Introduction to Rural Clinically Integrated Networks

Rural Health Value

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What: Rural clinically integrated networks
Why: To deliver better care and participate in value-based care and payment opportunities
How: Maintain independence through interdependence

Summary

A collaboration of independent rural healthcare organizations (HCOs), incorporated as a clinically integrated network (CIN), can achieve the scale and develop the infrastructure necessary to successfully participate in value-based care and payment opportunities. Furthermore, CINs can be a powerful vehicle to deliver better rural health care, healthier rural people, and smarter spending. The purpose of this Rural Health Value topic brief is to define CINs, describe common CIN characteristics, and explore the unique value-based care advantages a rural CIN may bring to its members.

Clinically integrated networks (CINs) are neither new nor uncommon. Many vertically integrated and/or horizontally integrated health systems currently operate as CINs and have existed for decades. These health systems provide CIN organizational structure, own multiple healthcare organizations (HCOs), and employ a variety of clinical personnel. Additionally, many health system CINs also include affiliated (but not owned) HCOs with whom they share operational practices and accountabilities to varying degrees. As examples, Mayo Clinic, University of Pittsburgh Medical Center, and Kaiser Permanente operate as health system CINs. But CINs among *independent* rural HCOs are less common. The purpose of this Rural Health Value topic brief is to define CINs, describe common CIN characteristics, associate CINs and healthcare value, and explore the unique value-based care advantages a rural CIN may bring to its members.

Clinically Integrated Networks

CINs form a corporation of HCOs (generally hospitals and/or clinician practices) who join together to improve and coordinate clinical care and demonstrate market value (high quality and low cost) using proven clinical protocols and measures of quality processes and outcomes.[1,2,3] Furthermore, CIN members collaborate to "actively assess and modify services to deliver efficient and affordable coordinated care to specific groups of patients. They share pertinent information and data, creating a high degree of interdependence and cooperation among the clinically integrated providers to control costs and ensure quality, usually via an electronic platform."[4] In 2009, Federal Trade Commission (FTC) Commissioner Pamela Jones Harbor provided this CIN description.

> The essence of clinical integration is the creation of interdependence among health care providers. Put simply, each provider must have a vested interest in

> the performance of the other providers, such that their financial and other incentives are closely aligned to meet common objectives. In addition, physicians are most likely to conform their behavior to network goals when their performance is judged by objective standards, in comparison to their peers.[5]

More recently in its 2018 Health IT Playbook Glossary, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) provided this CIN definition.

> A clinically integrated network is a term used to describe a collection of clinicians from different specialties who create processes and systems for managing and coordinating the care they deliver to individual patients. If a clinically integrated network meets specific standards established by the Federal Trade Commission (FTC), the clinicians in the network can jointly negotiate with payers in ways that could otherwise be deemed to be a violation of anti-trust laws, even if they are not taking financial risk. The things that a network must do to show it is clinically integrated under FTC rules include developing and using detailed, evidence-based clinical practice guidelines; limiting participation in the network to clinicians who are committed to following the clinical practice guidelines measuring the participating clinicians' compliance with the guidelines; and enforcing use of the clinical guidelines.[6]

In summary, CINs are organizations composed of multiple healthcare clinicians and organizations that implement models of care integration intended to achieve higher quality at lower cost. They typically serve patients across broad geographies by integrating the roles of clinicians at various points of service. With their focus on care coordination and population health improvement they are well-positioned to realize the full potential of new value-based payment models as negotiated with third-party payers.

CIN Accreditation

URAC (previously Utilization Review Accreditation Commission) has an optional accreditation program for CINs. Although URAC accreditation does not guarantee FTC approval, the URAC program provides helpful guidance through key CIN characteristics and responsibilities in six categories.[7]

1. **Structure and Operations** – CINs should maintain policies regarding business agreements and documents, CIN organizational structure and governing body, staff and provider qualifications and training, consumer safety mechanisms, financial integration, and fiduciary responsibilities.
2. **Health Information Technology** – Collection, aggregation, analysis, and sharing of clinical and financial data is key to a high-functioning CIN. CINs should evaluate various technologies, validate data accuracy and completeness, and ensure information security.
3. **Clinical Management** – Delivering better care and promoting healthier people requires evidence-based clinical care protocols implemented across the CIN. CINs should select and use clinical protocols appropriately, coordinate care for patients with chronic conditions, and support patient self-management.
4. **Population Health** – In the interest of healthier people, CINs should manage population health improvement activities, health risk mitigation, and provider access programs.

5. **Care Coordination** – Care coordination deliberately organizes patient care activities and shares information among all the participants concerned with a patient's care to achieve safer and more effective care.[8] CINs should support care coordination and transitions of care.
6. **Performance Measurement and Reporting** – Supported by health information technology, CINs should develop performance metrics (both clinical and financial), develop internal and external performance-sharing processes, and continuously improve performance.

Clinical Integration and Healthcare Value

Healthcare value is represented by the concurrent goals of better care, healthier people, and smarter spending.[9] In the Innovation Center 2021 Strategy Refresh, the Centers for Medicare & Medicaid Services (CMS) stated that all Medicare fee-for-service beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030.[10] These two accountabilities, quality and cost, are fundamental to value-based care and are supported by value-based payment. Value-based care contracting is also becoming increasingly common in state-based healthcare programs (e.g., Medicaid) and commercial health insurance payer programs.

Research by the Rand Corporation in 2020 could find no studies that evaluated the clinical impacts of CINs.[11] However, a CIN focus on clinical performance improvement and operational efficiency suggests that CINs are well-positioned to be an effective vehicle for value-based care success.

Rural Perspective

Many rural HCOs participate in value-value-based plans and programs. But overall, rural healthcare organizations' participation in value-based care and payment plans has lagged urban participation. This is due to a variety of factors including low patient and service volumes (making it more difficult to achieve enrollment thresholds and leaving organizations at higher risk for loss due to statistical variation), less experience with managed care, fewer financial management and population health resources, and low financial risk tolerance due to thin operating margins.[12]

Rural HCO senior leadership teams and boards often remark that they wish to remain independent; that is, not owned by a larger and distant organization. In other words, rural HCO leadership and boards wish to retain local control of their community's healthcare future. As noted above, value-based care and payment contracts are rapidly expanding among all payers. But participation in value-based care contracts requires patient volumes and supporting infrastructures, often unavailable in rural areas. Historically, some rural HCOs have affiliated with, or sold to, larger and distant health systems to achieve the scale and resources necessary for value-based care program participation. But by doing so, rural HCO senior leadership teams and boards lose at least some, if not all, decision-making authority regarding their community's healthcare future.

Rural Clinically Integrated Networks

CINs composed of *independent* rural HCOs are an alternative to health system affiliation. Independent rural HCOs can legally incorporate as a CIN. By aggregating patients and service

volumes, sharing expertise and clinical protocols, and investing collaboratively in value-based care infrastructure (including clinical data aggregation and analysis systems), rural HCOs can achieve the scale and support necessary to participate in value-based care programs. Furthermore, rural CIN members share decision-making authority typically through a representative board governance, articles of incorporation outlining decision-making authorities, and physician (and/or other clinician) input regarding clinical issues. Thus, rural CIN members maintain independence through interdependence.

URAC provides the best guidance for CIN structure and function, but there are minimal prescriptive CIN roadmaps or checklists promulgated by the FTC, Department of Justice, or state attorneys general. In her 2009 remarks referenced above, FTC Commissioner Pamela Jones Harbour stated that the FTC will not issue regulatory guardrails and safe harbors for CINs. Rather, "based on what we know right now about the relative benefits and risks of clinical integration – a flexible, case-by-case approach may be best for market participants as well as consumers."[13]

In the 1990s, few value-based care plans existed (except health maintenance organizations and isolated experiments with capitation), quality measures were underdeveloped, and clinical quality and cost data systems were rudimentary compared to current population health information technology platforms. And even since the 2009 FTC remarks, clinical performance analysis systems have become markedly more sophisticated. Considering new healthcare realities and absent clear regulatory guidance, it appears *reasonable* that rural CINs of independent rural HCOs should demonstrate interdependence through the following characteristics:[14]

- Clinical integration per URAC accreditation standards
- Distributed evidence-based clinical guidelines
- Physician (or other clinician) governance
- Use of a common population health information technology platform

Rural CIN Examples

Illinois Rural Community Care Organization – "The Illinois Rural Community Care Organization (IRCCO) is a group of physicians, hospitals, and clinics who voluntarily work together with Medicare to provide high-quality services and care through the Medicare Shared Savings Program. IRCCO is dedicated to quality, collaboration, excellence, and service. IRCCO strives to deliver the best healthcare possible to rural communities in Illinois. As a collaborative organization IRCCO believes primary care, chronic disease management, care coordination and social services are best delivered and supported on a local level. The IRCCO mission is to improve the health of the individual seeking care and services, improve the overall health of the rural population served, and reduce the individual healthcare beneficiary spend and reduce overall healthcare costs." (https://www.iruralhealth.org/)

Rough Rider Network – "The network of 23 North Dakota hospitals and their associated clinics join forces on clinical and operational fronts, amplifying the accessibility, affordability, and quality of care in North Dakota's rural communities. The network is a beacon for nearly 300,000 patients, ensuring they receive nothing but the best care. The Rough Rider Clinical Integration Network (CIN) was established to further enhance collaborative efforts. The CIN empowers member hospitals to offer continuous care to patients across the network, from surgery and ophthalmology to mental health and obstetrics. The CIN's Clinical Integration Committee, comprising a practitioner from each member hospital, supervises all clinical and quality initiatives." (https://roughridernetwork.org/)

Western Health Alliance – "The Western Healthcare Alliance (WHA) helps rural providers with collaborative solutions and resources focused on rural healthcare. WHA members have the independence and freedom to make decisions with confidence to ensure the best care in their communities. Hospitals and clinics alike receive the education and support needed to be able to manage day-to-day operations while planning for the future. WHA began in 1989 when a small group of rural Colorado hospitals decided that there was power in numbers. Today, WHA has over 30 healthcare members in Colorado, Utah, and Michigan. As members embark on the journey towards alternative payment models and population health, WHA formed the Community Care Alliance (CCA). The CCA is dedicated to creating solutions that ensure quality outcomes during the shift towards a reimbursement model focused on value. Members learn and work together to coordinate care and ensure success as their medical communities are rewarded for maintaining healthy populations through better care at lower costs." (https://www.wha1.org/)

- Shared goals of improved quality, increased efficiency, and reduced inappropriate utilization
- Shared financial risk in value-based payment contracts between the CIN and payers.

As noted above, the ASTP/ONC Health IT Handbook stated that "the clinicians in the network can jointly negotiate with payers in ways that could otherwise be deemed to be a violation of anti-trust laws, even if they are not taking financial risk."[15] However, before proceeding with payer negotiations, CINs should obtain antitrust legal counsel to help ensure that their activities meet reasonable criteria for clinical integration.

Conclusion

A collaboration of independent rural HCOs, incorporated as a CIN, can achieve the scale and develop the infrastructure necessary to successfully participate in value-based care and payment opportunities. Furthermore, CINs can be a powerful vehicle to deliver better rural health care, healthier rural people, and smarter spending.

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