Anatomy of a State-Wide Physician-Only CIN
(a.k.a. Cat-Herding For Fun and Profit)

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Why in the World Would Physicians Try This on Their Own?

In today's brave new world of healthcare reimbursement, physicians are seeing large portions of their revenue being diverted from traditional fee-for-service ("FFS") payments into quality incentives based on value.[1]

> "Value-based care" (VBC) can be defined as a reimbursement model in which healthcare providers (including physicians, hospitals, pharma or health technology companies) are paid, by health insurers or other purchasers of care, based on patient health outcomes. Started by employers in self-insured arrangements long before the passage of the Affordable Care Act, this payment model has been adopted in various forms by commercial and government insurance entities, and is highly likely to grow in scope…Significant peer-reviewed literature on the topic of VBC suggests that these arrangements can be associated [with] measures of preventive care, and reduced emergency department visits and hospitalizations.[2]

Although the approach of VBC may be like an oncoming train, most physicians maintain (at best) a healthy skepticism about the benefits of VBC, not only for patients and insurers, but also for their own bottom lines.

> Physicians are aware that many measures of quality are often process-based and/or narrow, and only a small minority are based on actual outcomes that are valued by patients. They are also aware that measurements themselves can be inaccurate or statistically suspect, and fail to account for the real-world complexity of patient care. In addition, business cost to a practice of obtaining quality measures is burdensome and interfering with their ability to fund clinical programs. The tension between the ideal of enhancing quality and the reality of "checking boxes" underlies a prevailing attitude among doctors that the quality measures used in VBC are having no or a negative impact on their ability to provide quality care to their patients. Their hands-on experience has also taught them to be skeptical of the chief underlying assumption that VBC will ultimately lower healthcare costs, a finding which

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> has been confirmed in multiple peer-reviewed studies that have found that there is no relationship between "quality" and "cost."[3]

In short, many physicians feel that VBC is not being done correctly. Nevertheless, some forward-thinking physician felt that VBC could be effective, if physicians took the lead in designing and implementing a VBC program.

However, to implement an effective VBC program, physicians must have the ability to share records systems (including electronic health records ("EHR") from multiple vendors), track data, and rely on evidence-based guidelines to provide high quality care across all participating providers.[4] The personnel costs involved in care management, as well as the capital cost of a population-based data platform to track and manage outcomes on a real-time basis are considerable, and are typically out of reach for small physician-led entities interested in pursuing VBC.[5]

Fortunately, in Pennsylvania, organized medicine came to the rescue. The Pennsylvania Medical Society, through the aptly named "Practice Options Initiative" authorized creation of a new subsidiary and funding of up to $15 million to create a physician-led clinically integrated network ("CIN").[6]

Is a Physician-Only CIN a Good Thing?

Few would deny the central role of physicians in managing patient care. The physician is the individual who has the actual contact with the patient, and can best use his or her judgment in determining what is needed. Physicians are trained from day one to keep their patients' interests as their major focus, and are the professionals who are most likely to understand the patient as a person. Having your physician (as opposed to a faceless bureaucrat) managing your care can only improve patient satisfaction and the quality of care.

For physicians, having a real seat at the table allows the folks who are implementing quality guidelines to analyze and discuss these guidelines and assure they are appropriate **before** being asked to implement them. Control of the CIN also gives physicians the best chance of receiving fair compensation for the additional work required to increase healthcare value.

Health systems benefit from a physician-led CIN by being freed from the massive capital and personnel investment required to run a CIN. In addition, given the friction common between hospitals and physicians, a hospital-led CIN is not likely to receive the same physician buy-in as one led by physicians.

Payors may be the biggest winners in physician-led CINs. Not only are these entities saved the expense of formation and operation of a CIN, but they can also profit from the payments that buyers (such as employers or government) are willing to make to incentivize increased quality. Payors can also profit from the savings generated by reductions in avoidable or unnecessary utilization that a CIN can achieve with a committed network of physicians.

How Do You Get the Physicians On Board? (Cattle Prods are NOT the Answer)

Physicians are naturally skeptical about any movement away from FFS reimbursement. Although they may generally accept the concept of physician leadership, independent physicians tend to be overwhelmed with patient care and all the administrative hassles of running a practice.

Having a trusted entity that can assist in the creation of a CIN helps. Sponsorship by a known entity (the Pennsylvania Medical Society in this case) helps allay suspicions that this is yet another scheme that will suck up the physicians' time and money with no potential upside, or an upside that fails to make them whole for the time and money invested. However, good intentions and a beneficent sponsor will only take you so far. The CIN needs to demonstrate a true bias toward helping physicians.

In our case, the bona fides of the CIN were established in two main ways: contractual provisions that are more physician-friendly than most; and a fair (extremely generous) allocation of overhead and income.

Contractual Provisions

Under the Participating Physician Agreement ("par provider agreement"), no contract will be accepted unless the physician-led Finance Committee of the CIN, as well as the physician-led board of directors of the CIN approves the agreement.[7] In addition, the par provider agreement can be terminated by the practice upon only 90 days' advance written notice.[8] Although the CIN needs to maintain flexibility in its contracts, the par provider agreement also provides that the agreement may be amended by the CIN with 90 days' notice. The practice may object to the amendment and terminate the agreement upon the effective date of the proposed amendment.[9]

Financial Terms

Most physicians can regale you with multiple stories of "successful" ventures where good outcomes were achieved, and a reasonable return was obtained by the entity. However, the common thread in all these ventures is that the financing partner (generally a payor or a health system) ended up with the vast majority of the funds generated, based upon a recoupment of "overhead." In these types of arrangements, there never seems to be any significant funds left over to pay the physicians. The sense of most physicians is that payors and health systems are awash in (excessive) overhead expenses – and these expenses always seem to ultimately come out of physicians' pockets.

This perception was addressed by providing that physicians participating in the CIN would receive 70% of all income generated. All staffing, legal, and operational support would be provided by the CIN in return for the 30% share of revenue generated.[10]

In addition, the CIN promises to fairly compensate physicians for participating in any committees of the CIN.[11]

Unique Aspects of Credentialing When Physicians are Balancing Cost and Quality

A physician-driven CIN has all the cost and quality concerns of any other managed care entity. At the same time, there should be a bias toward accepting physicians into the network, rather than refusing admittance based on prior perceived (by payors or health systems) inefficiencies.

The CIN intends[12] to bring in most physicians who apply, and to use best efforts to review cost and quality concerns with the participating physicians in real time as issues are presented. This is partially a nod to the physician-led aspect of the CIN, and partially a business decision based on a desire to quickly get into the marketplace with a robust network.

Although the CIN requires participating physicians to supply provider or performance profiles created by payors if not prohibited by law or contract[13], these profiles are intended to be used to highlight potential issues, rather than to deny membership in the CIN.[14]

The leadership of the CIN has made it clear that physicians will drive credentialing and quality. Rather than "cherry-picking" physicians who are currently perceived to be high quality, efficient providers, the CIN intends to work in real time to educate physicians on established guidelines, and work with physicians to raise quality and efficiency.

Obstacles to Clinical Integration

Battling the EHR Companies

The CIN has invested hundreds of thousands of dollars in a state-of the-art population health management system. This system is "agnostic" in the EHR being utilized in the practice. In theory, the physicians should be able to "hook-up" their EHR to the population health platform and begin managing care at the population level.

The reality, sadly, is somewhat different. Many EHR companies feel that their product, standing alone, is suitable for population health management. These companies are typically extremely resistant to allowing the population health platform access to the physician's EHR. Think about that for a moment – the physician has paid big bucks for this EHR. There were large set-up fees, staff and physician training, and ongoing maintenance fees. The physician is putting the information of that physician's patients into the expensive EHR. But the EHR company won't allow access to the physician's data.

We have learned that negotiations are required for each new EHR brought into the system. These negotiations can take weeks, and no data will be flowing into the system until the issue is resolved. Even after the EHR company consents, we have found that the CIN has to send a highly trained "super-user" into each practice to test connections, and individually onboard every new practice.

Physician Concerns About Potential Disclosure of Fee Schedules

Another issue that we needed to address was a concern on the part of larger practices that the favorable terms they have negotiated with managed care companies would be discovered by smaller practices. There was a misconception (common to most large practices we approached) that physicians on the population health platform could tap a few keys and discover what other physicians were charging.

Any antitrust lawyers reading this probably had to breathe into a paper bag thinking about the implications of that sort of discovery. However, this misconception is wrong on two counts: first, until the CIN has a contract in place with a managed care company, there will be no claims data, so the system simply won't have information about charges. Secondly, even once claims data is in the system, as a practical matter it is clear that the population health platform itself probably won't be utilized by individual physicians – reports will be generated by the CIN concerning possible care gaps, but it is not anticipated that practicing physicians will actually log into the platform at all.

Governance of the CIN

One of the early concerns addressed by the CIN was that physicians, faced with the potential of a large pot of money to be distributed after a successful year of a VBC agreement, would try to allocate as much money as possible to their particular specialty. A common issue with physicians who are not primary care physicians ("PCPs") in joining the CIN was that "the PCPs will get everything." One way to counteract this perceived inequity would be to assure that the specialists had adequate representation on the committees of the CIN (especially the Finance Committee) to assure that they got their "fair share."

Taken to an extreme, there was a concern that **each specialty** would attempt to get on the Finance Committee to assure that that specialty was appropriately awarded for a successful year. However, this concern appears to have been overblown. As one large specialty practice told us "We know we are efficient and high quality. Once the PCPs in a VBC contract see what we're doing, and how we save money, we're comfortable that the money earned from additional referrals will be significant. That's where we see our money coming from in this deal."[15]

Lessons Learned

As of this writing, the CIN is still in the formation stage, with approximately 200 physicians having executed participating provider agreements. There is a long road ahead, but signs are promising that the CIN will be successful. Several important lessons have been learned in this long and arduous process:

Build or Buy?

One of the earliest decisions was that of "buy or build." A major accounting firm was commissioned by the Medical Society to perform a feasibility study. When the concept of a

state-wide physician-only CIN was validated by that study, the same firm was engaged to plan and begin implementation of the CIN. The consultants were top-notch – an excellent team of experts was assembled from across the country. Not surprisingly, the consultants were also quite expensive.

After the planning was completed, a proposal was produced to begin implementation. The total combined fees quoted (including the feasibility study and planning done to that date) was many millions of dollars. At this point, the CEO and CFO were on board, and they decided that they could do it more cost effectively if they built a staff from the ground up. It was a courageous call (if the CIN had failed, there would no doubt have been questions as to why the experts weren't utilized). However, it became clear early on that building rather than buying was the right choice. An outstanding staff has been assembled, and the feeling is that training "boots on the ground" trumps purchased expertise in cajoling physicians to join and then onboarding them into the population health platform (more about that later).

Hitting the "INSTALL" Button on the Population Health Platform

The effort needed to move from a population health platform in the sky to a working network of connected physician practices proved to be much more than initially anticipated. Although nobody thought it would be a case of "download the software and hit the 'INSTALL' button", the difficulties of bringing each practice into the population health platform were not fully appreciated until the network began to go live.

I have previously discussed the problems in getting the EHR companies to consent to access of the data in the physicians' files. Once that consent is granted, actually connecting the EHR to the population health platform is a time-consuming and labor-intensive task. A highly trained "super-user" Registered Nurse is currently dispatched to each practice to get the practice on the platform. It typically takes up to a week for that person to get the connection working properly, and to test for bugs.

One for the Lawyers – Antitrust Issues

Antitrust issues raised their head early in the process. Many physicians were excited about the process of building a network of physicians to negotiate with managed care companies. The Department of Justice and Federal Trade Commission have indicated that they would not challenge a clinically integrated network that negotiated fees.[16]

However, we decided early on that the CIN would NOT negotiate FFS rates for participating physicians. This was based on our assessment that negotiation of FFS rates by a state-wide organization – especially one that is sponsored by an organized medicine trade association such as a state medical society - would quickly raise the attention of the regulators.

There is little doubt that this organization, *once fully operational,* will meet the definition of a "clinically integrated network" as contemplated by the regulators. The FTC has indicated

that it would probably not challenge a program that negotiated fees, based on assurances of what the program would eventually look like.[17] Nevertheless, we decided to err on the side of caution. The CIN intends to negotiate value-based contracts that are an "add-on" to the payor agreements of the physicians participating in the CIN. That is, the CIN physicians will have existing FFS contracts with the managed care company that will remain in place, so they will be paid their standard FFS. At the **network level**, the CIN will seek to obtain a share of the savings generated by the network over a given population[18]. This network payment will then be distributed to the network providers.

Small is Beautiful

Another lesson learned is the vital role of small practices in building the network. Although having small practices in the network was always assumed, the early plans called for bringing in several large independent practices to create the base of the network. These large practice "whales", however, proved to be difficult to land.

A meeting of several large high-performing primary care practices gave an early warning that large practices would not come into the fold easily. Unfortunately for the CIN, the CIN staff were not the only people who recognized the value of these practices. One of the parties who recognized the value of these practices was the practices themselves. One large practice opined that they could form their own CIN, and thereby not have to share any distributions.[19]

In addition, it quickly became clear that a few of these practices were either in play, or were at least entertaining multi-million dollar offers from health systems and/or managed care companies. Given the enormity of the decision to potentially give up their independence, it's not surprising that entertaining the concept of joining a CIN was not in the forefront of their thinking, or a top priority.

Although one large independent practice association/CIN ultimately joined the fold[20], the state-wide CIN continues to sign up small practices as a major focus of recruiting.

If You Build It, Will They Come?

The difficulty in recruiting physician practices into the CIN is undoubtably the biggest lesson learned to date.

As a subsidiary of a trusted organization (the Pennsylvania Medical Society) it was initially assumed that the CIN would "build it and they will come." This proved to be far from the case. Although trust has not been an issue, physicians have proven to be extremely hard sells.

The first outreach to physicians often consists of a public meeting, where many physicians in the area are invited to a lecture/Q&A. Although a few physicians have joined following these public events, the general trend is that three or four additional follow-up "touches" are

required. It has become increasingly clear that multiple **in-person** contacts are required for each practice before a participating provider agreement is executed.

The staffing implications of this discovery are obvious. The CIN began with a physician CEO, and a CFO. A Vice President of Partnerships was quickly added after the decision was made to build the infrastructure of the CIN rather than purchase it from the consultants.

The initial idea was that the VP Partnerships would design a marketing/education program which would attract physicians and quickly sign them up. We would host a public event and have people in the rear of the room to sign up the attendees. It soon became obvious that more contact would be required for each practice.

The CEO and the VP are continually crisscrossing the state meeting with physicians and explaining the CIN. It didn't take long to realize that two people, no matter how dedicated and qualified, were not going to be able to develop a critical mass of physicians in any reasonable timeframe. Because of the sophistication of physicians, adding additional marketing personnel required careful selection.

The staff has been slowly but deliberatively built, so that four individuals (in addition to the CEO and VP[21]) are now traveling around the state, meeting with physicians, and providing the information and assurances that physicians need before they commit.

The business savvy of physicians ranges from severely lacking to highly sophisticated. At both extremes, and at all points in between, physicians require personal contact and attention before they will commit to anything. "Build it and they will come" is a recipe for disaster – any entity contemplating initiation of a CIN must be prepared for a serious commitment of staff and money for physician recruitment if it hopes to achieve success.

Endnotes

[1] Sidorov, Jaan: It's Time for the Docs to Lead (Attached as Exhibit 1), at 2 (citations omitted)
[2] Id., at 1 (citations omitted)
[3] Id, at 2 (citations omitted)
[4] Id., at 1
[5] Id., at 3
[6] Id., at 2
[7] PA Clinical Network Participating Physician Agreement (Group) (Attached as Exhibit 2), § II.A.
[8] Id, § V.A.
[9] Id. § IX.H.
[10] Id., §§ II.B., II.D.,VII, Attachment A-2
[11] Id., § II.J.
[12] As of this writing (January 2019), the Credentialing Committee of the CIN has not yet been stood up
[13] Par provider agreement, § III.T.
[14] Of course, the physician-led Credentialing Committee, when fully operational may choose to utilize these profiles differently
[15] As of this writing (January 2019), there has been no VBC contract entered into, so the question of distribution of gains remains theoretical.
[16] See Joint Statements of Antitrust Enforcement Policy in Health Care (August 1996), 4 Trade Reg. Rep. (CCH) ¶ 13,153 at Statement 8 at C.1
[17] See, e.g., TriState Health Partners, Inc. Federal Trade Commission Advisory Opinion (April 13, 2009)
[18] Ultimately, the CIN anticipates entering into risk-based contracts as well
[19] Given the cost of purchasing and implementing the population health system, I don't believe this was an accurate assessment.
[20] Several others are in active discussion as of this writing (January 2019)
[21] Now Senior Vice President