FEATURE STORY

Daniel Grauman
John Harris
Idette Elizondo
Sean Looby

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developing a CIN for strategic value

Having a clinically integrated network allows a health system to align with independent physicians as a single entity that can build or retain valuable market share.

AT A GLANCE

- Clinically integrated networks (CINs) allow health systems and independent physicians to join in a mutually beneficial effort to adapt to new payment models.
- Key issues during planning for a CIN include organizational structure and governance, payer contracts, and incentive funds distribution.
- In assessing the network's potential financial impact, CIN planners should think in terms of managing total cost of care rather than in terms of revenues for care delivered.

Many hospital and health system leaders continue to examine whether or when to embrace value-based payment models, such as accountable care, bundled payments, or shared savings/shared risk. Some fear the financial consequences of driving down utilization while still being paid on a volume-based, fee-for-service basis for much of their care. Others see the need to keep up with competing hospitals or physician organizations that appear ready to drive down utilization regardless.

A critical question in this dynamic, competitive environment is whether to include employed physicians, independent physicians, or both in new payment models. If shared savings or other incentive payments represented the primary value available in these new models, there would be considerable flexibility in deciding whom to include.

However, new payment models are likely to have greater value in allowing hospitals and health systems to build or retain market share (Harris, J., and Hemnani, R., "The Transition to Emerging Revenue Models," *hfm*, April 2013). That means engaging independent physicians is likely to be a central focus of implementing the new models.

Enter the clinically integrated network (CIN), an organizational structure that aligns hospitals and physician providers through the creation of a new, jointly governed entity. Within a CIN—a single, organized network—independent physicians, hospital-employed physicians, and the hospital work together to govern the entity, design care initiatives, improve data and information sharing, measure quality outcomes, and garner rewards from payers for managing quality and cost.

Benefits of Clinical Integration

Through CINs, health systems can improve patient care and engage physicians who are interested in focusing on population health and improving

quality. These steps can increase hospital market share by attracting new patients and physicians and reducing leakage from patients and physicians who otherwise might be inclined to split their allegiances among competing organizations.

For physicians, a CIN offers a collaborative model in which to:

> Respond to new payment arrangements
> Preserve independence
> Improve coordination of patient care and clinical data sharing
> Work collaboratively with hospitals to leverage existing IT capabilities, thereby helping to minimize incremental IT costs
> Earn rewards for improving care quality and cost-effectiveness

Primary care physicians may consider a CIN as one of multiple opportunities for revenue enhancement, while specialists and hospitals typically are interested in securing referral sources and market share during times of tightening utilization.

For hospitals, a CIN provides a structure in which to:

> Align with independent community physicians
> Improve management of cost, quality, and population health
> Pursue opportunities to work with key payers while proactively responding to changing policies and payment models
> Offset portions of their utilization losses by sharing in the savings achieved by the CIN

Achieving clinical integration through a CIN also provides a means for organizations to comply with antitrust regulations regarding arrangements between independent providers. CINs can be hospital-owned, thus enabling the hospital, rather than independent physicians, to shoulder the bulk of the up-front capital investment and operating expenses. Typically, when the CIN begins generating payer incentives, the hospital can recover these costs before the CIN distributes incentives to the hospital and physicians.

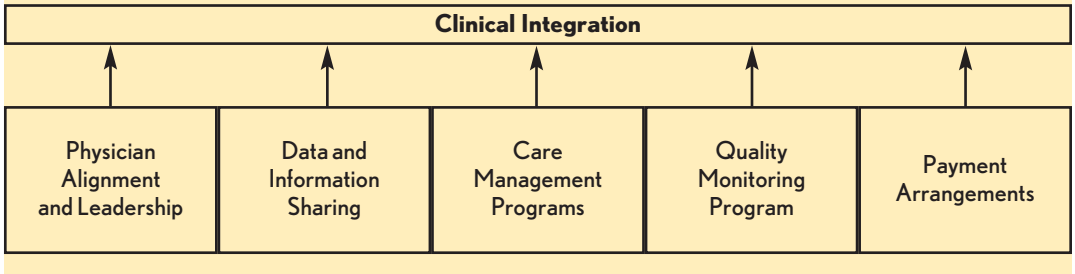
Despite the potential benefits of CINs, their development poses various challenges and must be tailored to the specific hospital and market. Healthcare leaders can undertake a number of strategies to effectively plan a CIN, address key issues that arise during the development phase, and proactively assess the CIN's financial impact.

Planning and Engagement

A focused effort of at least six months is required to plan and design a CIN. Having a physician-led steering committee, with a mix of employed and independent physicians and hospital representatives, ensures all perspectives are considered. Strong representation of independent physicians, particularly those in primary care, may be vital to attract this stakeholder group when the organization is launched.

The planning process should respond to all voices and concerns along the way. By dispelling myths and focusing on key issues, committee members can ensure planning progresses steadily and gains momentum as all stakeholders become advocates of the organization they are helping to build. The process often blurs the boundaries between hospital-employed and independent physicians as

THE FIVE PILLARS OF CLINICAL INTEGRATION



committee members start to think of and present themselves as a unified group.

Building trust. Through the planning process, steering committee members learn about all aspects of a successful CIN, openly discuss and decide how the organization will be set up, establish common goals and activities, plan for resource requirements, and ultimately build a high degree of interdependence and trust. The trust, commitment, and collaborative process of the steering committee are critical to the development of the CIN, including preparation of the required legal documents and solicitation of other physician participants.

Getting physicians on board. Recruitment of physicians is necessary to increase the size of the patient population and spread fixed costs across the integrated network. A well-articulated solicitation plan is required to ensure all potential participants are aware of the CIN's development, and provides multiple avenues to helping them understand how the CIN will operate and why they should join. Physician meetings allow physicians to learn about the organization, ask questions, and raise concerns. Ultimately, success depends largely on one-on-one discussions led by physician members of the steering committee.

Sizing up the competition. By learning about competing organizations during the planning phase, the CIN steering committee can identify and address factors that might lead to physician defection to other networks. The committee can build on the CIN's unique value to physicians, or purposefully differentiate itself to ensure it has such value. This value proposition could be strong physician representation on the board, meaningful primary care leadership, low membership fees, or the approach taken to payer contracting.

Addressing Key Issues

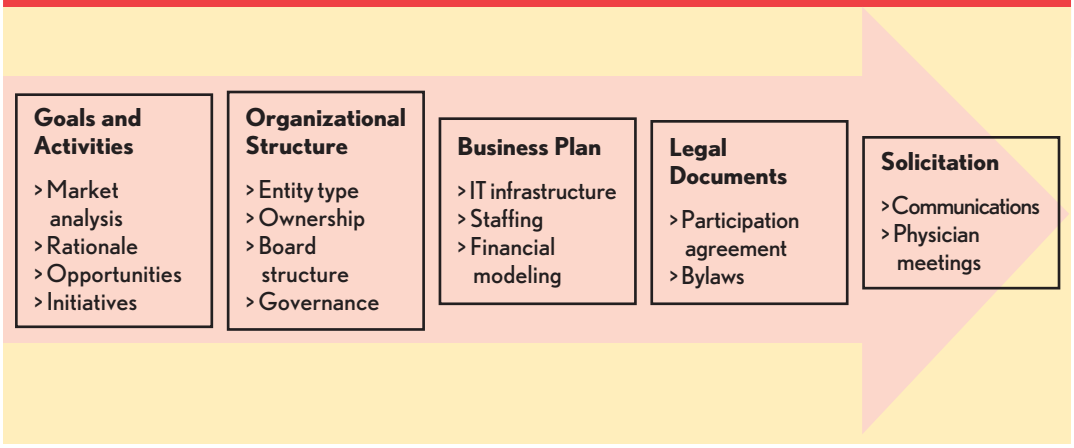
Each CIN will face its own hurdles and sticking points during development. CINs can resolve these issues by using a comprehensive, systematic process.

Organizational structure. When considering options for organizational structure and ownership, including knowledgeable legal counsel in the decision-making process is important.

A key question is whether physicians will be asked to provide investment capital to help launch the organization. The two basic models are the jointly sponsored model, in which physicians and the hospital or health system invest funds to capitalize the CIN, and the hospital-sponsored model, in which the hospital provides the bulk of the initial investment.

Although physician-hospital organizations (PHOs) of the previous generation typically included joint investment, most CINs today are funded by hospitals or health systems. Ideally all

CIN DEVELOPMENT PROCESS



ILLUSTRATIVE CIN PAYER CONTRACTING PHASE-IN

	Year 1	Year 2	Year 3
Self-Insured Employees	✓	✓	✓
Medicare Shared Savings ACO	✓	✓	✓
Commercial 1		✓	✓
Commercial 2		✓	✓
Medicare Advantage		✓	✓
Medicaid		✓	✓
Commercial 3			✓
Exchange			✓

incentives earned from payers should be distributed based on the performances and effort of participating physicians. As a result, little if anything is left to pay dividends to investors. Hospitals do not seek investment returns because they benefit from improved alignment with physicians and the hospital's share of incentives.

Furthermore, requiring up-front investment could significantly decrease the number of physician participants, and in a CIN, physicians can be given significant board authority even if they have not invested.

Governance. A robust governing structure is necessary to run the CIN effectively. The board structure and composition are more significant than the actual ownership. All parties and participants need to feel well-represented, and strong physician leadership ensures that clinical and practice insights are central to all decisions.

Board composition requirements vary depending on local hospital and market dynamics. Many CINs include a set number of board positions for hospital representatives and for primary care physicians and specialists, possibly with further allocations for employed and independent physicians.

Physicians and hospital representatives can be part of a single board class or broken into two separate classes, with approval of board actions requiring the majority of both classes. If the CIN is a subsidiary of a health system, the health system will require certain reserve powers, consistent with its funding and sponsorship role and its tax status.

Participation agreement. Earning incentive funds will require a considerable amount of time and effort by physician participants. The participation agreement should outline the requirements, which need to be comprehensive enough to ensure the CIN achieves clinical integration, but should not be so cumbersome as to deter physicians from participating.

Requirements will vary, but some key areas for consideration include:
> Data reporting and sharing
> Electronic health record use
> Primary Care Medical Home certification
> Adherence to clinical guidelines

Payer strategy. The CIN's approach to payer contracting determines the arrangements that are pursued and how physicians' existing fee-for-service contracts are affected. Much of this strategy depends on how much experience physicians and payers in the market have with value-based payment arrangements.

Contracts generally should be pursued in order of potential cost savings and quality improvement. Consistent with the programs implemented by many predecessor PHOs, the self-insured employee health plan of the hospital or health system often is the first contract under the CIN because it is a significant population, the benefits from cost savings accrue directly to the health system, and success builds credibility for contracting with other payers. An upside-only Medicare Shared Savings Program accountable care organization (ACO) often is next, generally encompassing the largest segment of the business and potential for cost savings, given high utilization and the presence of comorbid conditions. Medicare Advantage and other commercial contracts may follow.
ACO-like arrangements for Medicaid populations are being offered in some states, although requiring physicians to participate in a Medicaid arrangement could discourage some from joining the CIN.

ILLUSTRATIVE CIN COVERED LIVES AND TOTAL COSTS

Payer	Contract Type	Covered Lives	PMPM*	Total Annual Payer Spend
Self-Insured Employees	Shared Savings	7,500	$450	$40,500,000
Medicare ACO	Shared Savings	20,000	$750	$180,000,000
Commercial 1	Pay-for-Performance	30,000	$400	$144,000,000
Commercial 2	Shared Savings	5,000	$410	$24,600,000
Medicare Advantage	Shared Savings	5,000	$750	$45,000,000
Medicaid	Shared Savings/Partial Risk	10,000	$350	$42,000,000
Commercial 3	Full-risk Capitation	3,500	$390	$16,380,000
Exchange	Narrow Network	2,000	$400	$9,600,000
CIN Totals		83,000		$502,080,000

*Per member per month

ILLUSTRATIVE CIN POTENTIAL SHARED-SAVINGS REVENUE

	Year 1	Year 2	Year 3
Covered Lives	20,000	77,500	83,000
Total Estimated Payer Spend*	$220,500,000	$476,100,000	$502,080,000
Percentage Cost Savings	2.0%	2.5%	3.0%
CIN Share of Cost Savings	40%	50%	55%
CIN Potential Shared-Savings Revenue	$1,764,000	$5,951,000	$8,284,000

Note: Different arrangements and incentives are illustrative. Model assumes a range of contract terms across contracts.
*Estimated based on covered lives and per-member-per-month assumptions for total cost of care.

A related point of discussion is whether payer arrangements supplement existing fee-for-service agreements via incentives or supersede participating physician contracts.

Incentive funds distribution. Ideally, the CIN will enter into contracts that provide a pool of funds for distribution to reward the efforts of and results achieved by physicians. An effective distribution model should be transparent and easily understood while taking into account legal and fair-market-value considerations.

A key consideration is the approach to operating expenses, including care management and operations staff along with IT. These expenses usually are deducted from the incentive pool before any split between the health system and physicians. CINs should decide in advance whether any uncovered operating expenses from one year will be carried over to future years. Some CINs set aside a fixed percentage of incentive funds to be reinvested in network operations and future initiatives.

Once the approach to expenses and reinvestment is determined, the next question is how surplus funds will be split between physicians and the hospital or health system. The mix of employed and independent physicians and the norms of the market are among the numerous factors that determine the split.

Finally, many details of the methodology for distributing incentive payments to individual physicians can be decided by a board committee after the CIN launches. Among the possible components are measures of CIN administrative compliance and engagement, overall specialty performance, and individual or practice per-

ILLUSTRATIVE CIN POTENTIAL PHYSICIAN INCENTIVES EARNED

	Year 1	Year 2	Year 3
CIN Potential Shared-Savings Revenue	$1,764,000	$5,951,000	$8,284,000
Deduct Operating Expenses*	$1,000,000	$3,875,000	$4,150,000
Net Incentives to Be Distributed	$764,000	$2,076,000	$4,134,000
Percentage Distributed to Physicians	50%	50%	50%
Incentives Distributed to Physicians	$382,000	$1,038,000	$2,067,000
Number of Physicians	150	175	200
Average Incentives per Physician	$2,547	$5,931	$10,335

*Operating expense assumptions based on growth in covered lives.

formance based on specialty-specific metrics. A third party often is utilized to ensure the design is fair and equitable to all physician participants and to oversee the actual calculations.

Assessing the Financial Impact

The value of the CIN may be recognized only when considering the alternatives: declining or flat fee-for-service revenue, payer pressure to reduce cost and utilization, and the risk of losing patients to other integrated systems and networks. Financial modeling can assist in understanding the financial impact on physicians and the health system.

Estimate total cost of care. Because the CIN's financial performance is a function of its ability to manage care costs, participants' thinking should begin to shift from "revenues for care delivered" to "total cost of care for a defined population of patients."

Estimating specific figures for each contract can be difficult, but the total cost of care managed under the CIN will be driven by physician participation, covered lives, and payer phase-in. The CIN's total cost of care is separate from the hospital's annual revenue because it includes spending outside the hospital (e.g., independent physicians, other hospitals, etc.). Hospital revenue sources also include payers that do not contract with the CIN.

Model utilization impact and CIN revenues. After generating a high-level estimate of covered lives and total cost of care, the next step is to estimate potential cost savings and incentive funds that could be reasonably earned under each contract.

Over time—as the CIN gains competence and delivers results, and as the population served increases—a higher percentage of each physician's patient panel will fall under CIN contracts. This and other healthcare-industry factors will cause physicians to become increasingly focused on practicing in ways that improve quality and cost-effectiveness—thereby resulting in greater incentive payments.

Consider the physician impact. Physician incentives will be distributed based on factors that include individual performance in improving quality and cost-effectiveness. Providing steering committee members with a range of estimates of potential incentive earnings will help guide the planning process. Moreover, calculating what is achievable will confirm whether opportunities for physician incentive funds are sufficient to make developing the CIN worth the effort.

Physicians may look at this type of analysis with concern that they will not see a worthwhile ROI of time and effort. However, averaging total incentives across all physician participants often is misleading. Some physicians will not be engaged, thus earning little to no incentives, while others easily could earn many times the average.