Developing an Effective Clinically Integrated Network

Part Two

White Paper

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The formation and operation of a Clinically Integrated Network relies on a number of components in its legal structure and may take many forms. The legal structure of a Clinically Integrated Network (CIN) can be in the form of a joint venture, and sponsored by payers, other integrated systems, PHOs, multi or single specialty groups, IPAs, as well as hospitals.

Each of these legal structures will require legal documentation to support its particular structure and purposes. All of these organizations, regardless of form, will need to obtain a commitment from the physicians who are part of the organization to participate in its activities and its operations. Specifically, each physician will need to agree to perform in ways that are required for the CIN to achieve clinically integration and/or financial integration. Additionally, the physicians will need to perform in ways that are consistent with the payment systems that are involved. The agreements between physicians and CINs are called Participation Agreements.

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Creation of the Participation Agreement between the physician and the CIN calls for consideration of a number of factors. The form of the Participation Agreement will be customized to the arrangement. For example, a group practice subsidiary model will normally create a Participation Agreement that is an addendum to an existing employment agreement. Other forms of CINs will utilize a Participation Agreement that is separate from any other existing employment or independent contractor arrangement.

The contents of the Participation Agreements must include a sufficient commitment from the physicians in order to pass antitrust muster. In order to do this, the physicians must commit to being sufficiently integrated either on a clinical basis or on a financial basis. The Federal Trade Commission has published "safety zones" that give guidance and meaning to the terms clinical integration and financial integration.

Additionally, the agreements should compel the physicians to adhere to protocols adopted by the CIN. These protocols would normally include adhering to evidence based medicine

activities, assuring access to the physician by the enrolled patients of the CIN and other related features. The contents of the Participation Agreements also would cause the physicians to collaborate on the metrics of quality and performance that are adopted by the CIN. The information technology infrastructure of the CIN will also be coordinated with the requirements within the physician's Participation Agreement. These agreements will require the physicians to collect and share data with the CIN and their fellow practitioners, subject to appropriate HIPAA safeguards. In summary, the physicians' Participation Agreements will cause the physicians to actively engage in the business enterprise of the CIN and to support its business purposes.

One of the big decisions every CIN faces is whether to charge an entry fee to physicians who wish to enter Participation Agreements. A conservative reading of the Federal Trade Commission safety zone would suggest that paying a fee is helpful and conservative in that it helps indicate that financial integration exist among the participating providers. However, it is not mandatory to charge a fee. In order to encourage physicians to agree to participate and to help all physicians feel like they are equals, many CINs do not charge an entry fee to the participating providers. Other CINs need capital in order to pay for information technology and other business resources that are necessary to their operations. By charging a large number of physicians a modest fee, the CIN can accumulate a substantial amount of capital that will help pay for its business infrastructure. Some CINs have begun charging annual dues or maintenance fees. Some CINs are partly owned or entirely owned by physicians. In these ownership situations, it is necessary for the participating physicians to purchase their ownership interest. Please note that purchasing an ownership interest in a CIN differs from paying a fee to be a participating provider. A securities offering will usually be necessary to establish any ownership arrangement of this type.

Another key consideration is whether to allow participation by medical groups, or by individual physicians. If participation by groups is permitted, the CIN will need to have authority established in the participating agreement to "reach through" the group and enforce certain provisions against an individual physician. For example, a CIN may want to terminate one non-performing physician, but retain the rest of the group. Other contractual provisions will need to be artfully drafted to accommodate group participation versus. individual participation, especially with regard to distributions and compensation.

The degree of commitment made by the participating provider to the CIN is also determined by the Participation Agreement. Participation Agreements may require that the physician participants only participate exclusively within that CIN. These exclusive provider arrangements are necessary for primary care physicians who are participating providers in Accountable Care Organizations within Medicare. When CMS created ACOs, one of its fundamental principles was that the primary care physicians could only be in one, single ACO.

However, specialists are permitted to be in more than one Medicare ACO. There is a trick involved in this too, however, because the way CMS has defined primary care physicians is based on the CPT codes that are predominantly used by the medical practitioner. The result of this is that some physicians who think of themselves as specialists may in fact be defined as primary care physicians by CMS in ACOs. If a CIN is not participating in the Medicare ACO program, then it is up to the CIN to decide whether it will require physicians to be in their CIN exclusively or an open structure that will allow physicians to be in more than one CIN. Some CINs have followed CMS's lead and are requiring certain kinds of practitioners, for example, primary care physicians, to exclusively be within their CIN but permit other specialists to be in multiple CINs. Some CINs have a completely open architecture that permits all participating physicians to be in as many CINs as they choose. One result of this decision is that in the determination of the distribution of profits from the CIN (or incentive payments) to the physicians, those physicians who participate in more than one CIN will dilute their opportunity to receive payments from any one CIN.

Another important element in every Participation Agreement is the right to terminate the agreement. On one hand, the CIN needs to be able to identify their participating physicians to employers and payers. A payer or employer who is deciding to enter a contract with the CIN is going to base that decision, at least in part, on who is in that "network." If the participants can terminate with short notice, the CIN is going to be less attractive to a payer or employer. Therefore, in order to be effectively marketable, it is usually necessary for participating physicians only to be able to terminate once per year or with at least significant advance notice. If a physician enters an agreement, under the Stark Law, the agreement must be for one year or more. If the physician terminates in less than one year, the Stark Law imposes a waiting period before the physician can rejoin the CIN.

Every organization that enters a CIN has to be aware that if the physicians are within the CIN but not actively participating, there is very little the CIN can do to compel performance. Obviously, those who are not participating actively will receive reduced distributions of incentive payments or compensation. Ultimately, it may be necessary for the CIN to attempt to engage in corrective activities, or penalties, or ultimately termination of providers who are not participating as needed.

The degree of authority delegated to the CIN by the participating physician will also be defined within the agreement. In most cases, Participation Agreements will authorize the CIN to enter payer agreements on behalf of the physician. These agreements could be with payers, self-funded organizations, and large employers. If the CIN is not the exclusive entity through which the participants contract with payers, a system or process has to be established for dealing with the same payers with which the physicians contract for other purposes. Participating

providers will also need to commit to engage in the collection and reporting of data that the CIN needs to qualify for performance-based payment systems.

In order to qualify to be a participating provider in a CIN, the physician will need to evidence credentials in the same way that they would need to become a member of a hospital staff or a participant in a payer network. During the term of the Participation Agreement, participating physicians will need to provide notice to the CIN of any significant changes in their status. They will also need to make available access to medical records, subject to appropriate HIPAA compliance and protections. The participating physicians will need to maintain their records as required by applicable payer contracts and statutes of limitations, and the physician will need to maintain all insurance coverages that are normally associated with the operation of a medical practice.

The Participation Agreement will also recite the responsibilities and the obligations of the CIN, itself. The Participation Agreement will state what the CIN's operations are and how they will be conducted. It will indicate the kind of information technology that will be developed and operated by the CIN, in what kind of performance and payment programs it intends to engage, and how distributable cash will be determined. In most cases, the CIN's business model will cause the CIN to receive revenue from payers, pay its own operating expenses, develop reserves, and then have available cash for distribution.

If a CIN requires exclusivity from its participating providers, the CIN may also require some form of restrictions on future practice or non-competition agreement or non-solicitation agreement as part of its terms. The enforceability of these agreements is highly customized based on the terms of the agreements and local law. In many jurisdictions, these kinds of restrictions are disfavored.

In summary, a Participation Agreement between a CIN and a participating physician includes most of the same elements as any other network Participation Agreement that a physician would enter with a payer. However, because of the unique nature of the business of CIN, this contract will be more sophisticated and more complicated than other network agreements.

II. LEGAL ASPECTS OF PARTICIPATION AGREEMENTS

Physician Participation Agreements live in the narrow intersection of five different legal and regulatory regimes. The laws involved include the Stark law, the anti-kickback statute, federal tax exemption laws, antitrust laws, and state insurance laws. The regulatory bodies enforcing these laws include CMS, the IRS, the Federal Trade Commission and Department of Justice, and state insurance regulators. The existence of this large number of laws and regulatory bodies affecting the Participation Agreements makes it necessary to include contractual

provisions that address certain fundamental provisions of all of these laws in order to be compliant. Additionally, these same laws present a series of options or opportunities for different contractual provisions that optionally may be included in a Participation Agreement.

If an organization decides to become a Medicare ACO, it is possible to obtain waivers from the Stark law, the anti-kickback statute, the antitrust laws, and from concerns about an organization's tax-exempt status. These waivers are a form of "get-out-of- jail-free" card that lifts the applicability of these laws. These waivers are "self implementing," meaning that properly structured Medicare ACOs do not need to file applications for waivers, but may simply proceed with their business with a degree of comfort that they would be exempt from challenge if they establish proper policies and procedures. In contrast, CINs that are not Medicare ACOs do not enjoy the benefit of the waivers and must structure their arrangements in ways that are compliant and consider whether to seek specific private letter rulings or other forms of regulatory approval that will allow them to operate their business successfully.

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Antitrust

Most physicians and hospitals in a geographic market would normally be considered to be competitors. If they join together in an unbridled effort to raise prices, that is a violation of the antitrust law and would be viewed as collusion. They could also attempt to reduce the quality or volume of care that is delivered or reduce competition, all of which would be viewed as harmful to the market place. Accordingly, the effect that a CIN or ACO has on the market place is an important consideration from the antitrust point of view. The Federal Trade Commission would weigh the relative benefits and efficiencies delivered by an ACO or CIN and weigh that against the anti-competitive affects that would be viewed as being harmful to the consumer on the market place.

The Federal Trade Commission has published the antitrust safety zones for health care. Within them, the safety zones indicate that organizations would be safe from antitrust challenge if they achieve sufficient "clinical integration" and/or "financial integration." Financial integration may include initial investments, annual dues, incentive payments, withholds, and shared risk, which may take many forms. Clinical integration involves aligning medical practice activities with quality of performance, outcomes, and value. Both clinical and financial integration will normally demonstrate efficiencies and both of them will normally require an

actual investment of both human and financial capital by all parties to the CIN. In order to avoid antitrust challenge, CINs need to evaluate and modify practice patterns. The CINs will need to create interdependence among physicians in order to help control costs and help insure quality. It will be important for CINs to monitor and control utilization. Additionally, although it can be a controversial subject, CINs will probably need to be selective in choosing physicians who are truly interested in focusing on efficiencies and enhancing the quality of care that is delivered in their market.

Antitrust concerns will be raised if the CIN inappropriately shares competitively sensitive information among its participants. It would be inappropriate for those involved to collude in their provision of health care. Participants in a CIN should also be careful about providing or creating any links between their activities in the CIN and other activities in which they may engage. Tying or linking arrangements are generally suspect.

In order to avoid or minimize these concerns, CIN's should focus on achieving clinical and/or financial integration, and focus on producing efficiencies.

The Anti-kickback Statute ("AKS")

The anti-kickback statute prohibits knowing or willful payments of any kind of inducement in return for referrals. Therefore, in order to avoid being attacked for a violation of the anti-kickback statute, it is necessary for the CIN to make sure that payments are not made with the intent to induce referrals and also not made with the intent to limit medically necessary services for patients. Thankfully, safe harbors are available. The terms of the safe harbor that is used the most is generally known as the "personal services and the management contracts" safe harbor. This requires that the physician Participation Agreement meet seven standards:

1. The agreement must be in writing;
2. The agreement must describe all of the services to be provided;
3. If the agreement is periodic, sporadic or part-time, it must specify exactly the schedule of the intervals;
4. The agreement must be for not less than one year;
5. Compensation must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals,
6. It cannot involve the counseling or promotion of a business that violates state or federal law, and
7. The aggregate services do not exceed those reasonable necessary to accomplish the commercially reasonable purposes of the agreement.

When parties enter these agreements, determining what is set in advance, fair market value and commercially reasonable are the most difficult aspects of the agreements. Normally, CINs will engage a third party valuation organization to come in and review and comment upon the terms of the Participation Agreements and the distribution structure of the CIN in order to assure that the agreement is properly set in advance, fair market value, and commercially reasonable.

Stark Law

The Stark law prohibits a physician from making a referral of a designated health services. Stark law is one that has a zero tolerance: the law must be met or an exception must be found, or it is illegal. Participation Agreements may fit into any one of several different Stark law exceptions including: bona fide employment, physician services, personal services arrangements, physician recruitment and retention, isolated transactions, and risk sharing arrangements. It is necessary for the parties to very carefully analyze the specifics of the CIN Participation Agreement to properly identify the correct Stark law exception that is going to be utilized. In order to meet these exceptions, the CIN Participation Agreement has to be structured to include provisions that are typically very similar to their requirements of the AKS safe harbor. Stark law exceptions normally require a written agreement of one year or more that does not vary compensation based on the volume or value of referrals, and the compensation must be set in advance, commercially reasonable, and fair market value. Again, this is a zero tolerance statute--that the law must be met or it will result in a violation.

Tax Exemption

If a tax-exempt hospital is involved in the CIN, it will be necessary to take steps to assure the protection of the hospital's tax-exempt status. No hospital will be willing to put its tax-exemption at risk in the formation of a CIN. Under Internal Revenue Code Section 501(c)(3), it is prohibited to have inurement or private benefit to individuals who are associated with the CIN. This affects all compensation arrangements between hospitals and physicians, including those of a CIN that involves a hospital. Similar to Stark and anti-kickback, payments that are commercially reasonable and consistent with fair market value are typically viewed as being acceptable. Again, it is necessary to obtain a third party opinion of the arrangement in order to be assured that the arrangement is appropriate. To further enhance the protection against IRS challenge, the CIN should avoid entering into unrelated businesses that would generate taxable unrelated business income. If the hospital is a major sponsor or owner of the CIN, it will also be necessary to include provisions in the documentation that recite that the CIN's principal purpose is consistent with the charitable mission of the tax-exempt hospital.

State Insurance Law

State insurance laws generally are going to regulate organizations that accept some form of financial risk for the delivery of health care. Additionally, the risk that has been accepted has to be the risk associated with other parties, not for itself. For example, if a hospital accepts capitation from a payer and the hospital's capitation only covers goods and services delivered by the hospital itself, that is not generally viewed as an insurance risk. However, if the hospital accepts a capitation payment for its own goods and services and those of other participants in the CIN (like physicians), that in many states will be viewed as an insurance risk that is subject to state regulation. Although there have been a variety of attempts to make insurance regulation at least somewhat uniform, the fact remains that the United States is a crazy quilt of 50 different sets of laws. Accordingly, when the CIN is being established, if any form of financial risk is being accepted, the CIN will need to evaluate whether the risk bearing arrangement is one that is covered by state insurance laws. If it is, the organization will need to take steps to obtain regulatory approval, licensure, and possibly qualification as a health insuring corporation with appropriate financial reserves.

In summary, the creation of a CIN involves not only the formation of a legal entity, and the execution of Participation Agreements, but also involves compliance with at least five significant laws and regulations and regulatory regimes. It is a situation where an ounce of prevention is worth a pound of cure. Good planning and preparation for meeting these regulatory requirements is not only extremely helpful and avoids unwelcome surprises, but is also absolutely necessary.

III. Compensation Methodologies to Participating Providers

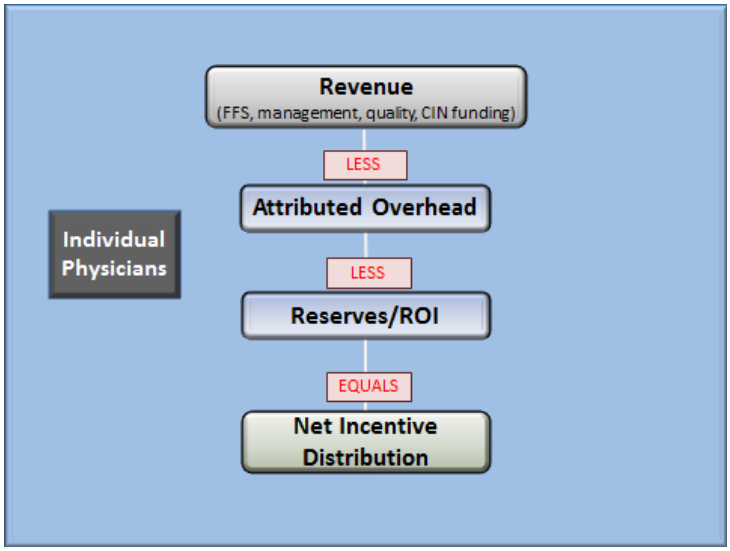
In current physician compensation models, productivity is a major focus driving physician behavior. In the era of clinically integrated networks, the compensation paradigm is shifting. Productivity will remain important, in that physicians will need to produce enough to meet volume requirements for overhead and related costs; however, going forward, quality of care and evidence-based results will become more of a focal point. To achieve these desired results, physician compensation incentives will need to be aligned with the goals jointly determined by the providers in the clinically integrated network. In this section, we will examine the types of payments being utilized in physician compensation inside a clinically integrated network.

Compensation flexibility is a key hallmark of a clinically integrated network, in that it can function under all payment models. A clinically integrated network is able to function under the current fee-for-service arena with pay-for-performance incentives. In addition, as a

clinically integrated network matures, it should transition to increased levels of risk with matching payer increases, which can be shared with providers.

Two methodologies of payments cover the spectrum of clinical integration compensation. First are the physician-specific models, which utilize payments such as fee-for-service, management revenue, and performance-based payments. While a clinical integrated network negotiates with the payers for their member's services, fee-for-service payments received from payers may be distributed to participating providers in amounts reflecting the amount of payments received by the network with respect to the provision of service by such participating providers. Medical management or consulting fees received from payers may be distributed to participating providers on a per member per month basis consistent with the amounts received by the clinical integrated network. In addition, payments based on the performance of quality measures, outcomes and value like gain sharing, shared savings, bundled payments, and similar payments received from payers by the network may be distributed to participating providers consistent with their performance under such programs. The revenue types discussed above, along with clinically integrated network expenses allocated to the individual physician compensation formula, are detailed on Figure III-1, below.

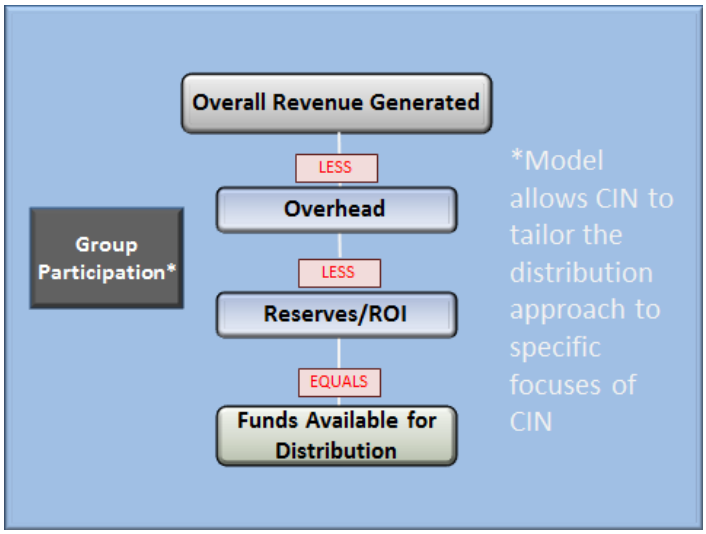
Figure III-1. CIN Incentive Methodology for Individual Physicians



Group participation serves as the second incentive methodology for the clinically integrated network. Similar to the individual physician method, the group participation method has expenses of overhead and reserves/ROI. However, the revenue in the group participation model has no individual component. Similar to the individual physician model previously described, multiple types of revenue (fee-for-service, management, quality and CIN funding) could be negotiated by the clinically integrated network. The key difference is that in the

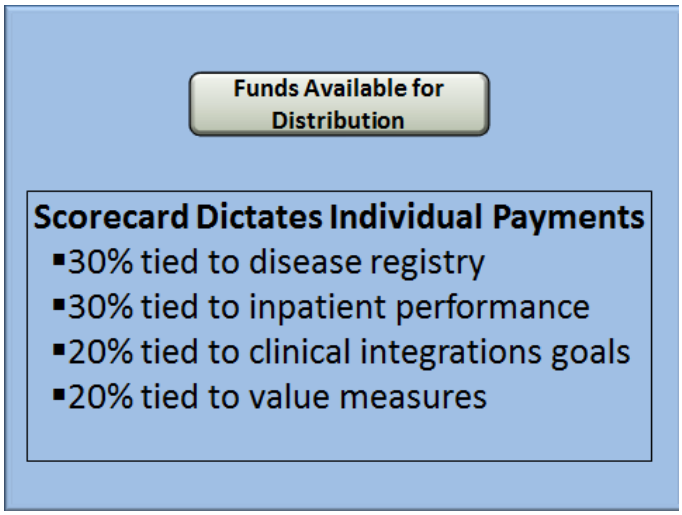
group participation model the revenue generated is consolidated by the clinically integrated network, and then after the mentioned expenses are deducted, a pool of funds are available for distribution to the physicians of the clinically integrated network. We illustrate the overall group participation model in Figures III-2 and III-3 below.

Figure III-2. CIN Incentive Methodology for Group Participation



The group participation model allows the clinically integrated network to tailor the distribution approach to specific focuses selected by the network. Examples of specific areas of focus are illustrated in the following scorecard.

Figure III-3. Sample Scorecard of Incentive Focus of CIN



Various measures are identified as key indicators of success for the shared clinical integration goals. Typically, these measures focus on quality, outcomes, and performance. These are represented and administered through group participation models. Examples of such group goals would include population management of chronic illnesses such as:

- Diabetes
- Coronary artery disease
- Heart failure
- COPD
- Hypertension
- Asthma

Likewise, they could participate in a disease registry program. Other areas of focus involving the hospitals would include length of stay of inpatients and the 30-day readmission rate. Lastly, quality outcomes will be an overarching goal of the network. This group participation model allows the clinically integrated network to tailor the distribution of compensation to specific focuses of the network.

Regardless of the compensation methodology chosen by the clinically integrated network, appropriate measures must be taken to ensure that any payments between the network and the participating providers remain within fair market value limitations and are commercially reasonable. The distribution methodology in place will have a direct impact on the fair market value of the provider compensation plans.

Quality and cost, or value in economic terms, are key components that need to be a part of every organization's goals.

Specific metrics must be established for assessing physician performance, which generates the compensation. Participating physicians can use established programs like Accountable Care Organizations, Shared Savings Program, EHR Incentive Program, and the Comprehensive Primary Care Initiative to develop the networks specific metrics. Standards that emphasize the importance of ensuring utilization of metrics that are relevant to the clinically integrated networks' mission, goals, and objectives must be created. In addition, the measures chosen should be properly weighted based on their relative importance to the goals and objectives of the network while being objective in their scoring. This would be accomplished by utilizing quantitative scoring methodology. As a result of these compensation scoring needs, the clinically integrated network must have the proper ability to track data and be able to report on the metrics being tracked.

Development of the payment methodology should involve administrative, legal and physician representatives so that all the constituents can offer insights relative to the potential compensation methodology.

Policymakers increasingly are looking to payment reforms as a means to promote greater clinical integration. Hospitals and physicians share many goals, but their priorities often diverge. Industry consensus is that provider compensation incentives must align the clinically integrated networks system goals. Each clinically integrated network must design an incentive model to meet its needs.

IV. ALIGNING THE CIN WITH ORGANIZATIONAL STRATEGIC GOALS

This section addresses aligning the clinically integrated network with organizational strategic goals. Organizational strategic goals may encompass many objectives including reducing overall healthcare cost, improving the quality of care, collaborating with other providers, capturing market share, developing contracts with payers, and others objectives that serve to add value.

The first step to achieving organizational goals is to begin with the end in mind. Where are we trying to go and who can help us get there? Leaders of the CIN must identify the goals through a structured process that involves all of the stakeholders in their development. This process creates buy-in for the participants and provides effective and attainable objectives that reflect the reality that front-line health care professionals face.

The next step is to refine the goals so that they can be monitored and measured to ensure that progress is made. Additionally, an incentive system needs to be put in place that will recognize progress in achieving the goals and reward the clinical and administrative staff and management who put forth the effort in achieving the objective.

Finally, organizational strategic goals need to be reexamined on a periodic basis to ensure that they remain relevant in the ever-changing healthcare context. As time passes and the organization develops, new goals will emerge to replace old ones and the process will repeat itself. An organization also has the opportunity to raise the bar and use previously achieved goals as a baseline for future improvement.

What are organizational goals and how should they be determined? One approach might start with the guiding principles of medicine found in the Hippocratic Oath to help determine wider goals. Prescribing regimens of good for patients, only acting for the good of patients, avoiding ill-doing and maintaining confidence are all well-known standards for physicians who have

taken the Oath. These guidelines can help guide the development of the goals and ultimately the goals themselves.

Quality and cost, or *value* in economic terms, are key components that need to be a part of every organization's goals. Not every patient can receive a comprehensive examination, testing, and procedure regimen with multiple specialists exhausting all possible avenues. There are simply not enough financial or medical resources to support such an approach. However, through collaboration and information sharing, each part of the medical value chain can make the highest quality decision that is most effective for a patient at the minimum level of cost to achieve the objective. For patients who suffer from multiple conditions and who receive medical care in a CIN, participating physicians can access information systems to leverage examination conclusions, reduce duplicate testing, avoid dangerous drug interactions, and narrow down potential diagnoses. Effective information systems help in this objective and can improve primary care and specialist information sharing. Enlarging the number of providers, hospitals, and clinics that are available in the same clinically integrated network is also important for high-quality, cost-effective care in that it allows patients to more easily utilize the network and it improves information sharing. As the ties between disparate providers in multiple disciplines improve through these efforts, other goals, such as market share expansion and leverage with payers will be the natural byproduct.

Determining goals is an important part of the process that requires extensive consideration and buy-in given the complexity of a network and the need for all parties to align themselves with the goals. While it may provide for a rapid implementation of the CIN's objectives, goals promulgated from the top down may not fit the reality of the organization. Additionally, there may not be clinical and administrative buy-in given limited participation from physicians and hospital staff. A process should be developed where the stakeholders that will implement the goals of the CIN are also involved in the process of developing the goals. Group meetings with medical directors and key stakeholders with senior network management should be conducted over a period to gather input on developing the goals and key considerations required to achieve them. Having the stakeholders who will implement the system also help develop the incentive and performance management system on an equal footing with senior management will also ensure buy-in with the next important step in the process.

Refining the network's objectives also plays an important role in ensuring that the goals are reasonable, attainable, and can be monitored and measured. The obvious aim of any organization is to deliver higher quality healthcare at lower cost, but what does this mean? How will this goal be achieved? Information systems can also help with the analysis of costs and quality helping management and physicians focus their limited time on areas ripe for improvement. Benchmarking supply costs to national averages can show if there is opportunity to lower costs through consolidating suppliers or taking a more aggressive stance

with device and pharmaceutical manufacturers. Patient outcomes can be tracked over the long-term to determine what care is most effective and what is not. As the goals are refined, stakeholders must create quantitative and qualitative systems to measure improvement and to ensure that progress is being made. Some areas of measurement may include patient returns to the hospital within a fixed number of days after discharge, repeat of patient complaints, and effectiveness of preventive efforts. As these are tracked and benchmarked, an incentive system can be created for improvements to the baseline.

Incentive systems are important as they help define the goals of the organization and reward the attainment of these goals. The incentive measurement system should observe the following:

- The number of goals should be limited
- Goals should be quantitatively measured
- Goals must be set at a level where they push the organization to achieve more than they have in the past but also attainable by a majority in the organization.
- The reward from achieving the goals must be material to provide sufficient incentive.

The goals behind the incentive system should find a balance between providing a broad enough mandate to capture the necessary outcomes, but also avoid a focus on the minutia. Four to six objectives are optimal. This is a range where physicians and administrators in the CIN can devote sufficient focus on achieving the necessary outcomes and see a direct correlation between their efforts, achievement of the CIN's objectives and a financial reward at the end of the measurement period.

As time passes, the environment changes, previous goals have been achieved or have been successfully implemented as part of the network's daily routine, and new standards come into play. The old goals and incentive systems implemented to achieve those goals may no longer be relevant. When this occurs, goals need to be refreshed and the process must begin anew. Some catalysts that might drive a refresh of the process could include a change in health care delivery systems, such as the upcoming requirements of the Affordable Health Care Act and the exchanges that they will produce. Demographic changes in the patient population served also will force the CIN to navigate a different course to adapt to the new population's needs. Changes in reimbursement could also be a driver for adjusting the organization's goals as well as a desire to raise the bar and use past performance as the forward-looking baseline. As organizational goals progress through their lifecycle, the goal identification, development, and incentive system must be repeated to enable the CIN to be a dynamic organism that is consistently improving the value and quality of the patient services it provides.
This chapter has discussed the alignment of the CIN with its organizational goals. This multi-step process that requires the organization to identify and refine goals based on the

environment in which the CIN operates. As this first step progresses, all stakeholders should be involved in developing and refining the goals. Involving the entire group creates buy-in and helps the organization identify pitfalls that may not be clear at the senior levels of the organization. An incentive system must also be present in order to measure and reward those involved in the attainment of organizational objectives. This process is continuous and requires periodic review to ensure that the goals remain relevant and serve all the stakeholders in the clinically integrated network.

V. Conclusions and Next Steps

Previous sections have addressed some of the key components that hospitals and health systems should consider when developing their strategy related to clinically integrated networks. Still, many questions remain and organizations must address numerous items before launching a CIN strategy. So, what are the next steps leaders must take?

The first successful achievement that readers can already celebrate is that by starting this important process with detailed and meticulous planning steps, they are one step--a major step--ahead of the many organizations that have perhaps been a little too hasty in pursuing the development of a CIN. Hospital executives are aware of how challenging and comprehensive a successful CIN strategy must be, and how significant it could be--both positively and negatively--for the future of their organization. So, what is next? Assuming the majority of readers represent a hospital or health system that is considering a CIN strategy, it is also quite possible that the first step is proving to be the most challenging. Meetings and internal discussions can be coordinated to explore the legal, regulatory, financial, and other strategic factors discussed in this paper. However, meetings and discussions are more of those early-on efforts that lay the groundwork, before taking actions that are more significant.

Launching a CIN initiative generally calls for the expertise of those who have worked through the steps and stages with other organizations. For example, bringing in an experienced team from the right consulting firm will undoubtedly prove to generate a marked return on investment, and will most likely result in achieving greater success throughout the process in one way or another. This may come through different degrees and sources of value, such as quicker realization of financial returns; critical expertise that would have otherwise resulted in losses; access to resources that would have otherwise not been available internally; and/or, the difference between success and failure of the entire effort.

Collaborating with a consulting firm should be a positive experience for your organization. However, in order to make this positive experience a reality, it is critical to select with the right firm. While there are many determinants for choosing the ideal firm, there are some key qualities to look for in the process, such as the following:

- Experience implementing successful CIN strategies elsewhere
- Specialized expertise relative to the key components of a CIN (i.e., physician relations, financial management and funding strategies, physician compensation, operations, governance, structuring, etc.)
- Knowledge of critical variables affecting CINs (i.e., financial operations, operational considerations, physician alignment, technology variables, etc.
- Team of diversified resources to call on throughout the process
- Understanding of the healthcare regulatory and policy landscape, which will play a key role in any CIN strategy and implementation
- Access to the firm's senior level leadership and access to the firm's full resources throughout the duration of your partnership
- Ability to successfully meet your desired timeframe and achieve the objectives of your organization with this particular initiative
- Effective allocation of senior level experience and junior associates
- Efficiently-structured project management approach and team structure
- Reputation for honesty and integrity in everything they do

In addition to engaging qualified consultants to assist in developing the organization's CIN, it is also essential to retain legal counsel who can advise on legal and regulatory matters that will undoubtedly arise throughout this process. While most health systems will have an established relationship with its counsel, it is important that the leaders of this initiative have access to attorneys that bring specific knowledge and experience related to CINs and clinical integration in today's healthcare marketplace. As the market and policy landscape have evolved quickly in these areas, a world of nuances and unique variables have followed. As such, it is critical that consultants and attorneys advising on such matters be familiar with the range of variables that are likely to arise throughout the CIN development process.

But even still, consultants and lawyers will ultimately not be responsible for the overall success and failure of such a major initiative like developing a CIN; that will come down to the organization and its leaders. Moreover, the impact of these efforts will be felt for a long time by the patients and communities that the organization serves. As such, it is critical to approach this process with the appropriate expertise, resources, assistance, timeframe, and overall expectations.

The first step is to develop the confines of the organization's CIN strategy. What are the goals and objectives? Who are the leaders, and what are the expectations from the various stakeholders, such as the management team, board, medical staff, and community? Is there a timeframe for achieving the overall mission? What is the budget and what are the expectations in regards to the financial returns of this initiative? These are just a few of the questions that must be answered before an organization is ready to engage in this arena. The

issues can be addressed in the CIN "business plan" or perhaps more appropriate, the "strategy document", which is necessary for beginning this process. During this phase, the selected consultants and attorneys will be invaluable in performing the heavy lifting and in ironing out of necessary details, which will be critical for moving forward into the next steps.

Once the critical items are addressed and the strategy document is drafted, the next step is to establish the key performance indicators (KPIs) that will guide the organization throughout the process. The KPIs are the specific metrics by which the success of the initiative will be measured, and they will gauge the effectiveness of not only the strategy, but also the team and approach to implementing the strategy.

Some might argue that spending valuable time on a strategy document for how the organization is going to develop a CIN strategy and outlining a list of KPIs is excessive. Undoubtedly, considering these factors will be one of the most significant initiatives many health systems will pursue in today's marketplace, the impact of such an initiative will be great, and it will be felt for many years. For some hospitals, this venture could make or break the organization. For others, this initiative may launch the organization forward within its respective market, giving the advantage needed to edge in front of the competition. Then there are those health systems where this will be just another of the many major initiatives they will pursue in any given year.

CINs will be a key component of the future healthcare landscape.

The one thing that will remain for all hospitals and health systems, however, is that CINs will be a key component of the future healthcare landscape. Thus, successfully developing an effective strategy and launching it into the marketplace will lay the foundation for how an organization will adapt to the further changes and evolution that the healthcare market will experience in the future. As such, a lot depends on doing this right the first time around, even if the broader systemic impact and big picture perspective are not immediately evident. There will also be those organizations that fail to achieve the necessary success in their CIN strategy, and these cases will ultimately come at great costs to many.

With these and other critical elements of the strategic planning process complete, the organization should now be ready to launch the CIN strategy and development process, using the strategy document as its guide. This will help in guiding the CIN leadership, along with their consultants and legal counsel, towards developing a more detailed playbook for the CIN. This is where the CIN leadership team will come together to develop a "roadmap" for the future CIN.

The mapping process will begin that will include details like specific structures for the CIN, composition of the physician participants of the CIN, pro forma financials for meeting the desired and needed financial objectives, etc. The deeper the details of this process, the more will be uncovered regarding the need to create sub-committees and teams to address variables that will inevitably arise throughout that process.

From this point, the process can go any number of different directions, because the CIN will have reached a point where it will be taking on a life of its own. The CIN will now be a critical component of the organization, and as such, it will dictate the future path and options that the management team will ultimately pursue. In thinking about what it would look like from this vantage point, it is not difficult to understand just how critical it is to form the necessary foundation. This foundation will have ultimately allowed the team to reach that vantage point, and it will become even more critical with each new peak reached throughout the overall journey.