Independent and Integrated

A hospital-physician network spanning multiple partners may be an ideal fit for a smaller system

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Merger? Affiliation? Strategic partnership? Hospitals and systems are seeking scale in an unprecedented manner. Smaller organizations will struggle to compete in a market obsessed with generating scale, especially given the investment and organizational energy required to develop a system's clinical integration approach and infrastructure.

A clinically integrated network spanning multiple organizations, or super CIN, can be an alternative to merger for organizations that want to retain their independence yet not go it alone in creating the infrastructure and capabilities to participate in shared savings contracting. However, hospitals need to make sure they are designing the super CIN structure for long-term value, not just short-term savings. Before joining one, boards have a handful of issues to consider.

Wider Reach, Better Value

To understand a super CIN, first look at its predecessor. A clinically integrated network is an organizational structure uniting hospitals and employed and independent physicians to address costs, quality and outcomes in a way that allows them to contract collectively with payers. Because a CIN can contract on behalf of its participants, the Federal Trade Commission has specific guidelines that define one. Generally, the FTC considers a program to be clinically integrated if it:

- Establishes mechanisms to monitor and control utilization of services that are designed to control costs and ensure quality of care.
- Selectively chooses network physicians who are likely to further these efficiency objectives.
- Uses investment of significant financial and human capital in the necessary infrastructure and capability to realize the claimed efficiencies.

Most CINs involve a health system and its related physicians, but super CINs are emerging to consolidate local networks to provide geographic coverage, leverage investments across a broader base and create long-term value by managing care that is consistent, cost-efficient and of high quality. A super CIN can bring together the networks of multiple systems onto a common platform for integration. Super CIN participants can access several immediate benefits:

- Avoiding or consolidating investment in the infrastructure required to administer a clinically integrated network. A $3 million to $5 million investment in the systems, processes and people to get such a network started is a reasonable expectation.
- Collaborating on common ancillary areas, such as lab, pharmacy, patient transport and supply chain.
- Optimizing service lines to improve quality and lower costs for the community, such as neonatal intensive care and trauma.

While these benefits add short-term value and represent real dollars, the value of the super CIN is based not just on economies of scale, but also on improvement in cost, quality and outcomes. Most early-stage super CINs are pursuing Medicare Advantage lives and their own employees, but intend to move to commercial and direct-to-employer contracting once they establish FTC-approved clinical integration across the participants. While super CINs at this point do not mandate a particular approach to care delivery at each organization, increasingly they will seek to improve and standardize results. This can involve the sharing of best practices and facilitating a quicker transition to lower costs and better outcomes.

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If super CIN partners improve the value equation to patients and payers, they can be a desirable partner for employers and payers under mutually beneficial contract terms, such as shared savings and total cost-of-care contracts.

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Five Questions

The super CIN structure allows hospitals to get into the clinical integration game at a lower price than going it alone. It facilitates improvement in an organization's value proposition to its community and its payers, and it can lead to an improved market position. However, board members and leaders must confront some challenges before embarking on this journey:

1. Physician collaboration. It can be hard enough to collaborate with a system's own physician base, and the super CIN structure requires that multiple physician markets be engaged and collaborate — a tall order by any stretch. How will physicians be integrated into the structure?

2. Ownership and governance structure. Rather than defaulting to the "size equals ownership and ownership equals governance representation," in the super CIN, careful consideration must be given to the value each party brings to the table, as well as physicians' role in the governance structure.

3. Funds flow and distribution. Assuming that the super CIN is successful in capturing savings, how will those savings be distributed to the participants? Funds flow and distribution should reward performance and value contribution and not be exclusively based on the size of the hospital or physician network.

4. Care delivery model. Expectations for collaboration to drive improved performance should be laid out up front and be reflected in the organization's operating model. Will participants be measured on outcomes or process when evaluating care management?

5. Regulatory oversight. While the ground rules for CINs are well-established, the FTC's perspective on super CINs is still emerging. When and how the super CIN should approach payers for joint contracting should be carefully reviewed with legal counsel.

If it is structured appropriately, the super CIN can be one strategy to give smaller organizations the benefits of larger systems. However, board and executive leaders must focus on both the short-term economies of scale and the long-term value of delivering high-quality care at a lower cost. Trustees should insist that participation in a super CIN be vetted against a go-it-alone strategy and the long-term value to both the organization and the community. **T**

For a full list of questions board members should ask when considering a super CIN opportunity, go to www.greatboards.org.

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