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Health Law Reporter™

Clinically Integrated Networks Give Providers and Payers an Opportunity for Transformative Collaboration




By Lisa A. Hathaway, Rachel D. Ludwig, Peter A. Pavarini and Michael F. Schaff

I. Executive Summary

The health care sector is experiencing a series of market reforms that have the potential to reshape how care will be delivered and reimbursed for decades to come. Although a number of concepts such as accountable care organizations (ACOs) and patient-centered medical homes have attracted the most attention during the implementation of the Affordable Care Act (ACA), one organizational model that has been around for nearly 20 years has quickly jumped to the forefront of industry transformation. Clinically integrated networks (CINs) were first recognized by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) as a way for groups of competing providers to work together to improve quality and reduce costs without running the risk of violating federal antitrust laws,[1] but more recently have established themselves as viable alternatives to the development of more costly and complex arrangements, such as ACOs. This article explores opportunities in the new health care delivery paradigm created by CINs working together with health plans and payers to improve the quality and cost-effectiveness of care delivered to parties. This article is intended to be a practical guide to the best practices of CIN creation and implementation which identifies and reconciles provider and payer perspectives on this emerging area of health law.

Lisa A. Hathaway is assistant general counsel at Blue Cross and Blue Shield of Florida Inc. in Jacksonville, Fla. Lisa is also a board member of the American Health Lawyers Association.

Rachel D. Ludwig is a Healthcare Fellow at Squire Sanders (US) LLP and a member of the American Health Lawyers Association.

Peter A. Pavarini is a partner at Squire Sanders (US) LLP and president-elect of American Health Lawyers Association.

Michael F. Schaff is a shareholder and chair of the Health Care and Corporate Law Departments of Wilentz, Goldman & Spitzer PA and resident in its Woodbridge, N.J. office. Michael is on the advisory board of BNA's Health Law Reporter.

An oral presentation on this topic was made at the AHLA Annual Meeting in July 2013 by Lisa A. Hathaway, Peter A. Pavarini and Michael F. Schaff.

II. Payers and Providers Desire Collaboration

Health care reform commenced a paradigm shift toward reduced costs and improved quality of care grounded in new performance-based payment models. Health care reform fostered increased competition between providers and instilled growing uncertainty about the future of reimbursement. The ACA makes it essential that hospitals and health systems have a vehicle for managing patient care and receiving appropriate compensation. Payers also are feeling an intense pressure to reduce costs and improve quality of care.

[1] See Statements 8 & 9, Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, 1996 Revisions.

This pressure stems from increased scrutiny by regulators, employers, and plan beneficiaries and the new requirements from the ACA and the Centers for Medicare & Medicaid Services (CMS) such as risk-adjusted payments, medical loss ratios (MLRs), and various quality of care requirements including Health Care Effectiveness Data and Information Set (HEDIS) measures and Five-Star Quality Ratings. In conjunction with requirements for payers to reduce costs, the ACA requires payers to assume new costs, taxes, and rating systems of products that will increase operational costs for payers. Payers also face a demand for increased provider reimbursement due to declining government payments. Government promotion of, and commercial payers' interest in, performance-based payment has compelled the entire health care market to concentrate on developing models that successfully reduce costs while concurrently improve quality of care.

III. The Advantages of the CIN model

A. CINs: PHOs Version 2.0

CINs have been compared to the physician hospital organizations (PHOs) of the 1990s,[2] but CINs are unlikely to experience the same bell curve trajectory of the 1990s PHOs. The reason for this is that CINs have the following characteristics that enable opportunities for continual performance improvement, which position CINs for long-term success:

1. CINs provide more depth and breadth of coverage than other integration models;[3]
2. CINs are under-inclusive and only admit the best physicians to the membership organization. They usually are sponsored by the hospital but led by the physicians;
3. CINs allow hospitals to engage a mixed medical staff (independent and employed physicians);
4. CINs have the IT infrastructure and data aggregation ability to manage risk;
5. CINs encourage better quality and may utilize performance-based payment methods; and
6. CINs provide a competitive vehicle for joint contracting with third party payers.

B. Benefits of Provider and Payer Collaboration through CINs

In light of the shifting health care paradigm, independent medical practitioners and hospital-employed physicians continue to want a fair reimbursement for their services and some seek higher reimbursement for delivering better care along with providing more efficient claims administration, improved quality of care, and more efficient technology (especially health information technology). CINs offer these benefits with nominal or zero capital contribution requirements. Despite the dramatic increase in the number of physicians seeking employment by hospitals and health systems,[4] independent medical practice shows no signs of disappearing. CINs present providers the option to become employed physicians or remain independent. Independent practitioners face major hurdles in getting prepared for accountable care and health system integrations.[5] Small groups—the setting in which most independent physicians currently practice—generally lack the capital or depth of management to make changes required by health reform. Fee-for-service medicine, as long as it remains the predominant form of reimbursement, is a disincentive to taking the steps required to improve the quality and cost-effectiveness of most practices. CINs offer an arena for employed physicians and independent physicians to work together toward improving quality of care and attaining cost-efficiency.

For hospitals to compete in the new health care arena through controlling costs and improving care, they require cooperation from physicians. Hospitals are willing to employ those physicians who want to be employed, but they also want to align with independent physicians who may be some of the best doctors on their medical staffs. If hospitals fail to align with physicians through a network, they may see these physicians join other CINs that have performance-based payer contracts. The ultimate business purpose of a CIN is to allow providers who are not otherwise economically aligned to engage in joint contracting with third party payers.[6] Providers understand that performance-based contracting is the future of reimbursement and that CINs are an effective vehicle to achieve this goal.

CINs can help payers with today's changing provider structure and rapidly changing regulatory and accreditation requirements. CINs provide data aggregation and metrics necessary to demonstrate quality improvement and can align physician behavior to drive costs down. CINs allow payers to evaluate the efficacy of new payment and risk sharing methods including: global payments, bundled payments, and shared savings. Integration between physicians and hospitals reduces the likelihood of payments for overlapping services contrary to a fee-for-service model where hospitals and physicians function separately and each seeks payment for overlapping services.

IV. Payer and Provider Perspectives on CIN Creation

A. All Parties Require Regulatory Compliance

A basic foundational principle for CIN success is CIN compliance with federal and state regulatory laws. CINs

[2] See Barry S. Bader, ''Clinically Integrated Physician-Hospital Organizations,'' *Great Boards*, Vol. IX, No. 4 (2009), available at http://www.greatboards.org/newsletter/2009/Great-Boards-Winter-2009-reprint-Clinically-Integrated-PHOs.pdf.

[3] See ''Building the Performance-Focused Physician Network: Road Map for Assessing and Implementing a Clinical Integration Strategy,'' *Health Care Advisory Board*, September 2010, executive summary available at http://www.advisory.com/Research/Health-Care-Advisory-Board/Studies/2010/Building-the-Performance-Focused-Physician-Network.

[4] ''When the Doctor has a Boss,'' *Wall Street Journal*, Nov. 8, 2010, available at http://online.wsj.com/news/articles/SB10001424052748703856504575600412716683130.

[5] Mark Shields, M.D., et al., ''A Model for Integrating Independent Physicians Into Accountable Care Organizations,'' 30 *Health Affairs* 161 (2011).

[6] Mark Shields, M.D., ''From Clinical Integration to Accountable Care,'' *Annals of Health Law*, Vol. 20, p. 154 (2011), available at http://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1036&context=annals.

  HLR ISSN 1064-2137

should consult with a lawyer about compliance with all laws the CIN could potentially implicate, including antitrust laws, federal and state anti-kickback and self-referral laws, various tax laws, especially those dealing with Internal Revenue Code Section 501(c)(3) classification, federal privacy laws such as the Health Insurance Portability and Accountability Act of 1996, state insurance regulatory oversight, state corporate practice of medicine laws, state fee splitting prohibitions, state licensure requirements, and state security laws. We have not specifically addressed all of these laws in this article; however, the following is a short discussion of the federal antitrust considerations highlights:

Independent competing providers' joint negotiation of fees through a CIN may raise antitrust concerns. The FTC has not identified specific criteria to provide a safe harbor for CINs, but has provided some guidance through statements and advisory opinions.[7] In order to comply with antitrust regulations, the pro-competitive efficiencies of the CIN must outweigh the potential anticompetitive effects.[8] Demonstration of this principle is crucial. CINs should aim to improve quality of care and access to high quality care, while at the same time reduce costs.[9] It is imperative that quality improvement be more than just an objective, but that measures such as clinical practice guidelines are implemented to document and show the quality improvement.[10] Collaboration on patient and treatment information via health IT systems is another way to demonstrate quality improvement. The CIN should require providers to be active in achieving the objectives by developing the actual measures through serving on committees and the board of the CIN.[11] Participating providers' performance should be evaluated and monitored regularly.[12] The availability of significant capital to build the infrastructure shows the potential for substantial pro-competitive efficiencies.[13] The CIN should be nonexclusive in that payers that do not want to contract with the CIN still may contract with participating providers individually.[14] This is simply an overview of a few antitrust principles and is not a comprehensive analysis of antitrust law with respect to CINs. CIN development and implementation requires comprehensive and continued antitrust analysis by an experienced antitrust attorney.

B. Provider Perspective: Physicians-Hospital Collaboration

One key step in developing a CIN is appropriately balancing hospital interests and physician interests. A CIN often is structured as an entity for which the hospital provides the capital, information technology and administrative support and the physicians lead the organization and maintain a high level of self-direction. Hospitals usually expect to receive certain reserved powers that align the CIN's interests with those of the community. Balancing provider interests ensures mutual dependency between the physicians and the hospital and incentivizes the providers to work together toward the overarching goals of quality improvement and cost reduction. Providers must consider the following CIN developmental issues in light of the regional market, the specific participating providers, and the potential areas for quality improvement within the CIN.[15]

1. Choice of Entity

For regulatory reasons, CINs should be organized as separate entities. There is a strong trend towards structuring CINs as limited liability companies (LLCs) because LLCs provide the flexibility required to accommodate various classes of participants, certain tax advantages, and potential for equity appreciation over time. Other options include taxable, not-for-profit corporations or for-profit corporations. The specific business objectives of the participants and the governing state laws play the primary role in choice of entity.

2. Governance Structure

CINs often have a complex governance structure that involves multiple layers of decision making that act concurrently to carry out the mission of the CIN. The board of managers or directors (board) is a reflection of the ''balance of power,'' therefore it is imperative that the hospital, employed physicians, independent physicians, primary care physicians and specialty physicians are adequately represented. Physician-dominant boards are common. Tax-exempt hospitals must ensure the existence of class voting, super-majority voting or reserved powers when partnering with independent physicians. Officer positions should be distributed between practicing physicians, physician executives, and lay administrators. The CEO or board chair usually is a practicing physician. While the board makes policy and strategic planning decisions, the committees perform the majority of the work. Since committees make most day-to-day operational decisions, substantial integration and quality improvement will be achieved only if physicians agree to participate in and lead committees. Typical committees include finance, utilization manage-

[7] See Statements 8 & 9, Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, 1996 Revisions; FTC Staff Letter Regarding MedSouth Inc. (Feb. 19, 2002), available at http://www.ftc.gov/bc/adops/medsouth.shtm; FTC staff letter regarding Greater Rochester Independent Practice Association Inc. (Sept. 17, 2007), available at http://www.ftc.gov/bc/adops/gripa.pdf; FTC staff letter regarding TriState Health Partners Inc. (April 2009), available at http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf; FTC staff letter regarding Norman Physician Hospital Organization (Feb. 13, 2013), available at http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf; 76 Fed. Reg. 67026.

[8] See 15 U.S.C. § 1; Statements 8 & 9, Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, 1996 Revisions.

[9] See Statement 8, Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, 1996 Revisions.

[10] See FTC staff letter regarding Greater Rochester Independent Practice Association Inc. (Sept. 17, 2007), available at http://www.ftc.gov/bc/adops/gripa.pdf; FTC staff letter regarding Norman Physician Hospital Organization (Feb. 13, 2013), available at http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf.

[11] See FTC staff letter regarding TriState Health Partners, Inc. (April 2009), available at http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf.

[12] See id.

[13] See id.

[14] See FTC staff letter regarding Norman Physician Hospital Organization (Feb. 13, 2013), available at http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf.

[15] James J. Pizzo and Mark E. Grube, *Getting to There from Here: Evolving to ACOs Through Clinical Integration Programs*, 2011, available at http://www.advocatehealth.com/documents/app/ci_to_aco.pdf.

ment (UM), quality improvement, credentialing and contracting. The CIN must consider physician compensation for board and committee participation. Voluntary physician service on a CIN board or committee is common in the early stages of development, but many physicians are in a position to demand reasonable compensation for their administrative services once the CIN is fully operational.

3. Provider Participation

CINs may require a participation fee from physicians, but unlike other joint ventures, they do not expect physicians to contribute substantial capital. The most successful CINs require participating providers to have a willingness to deliver health care services in conformance with an agreed set of performance standards, meet the CINs credentialing standards, agree to share clinical data with the CIN, and actively participate in and develop clinical improvement activities. Unequal treatment of independent and employed physicians through membership classes or different governance rights and leadership roles has a polarizing effect that always impedes the development of a cohesive delivery network. While equal treatment of independent and employed physicians is not mandatory, creating an even playing field for all physicians cultivates collaboration between physician factions within the CIN. Likewise, embracing a diverse physician membership and ensuring diversity in leadership roles supports the CINs' clinical and business objectives by creating a broad, high-quality network.

As discussed in Part IV(A) above, developing CINs requires stealthy navigation of a variety of regulatory issues, particularly in the antitrust arena. Without engaging in an extensive discussion of CIN antitrust law, basic guidelines regarding appropriate behavior for competing physicians during developmental meetings must be obeyed to avoid antitrust liability. Each meeting should have a written agenda and that agenda should be followed closely. The CIN should record minutes of each meeting that document the specifics of the discussions and clearly set out up front (and include in the minutes) any items that should not be discussed. An outside third party should be used to collect and manage competitive information and a neutral facilitator should oversee meetings to ensure that the providers are not engaging in illegal conduct. Providers should exchange information which is reasonably necessary for the development or operation of the CIN. It is important that providers discuss the procompetitive reasons for the CIN, including how the network will enhance patient care in the service area, how the CIN will create efficiencies that will make care more accessible and competitive, and how health care is changing and how the medical community should respond to those changes.

Physicians should not discuss or agree with a competitor on any type of price fixing, including talking about current or expected prices for any provider. No discussions on limiting the amount of care for individuals or groups should occur. No fee schedules, market share data, or any contract negotiations or contract terms with third parties should be shared. There should be no discussion among providers about the elimination or reduction of competition in the market or division or allocation of markets or patients. Providers must not systematically boycott dealing with any payers or other providers. Adherence to these guidelines will provide powerful documentation that the CIN complies with the regulatory requirements for CINs established by the FTC.

4. Joint Contracting

The predominant benefit providers realize through CIN participation is the ability to engage in joint contracting and negotiate better payment while focusing on improving quality. Joint contracting is most effective when every physician participates in every contract, there is adherence to common set of quality, safety, and cost-effectiveness measures, physicians are able to share in incentive funds, there is appropriate infrastructure including effective electronic medical records (EMR)/electronic data interchange (EDI) and adequate physician training and education, and the CIN has the ability to achieve market recognition.

C. Payer Perspective: Does the CIN Formation Enable Payers to Meet Regulatory and Accreditation Requirements?

1. Risk Adjustment of Payments

Under the ACA, the new metal plans[16] must certify over 100 items and be accredited in order to participate in a marketplace (exchange).[17] The quality of care offered and the types of providers in a plan's network factor into accreditation for participation in the exchanges.[18] Payment for both metal and Medicare Advantage (MA) plans is on a risk-adjusted basis—based on acuity, diagnoses, age, sex, and other characteristics of the plan members. Generally, risk-adjusted payments require plans to accept less payment for healthy members than for members with chronic conditions and higher acuity members. With a set limited reimbursement, metal plans and MA plans need cost effective, yet quality care to meet CMS and exchange requirements. Risk-adjusted payments create additional administrative burdens on plans to document acuity, diagnoses and health condition, and to produce the clinical best record to support the payment the plan receives.

2. MLRs

Nongrandfathered plans are subject to MLRs.[19] Currently, for the large group market, plans must spend 85 percent of premiums on medical care (incurred claims) with the rest of the premium available for administration and profits.[20] For the small groups and the individual market, plans need only spend 80% of premiums on medical care.[21] If the MLR is less than the applicable required percentage, plans must issue a rebate to enrollees or the employer.[22] In May 2014, MA plans and Part D sponsors also will face a required MLR of 85 percent.[23]

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[16] Levels of coverage in the plans offered through the exchanges are designated by different metals: bronze, silver, gold and platinum.
[17] See 45 C.F.R. § 156.275.
[18] Id.
[19] See 45 C.F.R. § 158.210.
[20] Id.
[21] Id.
[22] See 45 C.F.R. § 158.240.
[23] See 42 C.F.R. § 422.2410; 42 C.F.R. § 423.2410.

  HLR ISSN 1064-2137

CINs may want to examine recent guidance on determining how to classify payments using the following four factor test: (i) entity contracts with issuer to deliver, provide or arrange for clinical services to enrollees but is not the issuer of services; (ii) entity contractually bears financial risk for delivery, provision or arrangement of specific clinical services to enrollees; (iii) entity delivers, provides or arranges for the delivery and provision of clinical services through a system of integrated care delivery that provides for coordination of care and sharing of clinical information, including provider performance reviews, tracking of clinical outcomes, and evidence based guidelines use; or (iv) functions other than clinical services that are included in the payment must be reasonably related or incident to the clinical services and must be performed on behalf of the entity or entity's providers.[24] Performance-based payments also must be evaluated under this four part test.

In classifying incurred claims for medical services and administrative costs, the type and the structure of the contractual relationship payers have with providers must be evaluated and have the potential to affect MLRs. Typically, capitation payments to physician groups or hospitals allow the entire payments to be considered an incurred claim. Capitation paid to a vendor who does not directly provide health care but who contracts the network for the plan and provides credentialing, claims payment, and UM activities will require analysis to classify what part of the capitation payment can be attributed to covered services for incurred claims, and which part of the payment will be classified as administrative. Additionally, there also could be a quality of care component. Payments to improve health care quality—if designed to (i) increase the likelihood of desired outcomes compared to the baseline and reduce health care disparities among specified populations using evidence based medicine; (ii) improve health outcomes, reduce hospital readmissions, focus on hospital discharges; (iii) improve safety, reduce medical errors and lower infection and mortality rates; or (iv) implement, promote and increase wellness and health activities—can be classified as ''health care quality expenditures'' and are not considered administrative costs.[25]

With the MLR requirements for health plans, payers will need the cooperation of providers and vendors to accurately calculate the MLRs and will likely introduce contract language to require MLR reporting. Prior to contracting, payers will internally decide how to classify payments with respect to MLR reporting, but payers may want to analyze the CIN structure, choice of entity, the services to be provided and the payment structure to ensure that the CIN's entire payments will be considered incurred claims for MLR purposes.

3. Quality of Care and Accreditation Requirements

Accreditation agencies—such as the National Committee for Quality Assurance (NCQA) and URAC (formerly known as the Utilization Review Accreditation Commission)—and CMS measure quality of care by many specific defined requirements. Currently, to receive state licensure or participate in the exchanges under the ACA, all plans must be accredited.[26] Accreditation not only requires licensure and other typical credentialing requirements but also now requires evaluation of the availability of practitioners in the plan's network and the plan's ability to meet members' needs in terms of primary care physicians, specialists, behavioral health care providers, geographic distribution of providers, and members' satisfaction with the plan and care. Providers have a direct effect on the accreditation and scores a plan achieves. Payers are likely to consider how CINs can assist the plan in meeting the ''elements'' to obtain and maintain accreditation and high scores.

(a) *HEDIS Measures and Five-Star Quality Ratings*

All payers use Healthcare Effectiveness Data and Information Set (HEDIS) measures to assess themselves, set goals and improve services. HEDIS scores serve as part of accreditation measures, which make them extremely important to payers.[27] Providers must understand that plan accreditation often hinges on appropriate HEDIS scores, and that plans utilize provider medical records to demonstrate that HEDIS measures were met. For this reason, plans are often interested in how providers manage patients and ''case manage'' an episode of care. Plans prefer care coordination and UM between a hospital, its staff, its employed physicians and ancillary service providers. Plans are increasingly recognizing the importance of EMRs in coordination and documentation of the quality of care. Plans are progressively offering financial incentives in the form of shared shavings, bundled payments, pay for performance or global payments to encourage sufficient care coordination, record keeping, cooperation and cost effective quality care.

Currently, HEDIS is the central component of the Five-Star Quality ratings, which is a CMS measure of quality applied to MA plans.[28] MA plans are rated on a scale of one star to five stars (with one expressing poor quality and five representing excellent quality). CMS currently utilizes over 50 stars measures primarily based on HEDIS; however, each year CMS has added, removed, or changed the stars measures. Stars measures evaluate enrollee experience, care provided, and plan structure, success and enrollee outcomes. As with HEDIS, stars ratings require care coordination and UM and require cost effective quality care, record keeping, cooperation and a high level of coordination. MA plans are currently able to receive additional payments if they are rated three stars or above.[29] There are also incentives for MA plans to contract with providers who focus on patient management, readmission prevention, case management, and providers need to understand HEDIS, Star measures, the necessity for thoroughness in documentation, and how to effectively handle chronic patients.

[24] See CCIIO Technical Guidance (CCIIO 2011002) Questions and Answers Regarding Medical Loss Ratio Interim Final Rule (hereinafter CCIIO Q & A); CCIIO Q & A # 20, #21, available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/2012-02-10-guidance-mlr-ipas.pdf; see also 45 C.F.R § 158.40

[25] See 45 C.F.R. § 158.150(b); CCIIO Q & A # 14.

[26] See 45 C.F.R. § 156.275.

[27] See id.

[28] See CMS fact sheet, ''Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration Quality Bonus Payments'' (Nov. 10, 2010), available at http://www.cms.gov/apps/docs/Fact-Sheet-2011-Landscape-for-MAe-and-Part-D-FINAL111010.pdf.

[29] See id.

With the extensive regulatory and accreditation requirements with which payers must comply, payers have incentive to analyze CINs with great detail prior to signing a contract. Payers will ensure the CIN meets FTC requirements and will scrutinize the structure and physician involvement and participation in the CIN; the contractual terms for providers that delineate their commitment to quality and cost reduction; the resources placed into the CIN; the breadth of services provided and service area covered by the CIN; already established evidence based guidelines, metrics, and performance standards; familiarity with regulatory requirements that the CIN and plans face; use of EMRs and documentation standards; ability to provide reports; types of payment schemes; and the payer products to which the contract would apply.

D. Tools for Success

1. Comprehensive Physician Performance Data

EMRs are only one part of the data required to successfully operate a CIN and contract with third party payers. To create a complete picture of the physician's performance and to properly assist payers, the CIN also needs to draw from billing records, scheduling records, CMS core measures reports, Joint Commission Ongoing Professional Practice Evaluations (OPPEs), and any other available reports. These data sets can provide valuable information including cost per case, patient volumes, hospital utilization, quality outcomes, hospital charges and costs, patient satisfaction scores, and comparisons with evidenced-based medical protocols and CMS core measures.

2. Physician Leaders Willing to Develop and Champion Practice Protocols

Development of metrics, protocols and other standards that minimize variation in the care delivery is the key to raising system performance. For the CIN metrics and standards to be effective, physicians must improve their understanding of the clinical and economic forces that impact care they deliver and be willing to collaborate with their peers to develop reasonable, achievable standards against which their performance is measured. CINs must focus on attaining physicians that exemplify the ''best practices'' and physicians that are willing to train and educate other physicians for service in leadership roles.

3. Performance Based Incentives, Both Financial and Nonfinancial

During CIN development, incentive funds will not be available from third party payers because CINs may not engage in joint contracting until clinical integration is achieved. Thus, it is desirable to institute incentive funds from the hospital (e.g. shared savings program) and physician incentive funds from withholds or other diversions of funds. Planning an incentive payment program requires thought about how much financial incentive is needed to change traditional practice patterns, the proper balance of group versus individual rewards, how frequently the CIN should measure the effectiveness of the incentive payment, how to structure the appropriate process of reform if the payment is not successful, and how regulatory issues should be addressed. Nonfinancial incentives such as awards for clinical excellence, research opportunities and improved administrative and technical support also serve to motivate physicians to improve quality of care.

4. Preparations for Evolving Reimbursement Models

Alternative payment programs such as shared savings or bundled payments require the CIN to have patient attribution techniques, chronic disease management programs, the ability to easily transition patients from inpatient to home-based care, patient-centric case managers, and improved patient communications and access to health data.

V. Payer and Provider Perspectives on CIN Contracting

There are many contract provisions that need to be negotiated and included in the contract between payers and the CIN. For purposes of this article, four of the more important areas are discussed below.

A. Representations and Warranties

In the representations and warranties portion of the contract, payers want providers to represent or warrant that the CIN meets FTC requirements for clinical integration; that the CIN complies with federal and state regulatory requirements; that the CIN is appropriately licensed; that the providers meet the plan's credentialing requirements; that the participants are bound to the terms of the CIN and the payer agreement; that no provider is excluded, suspended or disbarred from any federal health care program; that the CIN meets any applicable third party administrator requirements; and that the providers will participate in quality and efficiency metrics. Providers want payers to represent or warrant that the providers will be timely paid. Providers also want to see adequate dispute resolution processes laid out in the contract.

B. Data Sharing

With respect to data sharing, providers usually want aggregated data on their performance under quality of care standards compared with that of other providers so they understand where they stand in relation to their peers. Payers will restrict access to any data that could reveal rates paid to other providers and other confidential information. Due to the sensitive nature of the data shared, payers and providers both want as much confidentiality as possible with data and information that is shared and must comply with confidentiality and privacy laws. Generally, payers want access to clinical records and care plans and want the right to use/publish data from the CIN relationship and provide it to members of the plan and the government (as noted above, data are often required for MLRs, quality reporting to CMS and as a record to support risk adjustment). It is advisable to set forth clear requirements on record keeping, access to data, and terms on sharing member information that is necessary for quality measurements.

C. Technology Systems and Metrics

Incompatibility of the parties' technology systems and use of metrics will lead to inefficiency and may result in a strained relationship between the parties. Payers will want providers to have the appropriate technology system(s) and generally want the providers to mine the necessary data for the payer; however, as many providers may not have this ability, plans may need to provide this. Providers want a joint agreement on technol-

   ISSN 1064-2137

ogy with financial contribution from the payer, and may want the payer to use their EMR system, and generally want the payer to mine any data they require. The often opposing desires of payers and providers make it imperative that the contract lay out who will perform the data mining and the techniques that will be used to mine the data. The contract should directly refer to the technology system that will be utilized by the parties. Technology financing terms and statements about joint contribution commitments should be stated in the contract. Specifics about particular metrics (HEDIS/star and/or incentive-based quality metrics) and benchmarks also should be included in the contract.

D. Contract Term

One of the most important aspects of the contract is the language about the contract term. Payers want the right to terminate the agreement if quality of care, targets goals, metrics, or members' satisfaction is not met or the deficiency is not cured after a set period of time. Payers prefer ''with cause'' termination provisions such as failure to comply with laws or FTC requirements, change of control of the entity that is not approved by the plan, change in federal or state requirements, or loss of ability to participate in any federally funded health program. Payers also may contract for the right to terminate or to require that the CIN terminate individual providers or groups if there are quality issues that remain uncured or member dissatisfaction with particular providers. As a practical matter, payers need to contract to receive sufficient notice of providers withdrawing or being removed from the plan. Providers want to contract for the right to terminate the contract if they are not timely paid.

E. Tools for Success

Many of the contract terms are dependent upon the structure of the established CIN, so consideration of contract terms during CIN development will prove useful. Eventually, CINs will receive a contract offer from a payer that provides increased payment or potential for increased payment. While this contract is likely to be enticing for obvious reasons, CINs should not ignore the other contract provisions. It is always beneficial to review each contract provision carefully and to express concerns over all important contract terms and drafting issues. Ensuring that both parties have the same expectations and that those expectations are delineated through a clearly written, detail-oriented, fully negotiated contract will lead to the most effective collaboration between payers and providers.

VI. Conclusion

CINs are the latest chapter in the health care sector's decades-long attempt to restructure itself in response to the public's growing demand for health care that is both affordable and accountable. Although they may eventually be swept up by other reforms coming out of the ACA, for the moment CINs represent one viable way for providers and payers to work together in achieving sustainable improvement in the delivery system. The legal questions presented by CINs are similar to those that arise in the implementation of other managed care arrangements; however, the answers to those questions will continue to change as the laws and regulations come to reflect a preference for outcome-based payment and a greater level of cooperation among providers and payers.