FREQUENTLY ASKED Questions about Clinically Integrated Networks from The Care Centered Collaborative

What is a Clinically Integrated Network (CIN)?

CINs are generally formed by independent healthcare providers, who work together with health insurers and self-insured businesses to achieve higher quality, increased efficiency and a better care experience for patients. A physician CIN is made up exclusively of physician-owned practices, who work together to scale resources for better patient care while simultaneously maintaining their autonomy.

Why is the Pennsylvania Medical Society sponsoring creation of a physician-led clinically integrated network?

Pennsylvania healthcare is being carved up, forcing physicians and their patients to choose sides between large insurers in alliance with large hospital organizations. As value-based care arrangements grow, the Society is aware of reports that independent physician practices are being forced into take-it-or-leave-it contract terms using opaque measures that can commoditize physicians and fail to account for patient preferences. On behalf of those patients, the members of the Society are concerned that the promise of value-based care will be squandered, and have sponsored creation of a new CIN.

Isn’t a CIN sponsored by the Medical Society too little too late?

No. For the 40% of Pennsylvania physicians who still own and run their practices, value-based care is a significant opportunity to serve their patients and receive appropriate recognition for their work-effort. While the consolidation of healthcare in Pennsylvania continues, the provision of value-based care contracting has only just begun.

How can a physician network be taken as seriously as the large dominant health systems in Pennsylvania?

Physicians succeed in value-based care when they can manage the health care needs of a critical mass of one or more insurers’ population of “covered lives.” As the number of covered lives cared for by a CIN linearly increases, the ability to achieve statistically significant and clinically meaningful outcomes increases geometrically. While some larger physician groups in Pennsylvania have independently had some success with as many as 70,000 covered lives, value-based contracting based on more than 100,000 covered lives is well within reach and far more likely to succeed. And that’s just for starters.
Do I have to be a member of the Pennsylvania Medical Society to participate?
No.

How can a network made up of physicians possibly succeed as a CIN?
CINs led by physicians have a remarkable track record of success, according to numerous peer-reviewed reports as well as the experience of doctors in settings that are similar to yours. Once the information technology and care management systems are made available to doctors through a CIN, physicians have proven that they are the healthcare professionals best suited to reconcile quality, cost, patient satisfaction, patient preferences, risk, and uncertainty.

What is the cost for a physician to be a member of the CIN?
In general, CINs succeed when physicians meaningfully invest time, energy and financial resources. This CIN will ask that physicians share in the investment in a network-wide population health information system that is necessary to measure and track clinical and efficiency outcomes. There are no dues or stock purchases.

We are already getting value-based care payments from health insurers. How will this improve on that?
Even if you are getting some value-based care payments, you are being significantly underpaid. Only a small percentage of the funding being directed by government and businesses buyers toward the achievement of value for insured populations is making it to the physicians, and is insufficient to support clinical programs to promote wellness, prevent disease or reduce complications from chronic conditions. In addition, there are troubling reports from across Pennsylvania that suggest that many value-based payments are often based on faulty measurements that tend to underestimate true physician performance. This CIN will provide for timely information to drive clinical decision-making and better outcomes.

What will happen to my practice’s independence if I join the CIN?
The purpose of a CIN is to create an infrastructure through which independent providers can work together to improve the quality and efficiency of care. A participating practice will continue to bill and collect for services under its existing payer contracts and will remain responsible for its practice’s operations. Other than claims data, participating physicians will not be required to share financial information with the CIN.

Will my physician group be forced to give up our current value-based arrangements?
Generally, no. The physicians of a CIN should only agree to a value-based contract if it is to the advantage of the patients and all the physicians who care for them. In other words, your and your colleagues’ contracts are a floor, not a ceiling.
If I am a member of an independent physician association (IPA), such as the Medical Group of Pennsylvania (MGP), can I still join a CIN?
Yes. IPAs like MGP which serve as conduits (messenger model) for disseminating managed care contract terms to its members do not directly negotiate contracts with payers. As such, physicians who are members of messenger model IPAs can participate in the CIN.

If I am a member of another CIN, can I join this Pennsylvania Medical Society sponsored CIN?
Generally, no. CINs succeed when they can work with health insurers by speaking for all of the CIN’s physician members and their patients. However, we are in discussions with several other CINs to become a “CIN of CINs”. If you are a member of a CIN, please consider discussing this option with the physician leaders of your CIN.

Do all the members of my group have to participate in the CIN?
Yes. Each practice (Tax ID) will sign a group agreement and individual physicians and non-physician providers within the group need to sign an individual practitioner participation joinder to the group agreement. The group will be responsible for its activity as well as the activity of the individual practitioners.

Can the CIN negotiate fee-for-service rates?
No.

Given the dominant role of hospitals outside of a physician-led CIN, isn’t this doomed to fail?
No. The healthcare needs of a covered population will always be dominated by high-cost services. Until a network manages and measures tens of thousands of patients, meaningful and measurable shifts in quality, utilization and satisfaction won’t become apparent. This “Law of Large Numbers” has been successfully used by insurers for decades. With a CIN, the physicians now can use this “Law”, especially if the network can shift patients toward hospitals and other care providers that share in the CIN’s interest in value.

How many physicians does a CIN need?
It’s not the number of physicians, but the number of covered lives. The Pennsylvania Medical Society’s economic modeling suggests 20,000 covered lives is a good beginning, that 50,000 is likely to succeed and that more than 100,000 will be sustainable for years to come. We believe a statewide physician-led CIN has the potential for even more covered lives.
Based on initial physician interest in central Pennsylvania, we are well past a good beginning. In addition, having a critical mass of covered lives engages health insurers in meaningful negotiations with physicians as equal co-partners.

**What is the role of specialist physicians?**

Successful CINs generally run a ratio of 40% primary care (including women and children’s services) to 60% specialty care. The role of the specialists is critical. A high performing CIN welcomes the inclusion of specialist physicians who share in the primary care physicians’ interest in reconciling quality, cost, satisfaction, and patient preferences. Some insurers in Pennsylvania are interested in pursuing specialty “bundles,” which may be another opportunity for the CIN.

**What is the role of hospitals?**

They are cost centers to be managed.

**What is the role of “care management?”**

Care management is a team-based approach to care that extends the clinical reach of physician-led care outside of the clinic or bedside setting into the community, and is typically provided by credentialed non-physicians, such as nurses. Ample evidence suggests that when care management is paired with physicians, patients are more likely to engage in their care, better manage their conditions, use their medications more wisely and rely more on their trusted physicians. It is a building block of all successful CINs.

**What is the role of the data management system?**

Unlike EHRs and health insurer’s claims systems, population health information technology can honor HIPPA while simultaneously extracting, assembling, sorting and presenting actionable information to physicians and their care management teams, using metrics that are driven by patient need and physician specifications across all insurers.

This not only gives a real-time snapshot of a sub-population’s health status (e.g., how many patients with a particular disease have a particular level of control) but offers “drill down” capability to find which individuals are at greatest need. Because this technology reconciles multiple data feeds from multiple sources – including the physicians’ EHRs – it can provide auditable evidence of quality. In other words, physicians will no longer have to take the insurers’ word for it. Based on quality, cost and willingness to put some of their fees at risk, we have chosen HealthEC as our population health solution.

**Who will govern the CIN?**

The physicians. CINs rely on decision-making boards and committees to make quality, funds flow, credentialing and contracting decisions. A subsidiary of the Medical Society will provide administrative support; the doctors will make the discussions and lead the committees.
**Is there any downside?**

In addition to being able to deliver value for tens of thousands of patients, CINs also rely on single signatory authority. This means that participating physicians must allocate decision-making to their chosen peers and then abide by the decisions of their boards and committees. Although we believe that we can generate income for physicians in the CIN far in excess of the cost of the population health fees charged to these physicians, we cannot guarantee this result.

**Where can I get more information or talk to someone about this?**

You can reach us at [www.patientccc.com](http://www.patientccc.com) and post your inquiry – or call Gary Stelluti from The Collaborative’s team at 614-580-8879.