail in Section IV, vary from provider to provider. Figure III-2, below, illustrates the continuum of care among the providers but also employers who have a heavy involvement (or at least should have) in this process. The patient is at the center of a care continuum. Being patient centric is a key quality of the CIN. Any CIN that plans to be fully functional and operational must depend heavily on an IT infrastructure, and comprehensive and mature clinical integration must actually exist.

Figure III-2 – Characteristics of Clinically Integrated Networks



CINs that are mature in their development will meet the goals for the Institute for Healthcare Improvements Triple Aim, which include:

- Enhancing the patient experience of care (including quality access and reliability)
- Improving the health of the population
- Reducing (or at least controlling) the per capita cost of care

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These are the core components of an entire accountable care strategy and likewise the CMS ACO model.

A CIN is a functional vehicle for aligning providers, healthcare facilities, and other professionals within the industry through common goals and initiatives. This requires commitment on the part of all participants and further solidarity toward achieving quality of care through the exchange of clinical data and information, plus cost containment.

Key factors that exist when establishing a CIN include:

- Defining clearly the goals and objectives of the entity (these may evolve and in fact mature over time, particularly if the CIN initially is formed on a much more limited scale, perhaps through an IPA or PHO)
- Utilizing resources that are currently available within the organizational consortium to build the CIN
- Placing emphasis upon the utilization of a physician driven model
- Designing a program that meets the consumer healthcare needs of the service area of the CIN
- Initiating the process with modest clinical metrics and then maturing them as the process and CIN develops with both experience and success
- Establishing clinical protocols that cover a large continuum of care including inpatient, outpatient/ambulatory, home care, skilled nursing functions—all stages of patient care
- Committing to an investment in an effective infrastructure (especially an IT infrastructure) that electronically measures performance, compares against benchmarks, and targets improvements needed
- Establishing effective communication among the providers, employers, and other participants, including third-party payer contractors

Concerning third-party payers, a CIN can offer excellent returns to a managed care organization (MCO) and thus supply the providers of healthcare within the CIN better reimbursement though more favorably negotiated rates. Although these rates will not be at full fee-for-service levels, they should offer a total package that is as good as or better than that experienced in the current marketplace. When the CIN members can demonstrate improved outcomes through clinical integration, improved quality and patient safety, reduced medical costs, and ongoing collaboration between the medical providers within the CIN, third party payers (i.e., MCOs) can justify reimbursing at levels as good or better as now exists.

Summary

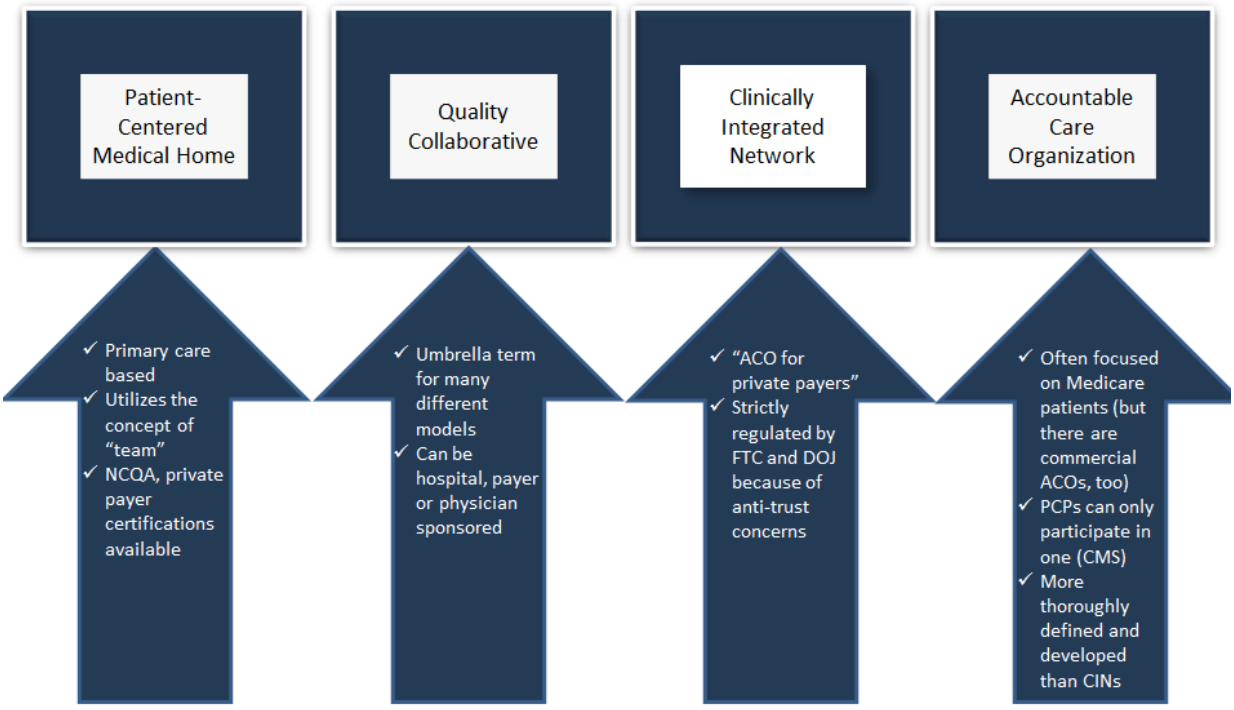
CIN development will encompass extensive planning and forethought, including recruitment of providers that will be a part of the organization. However, physicians and other healthcare providers are not required to be employed by a health system that might be the lead designer/developer (and even investor) of the CIN. Developing the CIN requires an organized effort to define its business plan, implementing that plan, and assessing the logistics to include payer contracting strategies, recruitment of physicians, and IT support. The process also entails devising a compensation model for distributing the funds that are derived through the CIN, including shared savings programs and ultimately developing a methodology for outcome measurement.

Forming a CIN presents real challenges. Nevertheless, once formed, the dividends for the effort can be quite significant.

IV. CIN Structural Models

The consideration of structural models for the CIN may call for a brief review of examples of the accountable care era structures. When a health system and/or major provider group is considering forming a CIN, they should also look at forming other similar models. Varying slightly, all have similar components and characteristics. The illustration below, Figure IV-1, identifies possible models that fit into accountable care era structures.

Figure IV-1 – Various Accountable Care Structural Models



Perhaps the most basic of models is the patient-centered medical home (PCMH); often, health systems initiate their accountable care strategy through the formation of a PCMH. In addition to those illustrated above, some health systems initiate the process through an IPA or a PHO. Often already formed and perhaps dormant, these IPAs and PHOs are being revived as an initial foundation for the ultimate plan of forming a CIN. Strategically, this action is reasonable in that forming an IPA, or reviving one that already exists, provides a firm non-threatening foundation to the physician constituency, especially for private practitioners who are considering participation.

...CINs do not have to employ all physician providers. In fact, there may be a large component of contracted specialists and primary care physicians.

In drilling down on these potential structural models, it is important initially to consider how physicians and hospitals should work together. As noted, CINs do not have to employ all physician providers. In fact, there may be a large component of contracted specialists and primary care

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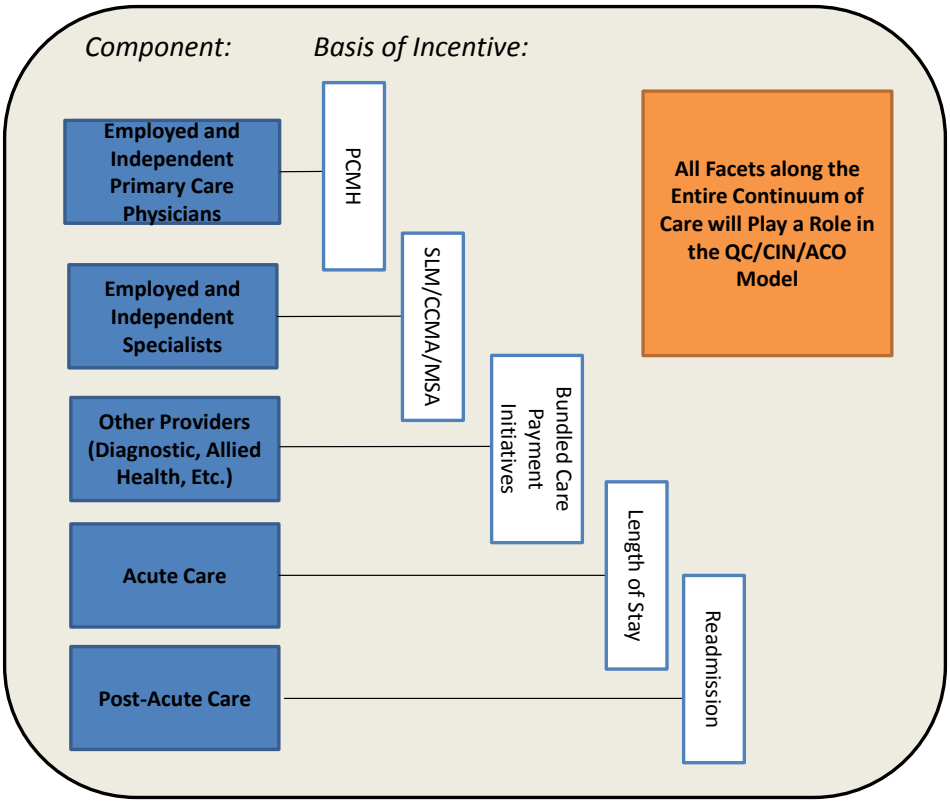
physicians. However, primary care physicians are more often employed than not in the current environment. Thus, the hypothetical CIN or even ACO structure would consider the following:

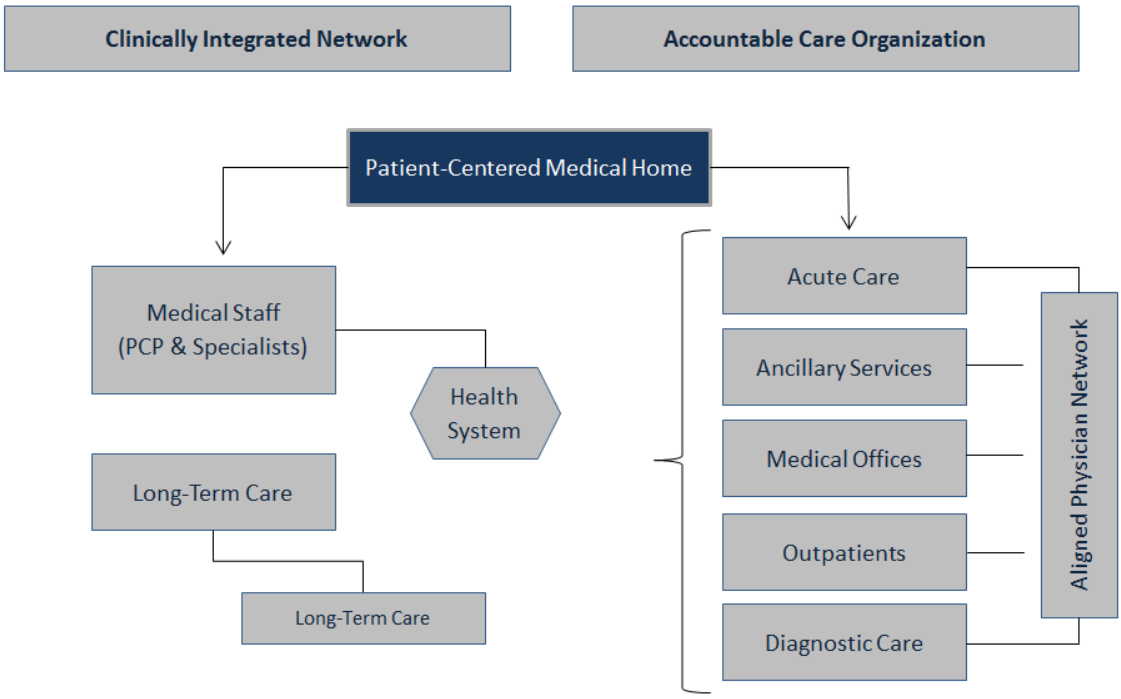
Figure IV-2 – Hypothetical QC/CIN or ACO (Medicare) Structure



This illustration shows that a continuum of providers is necessary to form the CIN, its "first cousin" the QC, and the CMS regulated ACO. For example, the key components to form the CIN are an acute care hospital with a multispecialty physician network plus other providers. This is also characteristic of the ACO. All these providers must be working together, committed to quality and cost improvement with support from jointly negotiated contracts. (The CMS ACO model is specific to government-related payer products, such as Medicare/Medicaid.)

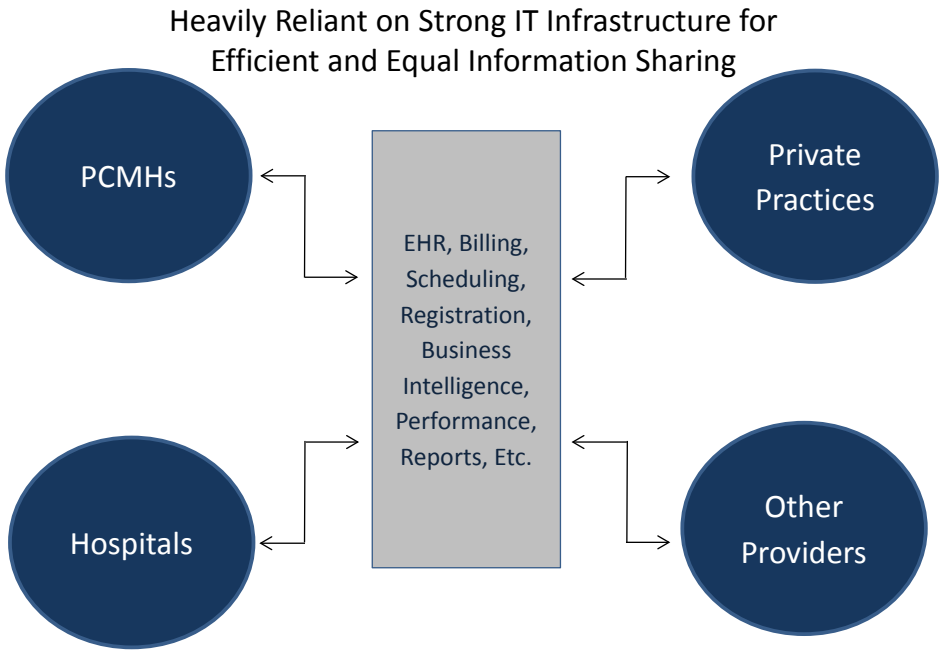
Broadly, the accountable care strategy, encompassing both the clinically integrated network and an accountable care organization (i.e., Medicare) will have virtually every component of the continuum of provider care within its structure. This is illustrated below in Figure IV-3.

Figure IV-3 – Accountable Care Strategy



It is also important to reiterate the essential nature of a strong information technology (IT) infrastructure. All of the provider players that are a part of the CIN (and the ACO) must be coordinated through such an IT infrastructure within the CIN. This is illustrated visually in Figure IV-4.

Figure IV-4 – Structures for CIN Development



The primary focus of a CIN is to create a high degree of interdependence among the participating providers. This will ultimately involve a disease registry and disease management information system, requiring physician and other provider involvement in various initiatives. As noted in Section III, such involvement includes:

- Governance
- Developing quality improvement initiatives
- Establishing reliable metrics
- Committing office staff to training
- Overseeing compliance across the network

The IT infrastructure is essential to assuming such a disease management system.

Centralized contracting is another essential element of the CIN and its goals and objectives. But doing this requires the coordination of information and data, as well as the assimilation of various providers to be a part of the CIN. It is important to coordinate both the information and other key characteristics of the CIN as an alignment structure among the various providers. This entails myriad legal, financial, and organizational structure considerations that will support clinical integration and will ultimately respond to the CIN in operation and functionality. The ultimate goal of the CIN is to provide the foundation and overall support structure to enable a legally-compliant entity that can function successfully

in financial, operational, and organizational areas. This entity will be the contracting medium which represents the provider constituents/participants among commercial payers.

The CIN should have some essential characteristics that most health systems and hospitals have already experienced during formation of various physician/hospital alignment models. This makes taking a physician/hospital alignment strategy one step further and forming the CIN a logical step in the progression. (Often, we refer to a physician/hospital alignment strategy as Stage I and the development of an accountable care strategy via CIN, ACO, QC, etc., as Stage II.) To this point, the following key characteristics exist:

- Agreement among the provider participants of the CIN to be subject to common financial risks relative to their performance (This also means that there will be an agreement on how best to internally distribute excess funds.)[4]
- Appropriately structured and defined governance and decision-making processes
- Financial incentives that are aligned toward common objectives among the CIN participants
- Single signature authority relative to payer contracts (Again, the CIN becomes the contracting medium. This could apply to both commercial and government payers, though an ACO would generally address the latter.)
- Adequate critical mass of representation of the various providers to support a comprehensive performance measurement and reporting system
- Appropriate legal structure (and malleability of that legal structure) to allow participants to collectively enter into contracts, with considerations for anti-trust issues
- A sufficiently large CIN, with a cross-section of providers to support an effective IT and administrative management infrastructure, thus enabling a true functionality of payer contracting representation and ultimate reimbursement from those contracts

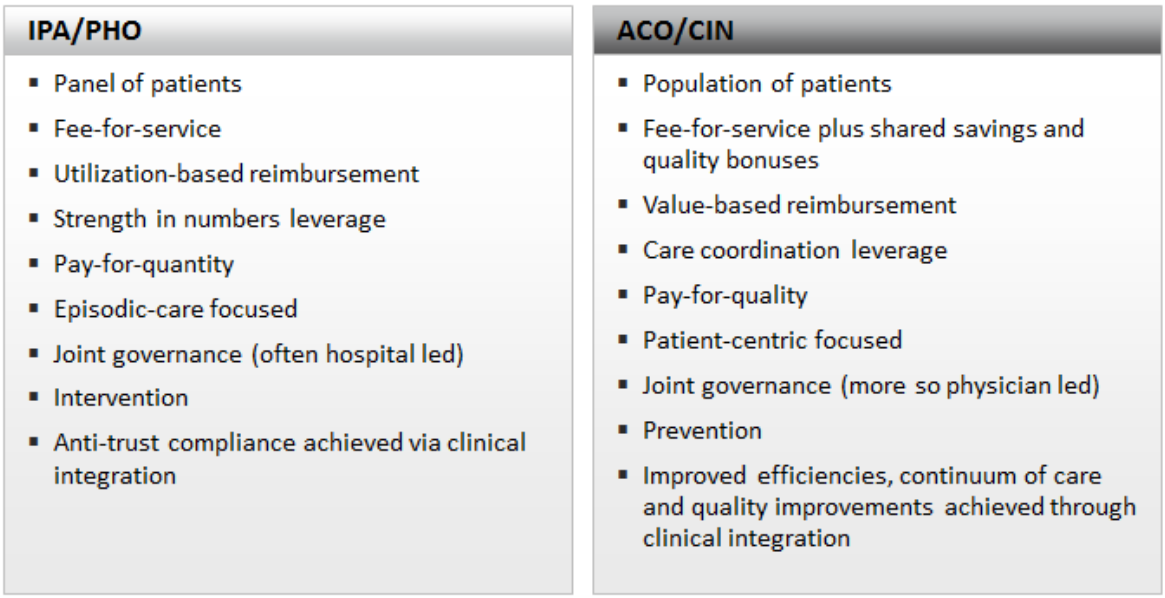
A CIN is a complex entity. In the process of considering forming a CIN, many health systems and larger groups have backed away from such a complex infrastructure, at least initially. Some have started this process (referred to as Stage II in the development of an

[4] Note: This topic is addressed in Part Two of this paper, detailing compensation methodologies to participating providers.

accountable care strategy with alignment being Stage I) much more austerely through an IPA/PHO structure that may only address some of the key deliverables of the CIN. For example, in some instances the IPA that is formed initially only provides a limited service offering with no contract negotiations--perhaps merely a shared savings program that will apply to that health system's employee health plan participants. Later, as their IPA matures and the overall participation among physicians increases, the strategy becomes to evolve into a full-fledged CIN, as in a more mature Stage II initiative.

Given the nuances of structural entities, a comparison of ACOs/CINs to PHOs/IPAs follows in Figure IV-5.[5]

Figure IV-5 – IPA/PHO vs. ACO/CIIN Comparatives



Payment Approaches

ACOs (and more specifically, CINs in the context of this discussion) have two major approaches to payments. The first is a combination of fee-for-service and shared savings. Providers are paid on a fee-for-service basis for a certain portion of their work, but the real extra benefit is realized through a shared savings program. Typically, the shared savings program delivers bonus payments based upon lower than expected cost levels while maintaining high standards of quality and outcomes. The other methodology is more tied to

[5] Note: In discussing these entities, the ACO and CIN are similar. In most circles, the ACO is relevant to the CMS product, while CINs pertain to the commercial payer contracts and relationships.

population-based payments wherein some semblance of a capitated system is structured. (Even within this system, there can be shared savings programs.)

Early on, shared savings programs have been received with moderate interest, primarily because many of the shared savings payments have not been large enough to incentivize providers to make meaningful changes. These providers do not want to see their fee-for-service payments reduced within this process. But, the CIN value proposition, i.e., achieving cost control and quality improvements, will not be achieved through a traditional fee-for-service payment methodology. As a result, the population-based program approach may have longer-term benefit, especially within the structure of a CIN, which as noted, by definition includes a large cross-section of providers, including hospital(s), physicians, and others. By managing an entire population of patients, the ability to truly affect a large group of people through coordinated care delivery is more likely. Providing payment incentives could fundamentally change the underlying incentives in patient care delivery which could lead to various improvements in total care and outcomes. Likewise, incentives within the population based program for cost reductions would be levered over a large number of people. Still, such programs are unproven and may not be the preference of the CIN, at least in its initial formative stages.

Possible Structures for the CIN

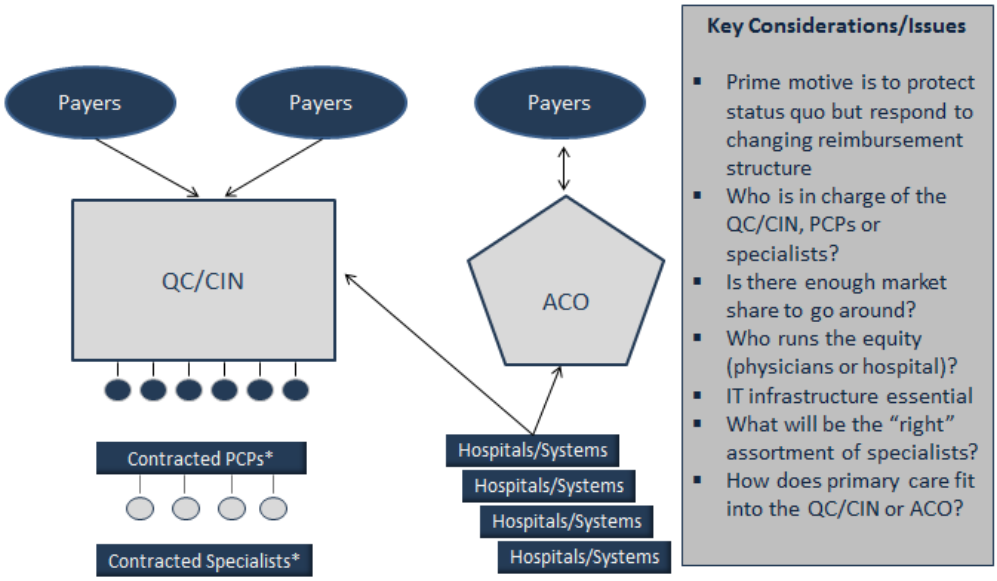
The following figures illustrate the possible structures for the CIN wherein various provider components might take the lead relative to the primary contracting source. These illustrate the various players that come together to be a part of the CIN and, depending upon the structure, involve such entities as primary care physicians, specialty care physicians, hospitals/health systems, IPAs and PHOs, and the CIN itself. Characteristics of these structures include:

- Outpatient services driven by aligned ambulatory physician practices
- Inpatient services driven by the health system network of hospitals
- Participants signing agreements to delegate contracting authority and coordination of care through and to the CIN
- Payers contracting directly with the CIN with appropriate clinical practice performance guidelines developed and expected to be coordinated

In some of the models that follow (Figures IV-6, IV-7, and IV-8), the CIN may subcontract with certain providers that may not be directly a part of the CIN, at least not at the time (but may join later). Regardless of the model, all CIN members must make a

commitment to develop IT interfacing that enables clinical integration and assures good coordination of care.

Figure IV-6 – Quality Collaboratives/Clinically Integrated Networks/Accountable Care Organizations--Fully Integrated Model



* Practices could be owners of the QC/CIN plus some contracted; varied practices being drawn from both private and employed practices are likely

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Figure IV-7 – Quality Collaboratives/Clinically Integrated Networks/Accountable Care Organizations--Payer Sponsored Model

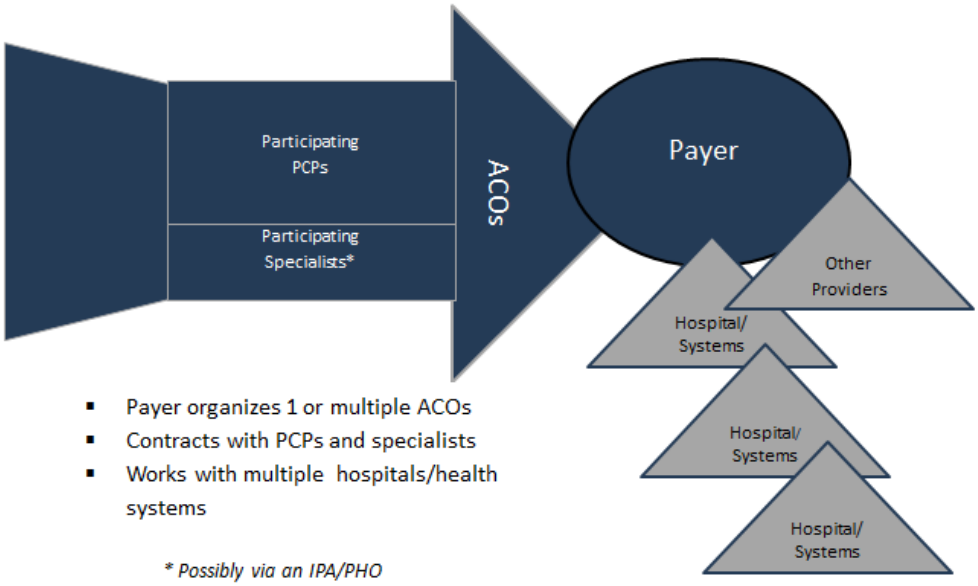

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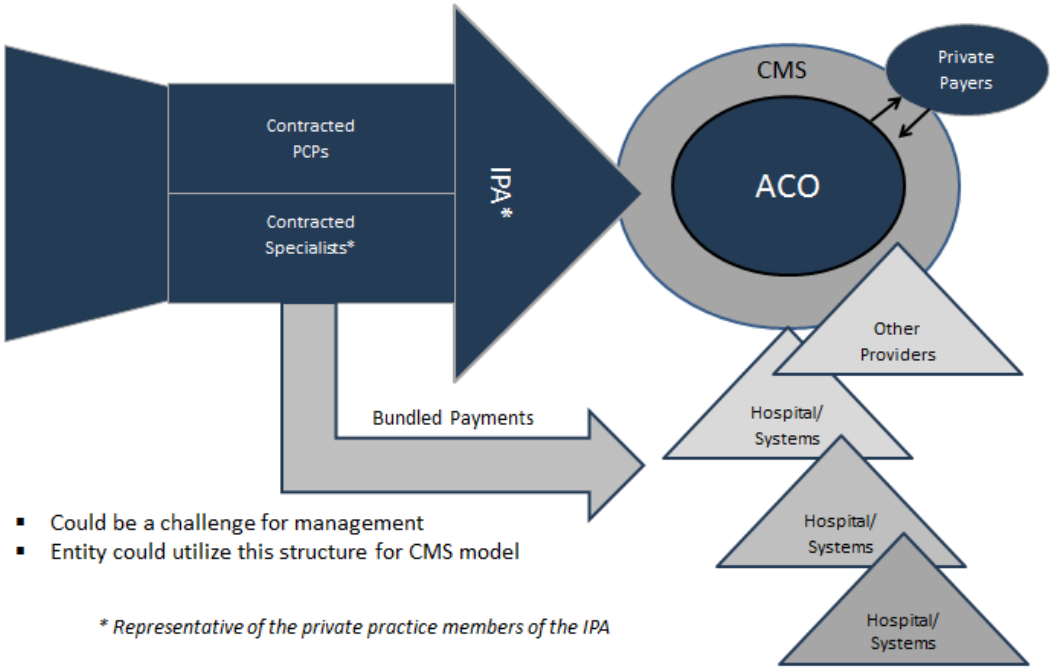
Figure IV-8 – Quality Collaboratives/Clinically Integrated Networks/Accountable Care Organizations--IPA Organized Model



Considering the above illustrations, let's drill down further on the various possible configurations and their characteristics, depending upon the primary entity that is driving the formation, at least at the beginning of the CIN's existence. The Federal Trade Commission (FTC) has allowed CINs to form by permitting primarily hospitals and physicians to align through integration. This has also enabled them to negotiate collectively without being subject to anti-trust violations, assuming certain criteria are met. This makes forming a CIN very important from a good business plan perspective (i.e., structured in such a way that the CIN has the greatest likelihood of performance and financial success), and also to make sure it is structured within the safe harbors of anti-trust legislation. Many IPAs and PHOs have been questioned in the past relative to their potential violation of anti-trust regulations, primarily because they were not clinically integrated and were negotiating fee-for-service contracts with commercial payers. While the jury is still out on CINs and anti-trust, caution should be taken to make sure that all CINs are configured to be compliant to avoid later questioning by the FTC. Thus, it is entirely appropriate and necessary to consider these virtual models as the various providers/players are considering the formation of their CIN.

IPA-Directed CIN

An IPA by definition is a grouping of independent physician practices with hospitals/health systems often also members. In this instance, the IPA (again, led by physicians) would take the leadership role of the CIN with possibly allied healthcare providers included. Often, since IPAs are physician led, hospitals and other healthcare provider assume a subordinate position. Hospitals could be a primary partner in forming the IPA. Thus, that leadership presumption position of the IPA being led by physicians may change. This model would also consider a PCMH structure as a part of the foundation of the CIN operation.

Multispecialty Group-Directed CIN

A multispecialty physician group, usually one that is quite large and has a large cross-section of representation of both primary care and specialists, could be the leader of the developing CIN. In such an example, the CIN (led by the multispecialty group) may go to a hospital or health system to contract for inpatient services.

The PHO-Directed CIN

This adopts a more traditional physician/hospital organization at the center of the CIN. The PHO creates the working relationships with both physician practices and a hospital system with generally the latter taking the leadership role in its development and often, the capitalization.

Integrated Delivery Network-Directed CIN

This model places the consortium of integrated delivery network providers at the center of the involvement and "ownership" of the CIN. As such, the integrated delivery network may employ and/or contract with its physicians and typically is led by a health system/hospital.

Payer-Directed CIN

This model focuses on a private payer's formation of a direct partnership with physicians, creating a physician-only CIN that would subcontract for hospital/health

system services. This CIN could also be constructed between IPAs and/or PHOs or multispecialty group models. The intent is for the private payer to be the partner that provides needed financial support for infrastructure development, including IT, data aggregation, and overall assimilation of the CIN's operations. It could contract with hospitals/health systems and even certain ancillary service providers that would be the conduit for the full continuum of healthcare delivery services.

Joint Venture Structures

CINs can therefore be assembled through joint venture structures. CMS requires a Medicare ACO to actually have a formal legal structure that allows that organization to receive and distribute the payments for shared savings to participating providers. Even within a joint venture scenario, private CINs have to be concerned about anti-trust and how best to form these entities legally. Examples of certain joint venture opportunities could include the following:

- An existing integrated delivery network affiliating through a joint venture and/or a merger with another health system or hospital and/or an existing CIN
- A primary care medical home practice combining with a multispecialty group practice
- A CIN merging with one or more medical homes and multispecialty group practices

These affiliations, as long as they are appropriately structured to respond to anti-trust considerations, have varied combination capabilities.

Summary

This section has considered a varied collection of models; some very basic, others more complex. The CIN is of a similar characteristic, meaning that it can be quite simply established (e.g., through a limited service IPA/PHO) or a much more complexly formed (e.g., involving an integrated delivery system, both employed and contracted physicians, other providers and even third-party payers). The industry is in a state of flux at this time with many organizations struggling to decide which model to form, or whether to form a CIN at all! Hospitals and health systems, along with physician providers, are redefining roles, responsibilities, and the way they provide care in the context of how they will be paid

or reimbursed. The suggestion is not necessarily that the practice of medicine and provision of healthcare service is changing from a technical/clinical standpoint; but in this new paradigm where volume and utilization are now less emphasized, medical providers must work together to coordinate care to keep patients healthy. As such, forming clinically integrated networks in the private sector and being a part of accountable care organizations relative to government reimbursement, will likely become more normal (or even required) than an option. Learning about the various models and possible structures is essential across all perspectives, disciplines, backgrounds, or specialties of healthcare providers.

V. Case Study

"If you have seen one CIN, you have seen one CIN" appropriately describes the structure of clinically integrated networks that currently exist throughout healthcare organizations. None are exactly alike. While all are targeted at accomplishing similar objectives, as a result of the infancy of this initiative and these structural models, each tends to approach the process slightly differently. Coker Group's broad base of healthcare clients provides the privilege of working alongside several healthcare organizations as they have begun to develop clinically integrated networks and/or other similar structures.

One example is a health system in the southeast comprising two hospitals, an affiliation with a local medical school, and a vision to be transformative in the way they deliver care. This vision began several years ago with a single physician executive's desire to form a non-governmental accountable care structure that would bring together the health system's employed physicians, the private practice physicians in the community, along with the physicians who are directly employed by the local medical school. At first, others in the organization were skeptical with respect to this vision, but they gave the physician executive the authority to move forward with this goal.

The structure they formed was "integrated delivery system" directed, requiring the physicians to sign up to participate only. Initially, participating physicians were not required to make any capital contributions. Due to the size of the employed physician network, as well as those physicians employed by the local medical school, the size of the network grew quickly, which then stimulated interest among the private physicians in the community. The end result is a CIN of approximately 500 providers, representing around 22 specialties. The make-up of the organization is approximately one-third employed, one-third private, and one-third medical school affiliated.

As with most CINs, a key challenge was (and still is) to garner participation amongst the participating providers. In the early years, there are limited (if any) funds to distribute, but future success really hinges upon the engagement of the participating providers to help better establish the clinical infrastructure of the CIN. Meaning, in this instance, the participating providers were each needed to establish various clinical initiatives that the CIN would then focus upon from a data gathering and clinical improvement perspective. This required a time investment by the participating providers for meeting to identify key clinical initiatives, refine them based upon data available, and finalize the metrics for future use. Further, due to the broad base of participating providers, gathering data was critical. This is common in all CINs (and ACOs), wherein practically all of the clinical initiatives rely upon data from the various providers. Thus, pathways had to be established in order for data to be gathered and reported in all manners (electronically and manually).

In the first year, some funds were available from various grants received by the CIN. It was decided that these funds would be used to incentivize participation. Thus, all participating providers were eligible to receive an approximate $1,000 payout for the first year, based on their performance of certain participation and data reporting activities (on clinical initiatives within their specialty). The organization was not profitable at this time, carrying a note payable on its books to the parent organization for certain start-up costs; however, the decision was made that some sort of payment had to be made to ensure that participating providers remain engaged. Otherwise, all future activities would be stymied.

Alongside its overall activities, as described above, the organization has a number of other activities in the works with various payers. This includes patient-centered medical home initiatives, bundled payment trials, and others. The organization continues to look for opportunities where it can use its existing platform to better the care in the community.

The organization is still experiencing growing pains, mainly on the operational side of the ledger. They continue to develop best practices as it relates to establishing incentive distribution models, what is necessary from a fair market value perspective, what approvals are necessary, etc. Further, they are realizing that the initial participating provider agreements they executed do not adequately cover all of the factors that the CIN has morphed into. Thus, they have to consider revisions to these agreements so that the included language matches the activity.

While it has taken some time, other key senior leaders within the organization are now on-board with the vision initially established by this physician executive. They are beginning to see the benefits of this initiative, how it is bringing key players together--

physicians, health system and payers--and how it is beginning to transform the delivery of care in the community.

The opportunities of this organization are endless and they have not yet even begun to touch upon their full potential. The same can likely be said with many other similar organizations that are beginning to find their way down this very new path.

VI. Conclusion

Clinical integration of providers encompasses working together across multiple entities to share clinical data to ensure the greatest care possible to patients; establishing best practices and processes in patient care; and employing an integrated IT infrastructure is the way of the present and the future of healthcare delivery. Still formative and continuing to define themselves, with no two models alike, the actual prototypes of clinically integrated networks are presenting positive results.

This paper has addressed the progression of physician/hospital alignment to clinically integrated networks, followed by a review of the purpose of CINs and their importance, and concluding with explanations of various CIN structures. The case study explores how one physician executive's vision, and his colleague's acceptance of it, transformed an entire organization into a successful entity that is continuing to progress in its efforts to provide better healthcare throughout its community.

But *where do we go from here?*

In Part Two of Developing an Effective Clinically Integrated Network, the topics to be addressed include the following:

- Legal Considerations
- CIN Participation Agreements
- Compensation Methodologies to Participating Providers
- Aligning the CIN with Organizational Strategic Goals

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