

Private Practice Checklist

Key Considerations in Forming, Operating or Joining a Clinically Integrated Network (CIN)



Many private practice physicians are evaluating, forming, or participating in a clinically integrated network (CIN)—a collaboration among multiple physicians and other health care providers. It typically covers a wide range of specialties and is designed to enhance the quality and efficiency of care delivery. A true CIN is allowed to contract on a collective basis with payors under applicable antitrust laws because it is bringing innovative health care delivery to the market. However, demonstrating true clinical integration requires the participating physicians to commit to developing and following rigorous quality standards, acquiring IT resources that allow advanced data analysis, and enforcing sanctions against physicians who are not meeting the network's requirements. The time, effort and financial commitment is significant and requires an appreciation of the sweat equity that will be required to be a successful CIN participant. In addition, networks must comply with complex state and federal health care laws.

This checklist is intended to help physicians evaluate their preparedness for clinical integration. It is important to consult legal counsel when forming a CIN.

Operational Considerations—Are you ready?

- Do you have access to comprehensive clinical and claims data (from payers, other providers, commercial databases, other sources)? For example, can you track the services that have been provided to individual patients over time and across providers? Can you evaluate the services that individual physicians are providing to patients with similar conditions? These and other data points make it possible to determine the quality and cost-effectiveness of the care being provided by the network.
- Do you have the ability to collect and aggregate data from participating providers to report key metrics? For example, when the network has established clinical protocols for certain conditions, does the network have the appropriate data to assess compliance with those protocols?
- Are you able to use data analytics and bi-directional data (e.g., push and pull) to support physician workflows?
- Are care management tools and personnel available for high-risk populations?
- Do you have population health management resources and evidence-based protocols? (For more information see [How to target population health](#).)
- Does your organization have referral management capabilities to reduce network leakage (subject to applicable law)?
- Are there systems in place to support alignment, leadership, communication, and engagement among clinicians?
- Does your practice already have or intend to seek [NCQA](#) credentialing?

Strategic Goals and Partners—Have you developed your strategy?

- What will be the focus of your CIN entity (specialty focus, primary care management, multi-specialty)?
- Have you identified clinical partners to promote that approach? In a single-specialty CIN, these could be other physicians in the same specialty, while in a multi-specialty CIN, it is important to ensure broad coverage across several specialties.
- What are your payer targets (commercial payers, federal programs, employers, joint contracting)?
 - Do payers in your region offer [value-based contracting models](#) or will you need to propose and negotiate a new model?
- If the CIN is being newly formed, will non-physician entities be included in your CIN (ASCs, freestanding facilities, a hospital)?
- If the CIN is being newly formed, who will own and capitalize the CIN structure?
- Will your partners provide resources (data, personnel, financial, analytics or other services) or will these be provided “in house?”

Financial Considerations—How will you be paid? What is at risk?

- What kinds of payment approaches will the CIN negotiate (shared savings, pay for performance, care coordination payment/support, quality bonuses, [investments in care transformation](#), etc.)?
- Will the CIN negotiate risk-based contracts and risk stratification methodologies; if so, what terms and conditions will it propose/accept? Or if you are considering joining an existing CIN, does that CIN already have risk-based contracts and risk-stratification, and what are the terms and conditions of those contracts?
- What CIN financial distribution methodologies will you use with participating clinicians to incentivize performance? Or if you are considering joining an existing CIN, how does its distribution methodologies work, and how have they been applied to historical distributions?
- How will you mitigate or manage risk (reinsurance, outlier thresholds, loss caps, or other approaches)? Or for an existing CIN, how does it mitigate or manage risk?
- For which patients will you be responsible?
 - If the clinician’s performance is being evaluated by payers with respect to a specific set of patients, how are those patients selected? These could be specific designations in the payer contracts, or they could be methodologies for attribution, such as assigning patients to the physician they select as their primary care physician, or others. Understanding the assignment or attribution methodology is particularly important in risk contracts, as they typically evaluate the risk-adjusted cost of care for the attributed patients.
 - Is there a threshold number of covered lives that are required to consider a contract with downside risk? Risk contracting usually doesn’t make sense unless the CIN has a sufficient number of covered lives to protect against the potential for a small number of outliers to skew the results for the whole group of patients.
- Will you be required to reinvest in the CIN to create a self-sustaining organization? In other words, does the CIN currently generate enough revenue on its own to maintain its operations.
- Do you understand the risk adjustment methodology and other technical adjustments?

Legal and Regulatory Considerations—How will your organization mitigate risk and maximize opportunity?

The questions below are most applicable to forming a new entity, but it will be important to understand the application of these regulations to existing CINs.

- Corporate formation
 - What is your choice of legal jurisdiction? (May affect laws applicable to structure.)
 - What legal form will your CIN take (LLC, PC, etc.)?
 - Are you structuring to maximize tax efficiency?
 - How will state corporate practice of medicine requirements (if any) affect CIN operations?
- State law issues
 - Is the CIN operating in a state requiring CIN or IPA registration or licensure?
 - Will the CIN provide peer review, quality improvement, or similar patient safety organization protections?
 - Will the CIN be deemed to take “insurance risk” under state insurance requirements?
 - Will state “any willing provider” laws impact the CIN’s flexibility in contracting?
 - Are there any Attorney General reporting requirements in your choice of legal jurisdiction or State of operation?
- Antitrust compliance if including competitors in CIN
 - Will the CIN’s membership reflect concentration in a relevant market?
 - Does the CIN require exclusive contracting?
 - If the CIN will engage in joint action, will it meet rules around “clinical and financial integration”?
- Tax and tax-exempt compliance
 - If the CIN or its members are non-profits, are its activities aligned with the charitable and tax-exempt purposes of those entities?
 - Does the CIN have a process to evaluate risks of private inurement/private benefit or excess benefit transaction prohibitions?
- Data privacy and security
 - Are the CIN’s operations structured to comply with HIPAA?
 - Have you addressed unique State law privacy or security requirements (through a Business Associate Agreement, Organized Health Care Arrangement, or otherwise)?
 - Will all data use activities comply with applicable payer Data Use Agreements or similar agreements?
- Fraud and abuse prevention requirements
 - Does your distribution of incentive payments comply with the Stark Law, Anti-Kickback Statute, and State requirements like fee-splitting rules?
 - Can you demonstrate that payments are fair market value?
 - Do you have procedures in place to ensure the CIN’s operations comply with civil monetary penalties against patient inducement, reduction of medically necessary care, “cherry-picking” healthier beneficiaries, and prevention of false claims or insurance fraud?