



North Carolina Medical Society
FOUNDATION
Opening Doors to Quality Health Care

THE PHYSICIAN'S CIN AND ACO CONTRACTING GUIDE



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North Carolina Community Health Center Association
North Carolina Foundation for Advanced Health Programs
North Carolina Healthcare Quality Alliance
North Carolina Medical Group Managers
North Carolina Medical Society

INTRODUCTION

This strategic guide is intended for physicians as they consider joining a “clinically integrated network” or “accountable care organization” to participate in value-based payment arrangements. While these types of organizations may involve a variety of provider configurations and may be organized/sponsored by any combination of health care organizations (i.e. large physician groups, hospital-based systems, independent practice associations, insurers and/or virtual networks of independent practices), the general purpose of such an organization is to link various health care providers so they can provide coordinated services to particular patient populations and bear some responsibility both clinically and financially for the outcomes and health status of that population. To be functional the organization must create and maintain a care delivery network to service those particular patient populations. As a provider resource to the care delivery network, you will be widely solicited to join via a participation agreement. The purpose of this guide, as further described below, is to inform you, the reader, of the nuances of participation and identify what you should look for in an organization offering to coordinate value-based payments on your behalf.

Part One contains background on clinical integration and accountable care, including a perspective on the movement to value-based reimbursement and employment trends driving the popularity of the model as well as other issues to consider prior to joining, participating in, or even forming such an organization. By identifying the opportunities and risks inherent in your participation in integrated care, you will more readily be able to maximize the benefits while protecting your interests. This sets up Part Two, the actual contracting process.

Part Two applies specific strategies and practical step-by-step guidance, including use of concrete examples of contract provisions typically found in physician Participation Agreements to help you navigate through the contracting process successfully. Particular attention is paid to those latent risks of which a practicing physician may not normally be aware.

This Guide is not intended as legal advice and should not be used or relied upon as legal advice. It is provided for general information purposes only and may not be substituted for legal advice. Specific legal advice is critical when preparing for or negotiating an important contract that would have significant financial and legal consequences: **ALWAYS SEEK THE ADVICE OF KNOWLEDGEABLE COUNSEL TO PROVIDE ADVICE THAT IS TAILORED TO THE ACTUAL FACTS AND CIRCUMSTANCES AND TAKES INTO ACCOUNT ALL RELEVANT LAW.**

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Part I

KNOW THE NEW OPPORTUNITIES AND RISKS BEFORE YOU NEGOTIATE

A. First, a Word about Words:

Question – What's the difference between a "CIN" and an "ACO?"

Answer – Names used to refer to an alignment method are, to some degree, terms of art that may have varying meaning based on the context, circumstance and individual/regional use of the term. The imperative is understanding your responsibilities and performance requirements of participation and the incentives or risks related to that performance rather than how the program or agreement is labeled. As both the terms CIN and ACO are prevalent in the current lexicon we have provided generally accepted use of the terms below. For the purpose of this Guide, we will often use the term CIN to be broadly read as either a CIN or ACO and believe the information is applicable for contracting with either type organization for the purposes of participating in performance-based payer programs/agreements.

The term "clinically integrated network" (or "CIN") is actually an antitrust term of art, first coined in 1996 by the Federal Trade Commission ("FTC") and the U.S. Department of Justice ("DOJ"), the federal antitrust enforcement agencies.¹ The agencies stated for the first time that even without financial risk of loss, a network of otherwise competing providers that jointly negotiate will not be viewed as *per se* illegal if the integration of the network is likely to produce significant efficiencies that benefit consumers and any price agreements are reasonably necessary to realize those efficiencies. Indicia of such integration that they would look for included commitments to modify practice patterns, a high degree of interdependence among providers, significant integration of monetary and human capital, mechanisms to monitor and control utilization and selectively choosing network physicians.

The term "accountable care organization" (or "ACO") was first used by Elliot Fisher in 2006 and was included in the Affordable Care Act. It is unhelpfully defined by the Centers for Medicare and Medicaid Services ("CMS") as, "a group of doctors, hospitals and other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients." Elliott Fisher, Mark McClellan and others more helpfully describe an "ACO" as follows:

- Provider-led organizations with a strong base of primary care that are collectively accountable for quality and per capita costs across the continuum of care.
- Payments linked to quality improvements and reduced costs.

¹ U.S. Dept. of Justice, Fed. Tr. Commission, Statements of Antitrust Enforcement Policy in Health Care, (Aug. 1996).

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- Reliable and increasingly sophisticated performance measurements to support improvement and provide confidence that savings will be achieved through care improvements.²

If you are thinking that these definitions sound pretty similar, you are right. In October of 2011, the FTC and DOJ compared the requirements for ACOs in the Medicare Shared Savings Program (“MSSP”) with their legal standards for clinical integration and declared, “The Agencies have determined that CMS’ [MSSP] eligibility criteria are broadly consistent with the indicia of clinical integration” and granted them a presumption of same when they became involved in commercial contract negotiations if they used the same mechanisms as they did in the MSSP.³

“CIN” has been given other definitions in the health care marketplace. The term “CIN” has occasionally been used as shorthand for a health system’s alternative way to assemble an ACO other than employing all the providers. Others have applied the term “CIN” to value-based payment contracts with commercial payers and the term “ACO” for Medicare arrangements only.

Strategic Tip: Don’t allow labels such as “CIN” and “ACO” to influence your decision to participate; clearly understanding the rights and responsibilities provided through the participation agreement is much more important.

B. Why Care About a CIN Agreement?

Health care transformation is being driven by new payment models based on paying for value rather than paying solely on volume. As discussed in more detail later, there is absolutely no way to thrive under the new model without collaborating or “integrating” with other providers, and moving to value-based care is no longer optional. With the passage of the Medicare Access and CHIP Reauthorization Act (“MACRA”), your Medicare fee reimbursement is directly impacted. These two little-understood drivers are real game changers for physicians. A physician typically becomes integrated either through employment by a large organization (financial integration) or by their practice negotiating and signing a CIN Agreement, usually called a “Participation Agreement” (clinical integration). The employed physician, although unlikely to be involved in negotiating incentive programs with independent physicians, is directly impacted by the arrangement. Thus, understanding CIN Agreements is essential to your professional future, whether you are employed or you are in an independent practice.

As clinical integration can provide a foundation for delivering value, and payers are moving to the value-based models, there has been a major influx in the number of systems and provider groups that are forming or participating in such networks. When used in this Guide, “CIN” shall refer to the contracting “entity” established to implement integrated care among providers and to coordinate with payers for

²McClellan, M. McKethan, Lewis, J. L., Roski, J., Fisher, E.S; National Strategy to Put Accountable Care Into Practice, Health Affairs, Vol. 29, No. 5, pp. 982-90, (May 2010).

³Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medical Shared Savings Program; 76 Fed. Reg. 67026 (Oct. 28, 2011).

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that care. CINs may be created by any combination of health care providers and/or systems either in their own name or as a new entity created for the purpose of clinical integration.

No doubt the costs of health care products and services have been increasing at a drastic pace. If the trend continues, by 2035, U.S. health care costs will be more than the total of all tax and other revenues collected in our country, and by 2080, taxpayer funded health care will equal all of our governmental revenues, meaning that everything else—defense, roads, education—must be funded by borrowing. In a 2014 report by the Commonwealth Fund, our country “ranked last overall among 11 industrialized countries on measures of health system quality, efficiency, access to care, equity and health lives.” Significantly, the U.S. was noted to have the highest costs while also displaying the lowest performance.⁴

The Congressional Budget Office laid the groundwork for accountable care’s “pay-for-value” underpinning when it reported that much of the blame for our runaway health care costs should be placed on our fee-for-service payment system where “providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.”

C. MACRA Is a Team Sport

On April 16, 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”), creating the two-track Quality Payment Program (“QPP”) and transforming the way providers are paid for providing services to Medicare patients. This law replaced the Sustainable Growth Rate formula (“SGR”) with incentives for physicians to participate in integrated models. Only risk-taking arrangements, however, qualify under QPP’s highly incentivized Advanced Alternative Payment Model (“Advanced APM”) track. Furthermore, the performance level expected of physicians who strive to obtain positive payment adjustments under the Merit-based Incentive Payment System (“MIPS”) track reinforce the need for CIN-like, interdependent, collaborative and coordinated care with other providers across the continuum of care. In addition to Congress’ action with MACRA, the United States Department of Health and Human Services has independently announced goals of requiring 85 percent of Medicare fee-for-service payments to be tied to quality or value by 2016 and 90 percent by 2018.⁵

Although Medicare is only one payer, previous trends have proven that ultimately, when CMS makes changes to payment policies in Medicare, often many other private payers and Medicaid agencies follow suit. The result of the passage of MACRA will accelerate changes to physician payment and care delivery currently underway.

⁴<http://www.commonwealthfund.org/publications/press-releases/2014/jun/us-health-system-ranks-last>

⁵<http://www.nejm.org/doi/full/10.1056/NEJMp1500445>

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Commercial insurers, as well as employers who insure through self-funded plans are also aggressively pursuing value-based purchasing arrangements. As integrated models develop and are fine-tuned, in large part through the CMS Innovations Center, more and more commercial plans are increasing value-based payment opportunities for doctors and health systems. In fact, a coalition of private insurers and provider organizations called the Health Care Transformation Task Force⁶, announced that its members are committing to move 75 percent of their contracts into alternative payment models by 2020. The task force, which includes Aetna and Blue Cross, aims to reach an accord on the most effective payment models for hospitals, private insurance companies and public payers to accelerate change in health care delivery.

D. The Top Six Reasons Physicians Should Joint a CIN

1. **To Grow Revenue – To Be a Winner under MACRA** – MACRA changes everything. As noted, you cannot hope to hold your own or gain Medicare payment increases if you do not practice in some type of network or team. Even under MIPS, many of the metrics and reports encourage collaborative, integrated care. In radical departure, you are being judged on overall patient health status and its cost. As an example, the typical primary care physician's patients consume an average of \$10 million. The physician only receives 7 percent or 8 percent of that total, but is now being judged on the total expenditure. It is essential to affect not only costs, but quality of patient care across the care continuum. As noted, MIPS success requires collaboration. The Advanced APM obviously moves the needle farther toward sophisticated CIN-type structuring. The significant 5 percent bump in income is a powerful indicator of CMS' intent to move all health care to integrated, value-driven arrangements. Advanced APMs must accept some sort of medical-loss risk, therefore a physician's choice of teammates becomes extremely vital to both professional and financial success.

Even without MACRA, as discussed, by economic necessity, we were already moving away from fee-for-service's "pay-for-volume" flaws. But MACRA, with its broad requirements and expedited timeframe for implementation now claims precedence in the strategic imperative for every physician seeing meaningful numbers of Medicare patients to move intentionally toward participation in an integrated program. Private payers, Medicaid and self-funded programs are following suit.

2. **To Grow Your Practice – Other Providers** – Primary care physicians, specialists, health systems, IPAs, CINs and other provider entities are realizing their fates are tied to their selection of collaborative partners. They are scrutinizing referrals with increased analytical proficiency to see who provides not only the lowest cost and the most reliable quality, but also who provides excellent communication, coordination and willingness to follow multidisciplinary care best practices for patients. It is essential that you be the "go-to" referral source for your subspecialty. Participating in a well-organized CIN usually gives a boost (but not guarantee) to referrals. Although "High-Value Referral Agreements" are

⁶<http://hcttf.org>.

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becoming more common for targeting referrals to identified high-value partners outside of an organized CIN, there can be significant additional benefit to participating as a provider within the CIN.

Participating in an integrated program allows physicians to extend and strengthen their referral networks. That said, it is more important to join one or more high-value CINs that are right for you than just signing up for any and all CINs to multiply networks. A reverse corollary to that notion is that CINs are becoming more and more selective about participation, especially as they move to risk contracts.

3. To Grow Your Practice – Patients – There is a major commitment by payers to gather and disclose heretofore private health care quality and cost information about you and organizations of which you are a part. Concurrently, high deductible plans and health savings accounts are specifically designed to make patients prudent purchasers by ensuring they have “skin in the game.” If you are in a good CIN, your quality, cost, patient engagement and patient satisfaction levels will rise. Even under the MSSP, with attribution based on historical primary care patient contacts, patient choice rules supreme. They can leave any time just by going to another primary care practice. You should seriously consider participating in a high-performing CIN because your patients will receive better care, encourage others to see you, and your improved quality and efficiency will increase your popularity with patients due to increased public reporting to a more discerning consumer.

4. To Grow Your Practice – Payers – Private payers are moving to “narrow networks” whereby only the documented high-value practices are included. Patients and employers are then steered to the narrow network. Often, it is the entire panel of CIN participants who obtain that status. One tenant of meeting indicia of clinical integration is to require participants to adhere to standards and protocols and failing to do so can result in expulsion⁷. Additionally, public payers, such as CMS, require ACOs to take remedial action including potential termination of chronically low-performing practices⁸ thus limiting your access to those patients and referrals.

5. To Access Advanced Technologies – To thrive in the MACRA value-based payment integrated population world, it is essential that a physician have access to technology. You need technology to:

- Find gaps in care;
- Identify patients with those gaps;
- Have actionable data and decision supports at the point of care;
- Be able to identify high-value partners and to coordinate and communicate across the continuum regarding your patients' care;
- Determine best practices and enable implementation by embedding technology into each initiative;

⁷U.S. Dep't of Justice & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care, Statements 8 and 9, at 71-73 (1996).

⁸42 Part 425.116(7)

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- Measure, monitor and constantly improve care;
- Leverage telehealth and telemedicine innovation;
- Report to get paid, including through MIPS.

By joining the right CIN, you will gain access to the robust and interactive technologies you will need, which often otherwise are unaffordable.

6. To Be Able to Practice the Right Way – Empowerment – Results of CINs that have been successful invariably cite physician engagement and leadership as the main reason. Postmortems on failing CINs cite the organization's inability to engage its participating providers. Physicians must be at the core of any CIN strategic care modeling. Once the anxiety over the newness of the approach starts to wear off, physicians find they are being asked to design their care models supported by technology and community resources; in short, to be empowered to practice medicine the right way. Additionally, physicians should no longer be in silos seeing one patient at a time, but designing best practices for thousands of patients. Many realize this connects powerfully with why they went to medical school.

E. The Top Seven Risks of Joining a CIN

1. Your Fate is Dependent on Others – Culture is slow to adapt – As outlined above, the creation and implementation of a successful CIN is truly a disruptive innovation. The skillsets required under the fee-for-service, pay-for-volume era are actually not only counter-productive in the value-based care era, but are actively destructive. Too many CINs have been “put together” under a fee-for-service mentality and culture.

Strategic Tip: By far the greatest risk you will face in joining an ACO/CIN is that its leaders either do not understand or, if they do, they do not commit fully to the value proposition.

It may be very hard, for example, for a hospital with 90 percent fee-for-service to be totally on board with reducing admissions. Even well-intentioned CIN leaders often just don't understand the elements for value-based care success are radically different from fee-for-service behaviors. Too often, high-volume proceduralists are recruited, instead of the documented high-value partners. It's more familiar to invest in objective analytics and legal paperwork than to focus on the very subjective, but more important, physician leadership and engagement components.

Another cultural concern comes when the CIN's founders may have set up the CIN and seek your participation to make a “profit” for themselves. This is a fundamental, but common, mistake. Return on capital is fine, but the shared savings or other performance-based payments made to the CIN are the modern remuneration for clinical care. They are not company profits; they are payments for health care services. Beware of this cultural concern.

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2. **Uncertainty** – Is this the “next big thing” to save health care? None of the others worked out as advertised. Aren't the policymakers all over the place these days? Will my managed care market move in this direction? Which of the competing CINs do I join, if any? What about my patients? I don't see a clear direction or winner yet.

3. **High Startup Costs** – Startup costs need not be significant if proper attention is paid to physician understanding and engagement, and the founders are fully committed to the value proposition. The budget of the CIN can show the burden startup costs—usually high technology costs—can place on the CIN. Startup costs for many CINs seem so high as to dim any prospect of meaningful physician shared savings distributions or the availability of other incentive payments. The development of a chronic care management program can help offset infrastructure costs. How does the CIN account for operational and infrastructure costs?

4. **Risk of Medical Loss** – CINs are moving to accept the risk of medical costs exceeding projections. Does the CIN have adequate financial reserves or stop-loss insurance? Is it operationally ready to take risk?

5. **Legal Compliance** – Most of the laws to regulate fee-for-service abuses, such as the Stark Law, insurance, the anti-kickback statutes and antitrust laws are still in place. They make suspect physician revenue and referral sharing as well as collective bargaining by competitors, all essential to CIN success. Physicians know enough about these laws to be wary of CINs. Was the CIN created with skilled legal counsel and does it have a sound compliance plan?

6. **“I Just Want to See Patients”** – Physicians often see CIN participation as creating too much bureaucracy and administrative distraction from hands-on patient care. Plus, physicians value their independence. CINs vary widely in reducing the hassle factor. A well-run CIN can reduce your Quality Payment Program reporting requirements and other administrative burdens significantly.

7. **Dependent on Patient Behavior But No Way to Control** – Physicians are skeptical of a compensation system based on patient outcomes when, as a society and health care system, we have very little influence on patient compliance. In fact, CINs can be successful in generating major patient adherence, but many have not yet discovered the solution.

F. Due Diligence BEFORE You Negotiate Contract Terms

The prior narrative has attempted to flag what attractive CIN components to seek and problematic ones to avoid. This section provides a “due diligence” approach to assist in discerning the key elements in the CIN relationship you are considering. If you are armed with a basic understanding of CINs, we

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suggest that utilization of this simple due diligence roadmap will be more helpful to you than the actual negotiation of specific contract terms, which we cover in Part II.

1. **What Should I Look For?** – Whether you are seeking out a CIN to join or the CIN has sought you, there are a few things worth considering prior to signing a Participation Agreement. Regardless of the CIN's organizational structure all will or should have:

- A common IT platform, or one that allows interconnectivity among multiple platforms, to ensure exchange of all relevant patient and business data;
- Clinical protocols and performance and quality measures based on those protocols;
- Review of care based upon those measures; and
- Mechanisms to ensure adherence to protocols - typically a binding Participation Agreement.

As CINs are first forming they will be less selective, as they will want to draw as many participants into the network as possible to have the best opportunity to identify high performers and build the program around those high performers. To encourage participation, the CIN may waive or charge a very nominal participation fee. Additionally, as it takes time to generate savings or other financial incentives to join, a CIN should offer participants non-financial incentives such as: (i) tools intended to aid in managing chronic disease, that assist in coordinating referrals, and that reduce unnecessary utilization of high-cost care; (ii) services to assist participants in implementing new, more effective models of care (this may include consulting and other resources to advance your practice or learn new technologies); (iii) opportunities to collaborate with peers and hold leadership roles within the organization; and (iv) access to payer contracts that financially embrace value-based health care delivery and payment.

2. **What to Ask?**

- a. How is the CIN organized? Who owns/funds the operational entity, who governs, how are decisions made, what is the mission? What are the operational committees, how do I participate, get appointed, serve on the board, etc.? Ask for bylaws/policies/missions you can share.

Why? Physician engagement and leadership are vital. Organizations that underemphasize physicians in these roles may signal a lack of commitment to value-driven care, or may be merely using the model to maximize market share.

- b. Does the CIN have any current business? What types of payer agreements (enhanced payment, shared savings, risk, etc.) are in place, and which will you pursue? Does it plan on participating in a CMS alternate payment model or initiative? For those entertaining risk contracts, how much of my revenue is subject to risk? What are the CIN's reserves?

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Why? What portion of the current arrangements are actually value-based? Of those arrangements what has been the CIN's performance track record?

c. How will I be measured?

Why? Physician participants must understand and agree upon the performance metrics the CIN will use to track quality, outcomes, service, patient satisfaction, overall cost of care and other operational and financial benchmarks. This is critically important since performance against these metrics is how the CIN will hold each participant accountable. The metrics must be specific, measurable, attainable, relevant and time bound. They also must be reviewed on a frequent and ongoing basis.

d. How does the CIN distribute savings or allocate incentive payments? How much goes to overhead and administration or repaying infrastructure versus what goes to the participants?

Why? This is one of the most critical due diligence questions. It probes the motivation/ understanding of the CIN. They call them "incentive" payments for a reason. This is the new provider clinical compensation model, and savings should be meted out on a merit basis, with distribution to each provider in proportion to contribution. Regardless of how the funds flow to participants, the method should be transparent and easy to understand.

e. What is the participation mix? Is there any distinction between employed and independent participants? Which specialists are included, which hospitals are within the Network?

Why? Is the panel strategically constructed to maximize value-based integrated population health (i.e., PCP core, select high-value specialists and facilities designed to best address identified modality gaps in care) or is it a thinly-disguised net to capture fee-for-service referrals?

f. What is its specific value-add strategic plan?

Why? If put together without a plan, this signals lack of understanding at best; lack of intent to drive value at worst.

g. Advanced, integrated organizations are constantly evaluating and evolving based on the results of such evaluations. Has the CIN performed a needs assessment? What are the opportunities identified in its needs assessment?

h. Do they include my skillsets?

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- i. Is the integrated organization exclusive—can I participate in programs outside of the CIN?
Note: a physician participating in a CIN's MSSP affects his or her ability to participate in other Medicare demonstration projects or programs that involve shared savings.
- j. Are there fees?
- k. Am I personally at risk?
- l. Has it spent millions on IT—may I see the budget? Will there be anything left of savings distributions after feeding the overhead?
- m. Does it have knowledgeable and empowered providers on the clinical, IT and finance committees?
- n. What is its community health partnering strategy?

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Part II

THE PHYSICIAN'S CIN PARTICIPATION AGREEMENT NEGOTIATION ROADMAP

A. Introduction

Part I addressed what you normally would want to get out of a CIN relationship, interests you want to protect, and the risks you need to avoid. It also provided “due diligence” questions to help probe the structure, strategic viability, culture, fiscal soundness and your role and corresponding chance for merit-based performance compensation.

Strategic Tip: Understanding the unique new opportunities and threats in value-driven care network, and determining the nature of your potential CIN partner by using the due diligence checklist in Part I, will often do more to guide your contracting success than negotiating particular terms, which is the focus of Part II.

The usual way for an independent practicing physician to “join” a CIN is by their practice entering into a “Participation Agreement.” It is merely the vessel to hold the mutual promises, set expectations, address legal compliance and allocate risk among the CIN, practice and individual physicians.

Strategic Tip: WARNING: Do NOT consider signing a Participation Agreement without understanding the new risks and rewards in value-driven health care and doing your due diligence homework on your potential partner covered in Part I.

The Participation Agreement also has a valuable secondary role—it is often one of the first things reviewed by payers and regulators to see if the CIN is actually designed to be a viable model to generate higher quality and savings through integrated population health collaboration and whether there are antitrust or kickback concerns.

Legal Note: If the CIN is likely to generate better and more effective health care by providers working together to improve population health, integrated via a common analytics platform, it is likely to be both successful in value-driven care, and meet legal muster as a “procompetitive” improvement in health care delivery for the region, achievable only by providers working together. If certain safeguards are met, this procompetitive network will be deemed “clinically integrated” in antitrust law parlance. (See Section A of Part I.)

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B. The Top Seven “Deal Killers” In a CIN Participation Agreement

Before diving into the details of a CIN Participation Agreement, it is important to forecast the most problematic terms, or “deal killers.” They are reflections of a material failure to meet the criteria of acceptability discussed in Part I.

Strategic Tip: The most important provisions are likely NOT the ones typically negotiated by physicians, such as who has 51percent of the votes on the board and how little the buy-in requirements are to add additional owners. Effective input into and control of governance on key issues can be better tailored through super-majority vote requirements on key issues such as budget, distribution policies, payer contracts, mergers, etc. A very low or absent buy-in requirement can easily lead to ceding of control of a CIN to other stakeholders who will not drive the CIN in a viable manner.

1. **Culture Not There** – The sponsors and potential participants of the CIN don’t “get it.” Back to Part I—is the organizational model based on a fee-for-service mentality in a value-driven care world? As Toward Accountable Care Consortium and Initiative Physician Advisory Board member Dr. Grace Terrell said: “They are still making record albums in an MP3 world.” Is it a hospital signing up everybody without regard to a value proposition in order to capture fee-for-service referrals (as opposed to focusing on recruiting the best doctors)? Is it too specialist-heavy and untethered to value-generating strategies? If the answers to these question are in the affirmative, this signals both CIN failure and possible antitrust concerns. Are the venture capital interests involved ultimately intent on extracting the maximum percentage of shared savings and other performance payments as “profits?” Are the physicians still highly independent, skeptical and not understanding of their new key roles as drivers of best practices to address identified gaps in care? Is the performance payment distribution model based fairly and sustainably on relative contribution by each provider, or is it nonexistent, not disclosed or used by the CIN sponsor as “profits?”

Key Participation Agreement terms touching on this culture include:

- Meaningful physician input on budget and performance distribution policies.
- CIN participant selection and retention criteria that favor the high-performing practices and providers. There needs to be a legitimate, meaningful, targeted direction to establishing a potent value-care strategy; and real expectations on providers to contribute to this new transformative process. Millions of dollars and access to, and quality of care for, your patients absolutely depend on this.

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Strategic Tip: This is counterintuitive to the normal physician's desire—"I just want to see patients." In practice, however, fully-empowered physicians who have improved care processes through their Clinical Committee and have seen the reach of targeted coordinated care that they have directed, find this to be a much more fulfilling (and financially rewarding) way to practice their art. They affect thousands of patients, not just the ones they see one at a time. A CIN "done right" goes to the core of why physicians chose to go to medical school.

In short, argue for, not against, real participation and leadership roles.

- Avoid a "take-all payers" contract clause, unless there are plenty of conditions that only considers those rewarding higher quality and higher collaborative care efficiency for a patient population with a merit-based performance payment distribution model.
- Evidence of a core population health strategy?

Strategic Tip: Beware of lip-service to integrated value-driven care to meet antitrust concerns and the absence **of any real strategic game plan or process to create one.**

- Absence of physician input to create a clinically-valid merit-based performance payment distribution model.
- Referrals – Are referrals prioritized to the sponsoring health system's employed physicians, regardless of whether or not they are on the high-value specialist list? If written at all, this may be in a policy and not the body of the Agreement.
- Absence of provider education and engagement prioritization.
- Does participation include fee-for-service arrangements? Does it limit your practice's ability to contract with certain payers on your own? Besides antitrust concerns, does this flag a lingering cultural motivation to use the network to raise health care costs, not reduce them?
- Key decisions must be transparent—how are decisions regarding contracting, compensation, etc. communicated?

2. **Not Right Mix of Providers to Drive Value** – At least one-third of the physicians in an effective CIN should be primary care. If the CIN is limited to Medicare, obstetrics and pediatrics may be de-emphasized, unless the CIN plans to expand its services into the Medicaid and commercially-insured populations where primary care, obstetrical, and pediatric services are vital. Ideally, acute and post-discharge facilities and specialty care should reflect the high-value collaborative initiatives chosen by the CIN. Too often, the CIN is non-selective and membership is recruited without a thought to the best value-driving team possible.

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Strategic Tip: In its lifecycle, the ACO and CIN infancy tends to focus only on primary care, given the obvious beneficial effects that prevention, wellness and medical home initiatives have on downstream health care costs. Some specialists decry this trend and are seeking MACRA Advanced APM relief because of it. Fortunately, this need not be the case. The Toward Accountable Consortium and Initiative, a collective effort spearheaded by the North Carolina Medical Society and including over 40 specialty and other provider and health care associations, have found high-value contribution for over 25 different specialty groups and health care entity types. (See www.tac-consortium.org)

3. **Lack of Due Process** – Physicians should agree to meaningful integrated care roles, but should also be afforded a fair corrective action plan, due process and remediation opportunity. Some variation of education-probation-termination is recommended.

4. **Lack of Legal Compliance Safeguards** – As noted, collective negotiation, sharing of patient information cross-referrals, and money exchanges among otherwise competing medical practices and other health entities raise a plethora of legal issues. The Participation Agreement should recognize the importance of these legal matters and ensure compliance by all concerned.

5. **Cumbersome Operations** – Beyond your due diligence investigation, the Participation Agreement may give a hint as to whether the overhead and operational structure is needlessly expensive and cumbersome. It should also give some sense of the “hassle factor” on the physicians. As noted, on one hand, it is vital that physicians have meaningful leadership input and all physicians have a material role with care management responsibilities, but on the other hand, this should be accomplished through support of a competent, well-run, well-staffed CIN organization. The CIN should facilitate appropriate delegation and make the use of technology a tool, not a burden.

6. **Flawed Governance** – Ask for a copy of the Bylaws (of a corporation) or Operating Agreement (of an LLC) to see who really runs things. Again, majority control at the corporate board of directors or LLC board of managers is not required, but meaningful representative input and super-majority vote safeguards on key issues are important. For tax reasons, there are limits on how much control a nonprofit health care entity sponsor of a CIN can cede.

7. **Mandatory Referrals** – Referrals, within and without the CIN, should be driven by value. A presumption is allowed that selected participating practices and facilities, which have invested time, energy and resources to practice collaboratively and share a common analytics platform, may be considered high-value referral sources. But value should always be paramount. A mandate to refer to a clearly low-performing, high-cost practice or facility will hurt the success of the CIN to meet the Triple Aim (improving the experience of care, improving the health of populations, and reducing per capita cost) and also raises antitrust and kickback issues, especially if a financing but low-performing entity is the recipient of the referrals.

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C. Key Expectations of Physicians and Their Practices

1. **Utilize the CIN's Information Technology** – You agree to provide the CIN with data and use the CIN's IT platform. CINs rely on clinical and administrative IT systems to collect, exchange and evaluate health care data. Participants will be expected to use platforms as a condition of participation. In some cases the CIN requires the participant to use an electronic health record, but typically a participant merely uses the internet to access the platforms. The commitment is to the active use of that platform. Your commitment to provide data could be from any combination of reporting practice level outcomes or merely allowing that data to be extracted from other platforms or systems to which the CIN has access. You should know in advance whether the CIN or your practice is responsible for paying costs related to onboarding.

2. **Provide Time and Clinical Expertise in Educational and Performance Improvement Initiatives** – You agree to work on specific initiatives and follow certain protocols. Medical decision making should always remain with the physicians, however, the CIN should expect you to be open minded to adapting your practice habits and referral patterns based on clinical evidence and other factors that are provided by the CIN through different educational and performance forums. The education and tools are designed to aid the participant in achieving quality goals of the CIN or help establish program strategy.

Strategic Tip: Time spent on these activities helps establish antitrust “clinical integration” “sweat equity” commitments, which are especially important when organizational dues are not required or are nominal.

Protocols should be developed by physicians for the purpose of reducing costs and improving care. It is important to use protocols as general guides, but each clinical decision must be left to the individual physician. Unreasonably failing to follow protocols can result in remedial action, including expulsion.

3. **Agree to Performance Monitoring** – You agree to be judged against others. Performance measurement is a key component of clinical integration. Programs need to track overall, group and individual progress towards network goals. Participant report cards, shared savings distributions, etc., should all be shared among the participants. CINs should rely on the intrinsic motivation of physicians to want to perform well among their peers. Lack of a value-oriented measurement policy (i.e., are your compensation bonuses still based solely on volume?) or lack of transparency are red flags.

4. **Cooperate with Remedial or Corrective Action** – You agree to comply with corrective action plans. Participation in a CIN should be limited only to those physicians who demonstrate a willingness as well as an ability to help the program achieve its goals. Network selectivity is another key for legal compliance. Oversight and commitment to correcting poor performance is an important function of a successful CIN. Lack of a reasonable corrective action remediation process is a red flag.

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5. **Participate In Some or All Network Contracts** – You agree to follow program requirements of contracts entered into on your behalf. In some circumstances, the participation is supplementary to your agreement with the payer (i.e., shared savings or enhanced payment on top of your fee for service.) Exclusivity can be at the CIN level. For example, some contracts state that you can join as many CINs as you want subject to potential program limitations (such as primary care practices can only be in one MSSP ACO), or it can speak to whether you have to participate exclusively in all of the CIN's payer contracts. It is common for a CIN to allow the participant to individually contract with payers outside of the network unless the CIN has already reached an agreement with the payer for all its participants. Ideally, physicians and payers will want to seek out a high-performing CIN, comprised of selective “A Team” players. It makes exclusivity mandates unnecessary. We will not be at that level until operational know-how and physician engagement reach higher levels. Exclusivity is very sensitive from an antitrust perspective because of its potential to force payers to consent to above-market fee-for-service terms.

D. Parts of Agreement

It is important to review each contract provision and to express concern over any important terms or drafting issues. We have attempted to flag the most crucial deal terms. A clear understanding of the expectations of both parties will lead to the most effective collaboration and will accomplish the intent of the relationship.

1. **Preamble** – The preamble identifies parties to the Agreement and often includes the effective date for which the obligations begin. Note whether the Agreement is with the CIN legal entity or a parent organization. **As noted, ask for the corporation's Bylaws or if an LLC, the Operating Agreement, to see who is in control of the CIN.** Is the agreement with you as an individual participant or your group practice? It is not uncommon that the agreement is with the single tax ID of a practice group, directing the group to “cause” its providers to perform. In this arrangement you may also see an addendum or exhibit where each provider also signs a joinder to the agreement (thus joining themselves to the rights and obligations of the agreement).

Sample Language:

*THIS PARTICIPATION AGREEMENT (this “**Agreement**”) is entered into effective **August 1, 2017**(the “**Effective Date**”), by and between NEWCO CIN, LLC, a North Carolina limited liability company (“**NCIN**”), and [], a North Carolina [professional corporation][professional partnership] (“**Group**”). NCIN and Group are sometimes referred to in this Agreement individually as a “**Party**” or, collectively, as the “**Parties.**”*

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2. **Recitals** – The recitals are not compulsory or necessarily even binding, but are often included to establish context of the arrangement and to emphasize the purpose of the relationship to bolster legal compliance protections. The terms of the Recitals are not usually binding unless the parties incorporate them by reference elsewhere within the operative provisions.

Sample Language:

WHEREAS, NCIN was formed to operate a clinically integrated network (“Network”) of independent physicians, hospitals, and other medical or health care providers or suppliers (“Providers”) to provide **high quality health care services in a cost efficient manner** to improve the health status of their communities; and

WHEREAS, NCIN and its Providers work together with a **high degree of interdependence and cooperation** to: (a) Improve the coordination of health care items and services; **invest significant capital**, both financial and human, in the infrastructure, capacity and redesigned care processes required for high quality and efficient service delivery; and incent higher value care (b) Develop, maintain and update evidence-based initiatives, benchmarks, performance standards and metrics (the “**Metrics**”) that are used and applied on a uniform basis to (i) measure the utilization, quality, effectiveness and cost efficiency of health care services performed by the Providers; (ii) aggregate, analyze and measure data and information received from Providers against the Metrics; and (iii) report on performance by Providers with respect to the Metrics; and (c) Identify and select Providers to participate in NCIN who are likely to enhance, promote and further NCIN’s objectives.; and

WHEREAS, NCIN intends to negotiate, manage, and participate in private and/or governmental reimbursement programs, including without limitation federal and state shared savings programs that promote and reward such collaboration among Providers; and

WHEREAS, Group desires to participate in the NCIN’s provider network pursuant to the terms and conditions of this Agreement.

3. **Consideration Clause** – To be binding, a contract must show “consideration,” an exchange of something of value between the parties. The consideration clause is a formalism found in most contracts, although consideration can be found to support a contract’s validity elsewhere in the agreement.

Sample Language:

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties hereby agree as follows:

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4. **Operative Provisions** – The operative provisions lay out key terms governing the rights and obligations of each of the parties. It should also include a period of time (term) that the agreement is effective and under what conditions and by what process can the agreement end prior to that term. Specifically, a CIN Participation Agreement should include:

a. **Definitions** – Definitions of legal terms of art may follow where first used throughout the agreement or in a separate definitions section. Those terms should appear as capitalized throughout. Note: If the CIN is participating in the MSSP, there will be specific definitions to comply with 42 C.F.R. Part 425. Likewise, if the CIN is operating in North Carolina and contracting with managed care companies, Chapter 58 of the North Carolina General Statutes and the Department of Insurance will require certain defined terms to be included in the agreement. It is not uncommon for a term to be defined as referenced to a provision of law or elsewhere within the contract, or other organizational document.

Sample Definitions:

“Beneficiary” means those persons who are eligible to receive Covered Services from NCIN Participants pursuant to a Payer Contract.

“Medically Necessary Services or Supplies.” When used in agreements with commercial payers, “Medically Necessary Services or Supplies” shall mean covered services or supplies that are: (a) provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under N.C.Gen.Stat. § 58-3-255, not for experimental, investigational, or cosmetic purposes; (b) necessary and appropriate for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease or its symptoms; (c) within generally accepted care in the community; and (d) not solely for the convenience of the insured, the insured's family, or the provider. For Medically Necessary Services, this definition does not preclude a commercial payer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies to be covered.

*“Payer Contract” means a written contract, directly or indirectly through a third party administrator or other customer of NCIN, between a Payer and NCIN under which some or all NCIN Participants will be In-Plan Providers[**defined term**] and provide Covered Services[**defined term**] to Beneficiaries[**defined term**]. Such Payer Contracts may include both: (i) non-risk contracts (e.g., preferred provider organization and other arrangements that do not involve sharing of financial risk through the NCIN), which are on a fee-for-service basis, sometimes, as allowed by law, with value-based, quality, outcomes and/or savings incentives, and (ii) risk contracts that involve the sharing of financial risk among NCIN Participants, including but not limited to through capitation, percent of premium, shared savings, bundled payments, substantial utilization-based withholds or global case rates.*

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b. **Obligations of the Parties** – Typically, the next two sections of the agreement will lay out each party's obligation to the other. It is important to avoid aspirational obligations as they are difficult to meet and enforce. **Further, as the participant, you will want to be mindful of commitments to comply with all CIN policies and rules without opportunity to review those rules or understand how the rules may be modified over time and to what extent your obligation carries over to the modified rule or process.**

Duties of the CIN will typically be to support and coordinate the activities of the CIN, including collecting data, monitoring and measuring performance, engaging third party payers, and compensating participants based on performance.

Sample Duties:

*XX. **Contracting Opportunities and Notice of Payer Agreements.** NCIN shall pursue contracting opportunities with Payers, including Payer Contracts involving fee-for-service payment and innovative mechanisms for health care delivery and payment, including but not limited to value-based purchasing, bundled payment and shared savings programs. The CIN shall serve as Group's agent for the purpose of soliciting offers from Payers, negotiating Payer Contract terms and entering into Payer Contracts on behalf of Group in accordance with the process set forth in Article 3 of this Agreement. The CIN is not obligated to include Group or any particular Group Practitioner or to offer Group or any particular Group Practitioner the opportunity to participate in each Payer Contract, nor is the CIN obligated to include Group or any particular Group Practitioner in a certain number of Payer Contracts.*

*XX. **Distribution Methodologies.** Shared savings, bundled payment, pay-for-performance and other payments received by NCIN under Payer Contracts under which Group is an In-Plan Provider will be distributed to Group in accordance with methodologies established by NCIN from time to time. **[You will want to see an example of the methodology currently in place, this is sometimes included and incorporated as an Exhibit]** Such methodologies may provide for the NCIN's retention of a portion of such payments to cover overhead and administrative expenses.*

*XX. **Support.** NCIN shall support and coordinate the activities of the CIN including but not limited to administrative services, data analysis, data support, and operational and policy implementation guidance to NCIN Participants.*

Duties of the participant include committing to program goals and providing data (requiring the execution of a Business Associate Agreement), and depending on the exclusive nature of the agreement, the participant will provide a limited power of attorney to the CIN to sign payer contracts on its behalf.

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Sample Duties:

XX. Obligations of Participants

Participants shall:

- a. *actively and meaningfully participate in all initiatives, efforts and requirements of the CIN.*
- b. *comply with all NCIN Policies (as updated from time to time by NCIN)*
- c. *cooperate with NCIN in the development of initiatives designed to improve the quality and efficiency of the health care services provided by NCIN Participants, promote patient involvement and coordinate care;*
- d. *meet participation criteria and standards of Payer Contracts*
- e. *meet information technology criteria and standards; including, but not limited to, maintaining adequate medical and other health records according to industry standards as well as NCIN and Payer policies.*
- f. *share data and information that is contained in Participant's medical records, billing, claims, practice management, or other systems, electronic or otherwise, consistent with the purposes contemplated by this Agreement. All such data and information shall be shared in a manner consistent with applicable law regarding disclosure and in the format described in NCIN Policies and Group shall make copies available to controlling regulatory authorities.*
- g. *agree to abide by remediation activities directed by NCIN with respect to its physician's practice patterns, up to and including expulsion and termination of this Agreement and/or participation under any or all Payer Contracts;*
- h. *maintain professional liability and other insurance policies, with such limits as are required by NCIN Policies or the applicable Payer, including notifying NCIN and Payer of adverse changes in such coverage.*
- i. *Comply with the applicable Payer's utilization management programs, credential verification programs, quality management program and provider sanctions program.*

5. **Term** – The term should provide how long the agreement will be binding to the parties. Terms can be in increments of one or multiple years. Terms may “evergreen,” meaning they will continue for additional periods of time after the expiration of the initial term unless either party provides notice by a certain period of its desire not to continue the relationship. There should also be language which governs how the agreement can be terminated prior to the completion of a term and what requirements participants are obligated to once the agreement has been terminated. Many programs, such as MSSP, expect the ACO to be able to still collect data until the end of the program year. Furthermore, there generally is a transition of care upon termination period that needs to be respected.

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Sample Language:

XX. Term and Termination.

XX. Initial Term and Renewal. *This Agreement shall commence as of the Effective Date and shall continue through December 31, 2020 ("Initial Term"). Thereafter, this Agreement shall automatically renew for terms of one (1) year each ("Renewal Term"), unless either party gives the other party notice at least ninety (90) days prior to the end of the Initial Term or of the then applicable Renewal Term, or unless otherwise terminated pursuant to the terms of this Agreement.*

XX. Termination Without Cause. *This Agreement may be terminated by either party, with or without cause, upon ninety (90) days' written notice to the other party, provided, however... [May see additional conditions that apply for early termination that are not contained within later Rights and Obligations section]*

XX. Termination With Cause.

- (a) *Either party shall have the right to immediately terminate this Agreement to comply with any legal order, ruling, opinion, procedure, policy or other guidance issued, or proposed to be issued, by any federal or state agency, or to comply with any provision of law, regulation, or any requirement of accreditation, tax exemption, federally-funded health care program participation or licensure which (i) invalidates or is inconsistent with the provisions of this Agreement; (ii) would cause a party to be in violation of the law; or (iii) jeopardizes the good standing status of licensure, accreditation or participation in any federally or state-funded health care program, including, without limitation, Medicare and Medicaid programs.*
- (b) *Except as provided for in subsection (a) of this Section, either party shall have the right to terminate this Agreement if the other party has materially violated its responsibilities under this Agreement and has failed to provide satisfactory assurances within thirty (30) days of notice of such material violation that reasonable steps are being taken to effect a cure, and in any event: (i) such cure will be completed no later than thirty (30) days from notice of such material violation; and (ii) the breaching party has taken reasonable steps to prevent the recurrence of such material violation.*

XX. Rights and Obligations of Parties upon Termination. *Upon termination of this Agreement, the rights of each party hereunder shall terminate provided, however, Parties shall cooperate in making reasonable and medically appropriate arrangements for the continued care of Covered Persons, as soon as reasonably practicable upon termination of this Agreement.*

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You will want to review in concert any further limitations post termination. Although not as common as you find with physician employment agreements, some Participation Agreements contain restrictive covenants limiting your ability to hire employees who work for, or vendors that contract with, the CIN (known as “non-solicitation” provisions) and even in some circumstances limiting your ability to participate in other CINs (“non-compete” provisions). These should be avoided, if possible. Likewise, provisions relating to the development of Intellectual Property should be flagged and negotiated out of the agreement, when possible.

6. **Standard Provisions Commonly Found in Health Care Service Contracts** – Other provisions you may see are not unique to CIN Agreements, and relate to the mutual agreement to comply with the law; indicate the relationship between the parties is that of an independent contractor (and not an employee); and provide for confidentiality of information learned through the course of the relationship. This is particularly important when dealing with fee information collected by multiple payers.

Sample Language:

*XX. **Legal Compliance.** The parties shall comply with all applicable local, state and federal civil and criminal laws, including, but not limited to, 42 CFR 425, the Participation Agreement with CMS, federal criminal law, civil monetary penalties law, Title XVIII and XIX of the Social Security Act, the False Claims Act (31 U.S.C. 3729, et seq.), the anti-kickback statute (42 U.S.C. 1320a-7b(b)), the civil monetary penalties law (42 U.S.C. 1320a-7a), the physician self-referral law (42 U.S.C. 1395nn), Title 12 of the Code of Federal Regulations, the Health Information Technology for Economic and Clinical Health (“HITECH”) Act, the Health Insurance Portability and Accountability Act of 1996 and any rules and regulations promulgated thereunder found at 45 C.F.R. Parts 160 and 164 (“HIPAA”), and federal regulations governing the confidentiality of alcohol and drug abuse patient records codified at 42 C.F.R. Part 2. Pursuant to such HIPAA obligations, the parties have executed contemporaneously herewith the Business Associate Agreement attached at **Exhibit B and incorporated herein by reference.** Furthermore, the parties shall comply with the Sherman Act of 1899, as amended, the Clayton Act of 1914, as amended, the Federal Trade Commission Act of 1914, as amended, and all other applicable federal, state, and foreign statutes, rules, regulations, orders, decrees, administrative and judicial doctrines, and other laws that are designed or intended to prohibit, restrict, or regulate actions having the purpose or effect of monopolization or restraint of trade.*

*XX. **Independent Contractors.** For the purpose of this Agreement and all services to be provided hereunder, the parties shall be, and shall be deemed to be independent contractors and not agents or employees of either party.*

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*XX. **Confidential Information.** Each Party acknowledges that, during the Term of this Agreement, it will receive confidential information of the other Party. Accordingly, the Parties agree that neither Party shall disclose to any unauthorized third party, including, without limitation, other NCIN Participants, confidential and proprietary information collected or exchanged pursuant to NCIN Policies or this Agreement (“Confidential Information”). This Confidential Information includes, but is not limited to (i) Fee schedules, payment criteria and other material terms of any Payer Contract; (ii) bonus, shared savings and incentive distribution methodologies; (iii) Clinical data and information collected by Participant on behalf of NCIN; (iv) Performance results regarding NCIN Participants; and (v) Business operations, practices and procedures of including staffing, strategies, financial plans and budgets, contractual relationships or terms, practice management procedures, health information technology systems and/or systems or processes related to the specific operation of Participant or NCIN Confidential Information shall not include information that is known to the receiving Party before its disclosure, is publicly known through no fault of the receiving Party, is received from a third party, or is approved for release by the originating Party.*

Strategic Tip: As mentioned in Section B.7., beware of a mandatory referral provision without a value override.

You will also commonly see *force majeure*, entire agreement, severability, choice of law, limitations on assignment and amendment provisions, which operate as in other agreements with which you are familiar and have no unique applications in this context. However, push back on unfair indemnity obligations. A physician's practice is not an insurer or even a well-capitalized traditional business. You should only be obliged to indemnify for damages and costs caused by your negligent or reckless malperformance or nonperformance of your contractual duties.

7. Exhibits – The exhibits (or schedules, as they are sometimes called) provide more details on specific obligations by describing a process or additional agreements previously referenced in the body of the main agreement. At the time of reference, there is usually functional language making the exhibit enforceable as part of the Agreement (i.e., “as attached hereto as Exhibit B, and incorporated herein by reference.”) In a CIN agreement, typical exhibits may include a Joinder Agreement (binding individuals to the agreement executed on their behalf by their practice); a Business Associate Agreement to comply with HIPAA, and shared savings methodologies or performance metrics that will be used. Because of their unique obligations or mandatory contract terms, there may also be attachments for particular arrangements, such as an MSSP track, CMS Next Generation ACO, or Medicare Advantage. These need to cover necessary contract additions, but impose no more obligations on you.

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Strategic Tip: The one question to ask before joining a CIN is: “What is your shared savings distribution formula?” If you get a blank stare, it may show that they have no clue about how to create a successful value-payment integrated network. If you get avoidance, it may show an intent to spend those funds other than as incentive payments to motivate those you created them. So, the compensation exhibit is very important. If a performance payment model does not yet exist, at least principles to further the Triple Aim and a process to establish a merit-based approach should be articulated. If you see emphasis solely on fee-for-service contracting, consider that a red flag.

CONCLUSION

As unique as each CIN may be, so too will be the Participation Agreement. As the Participation Agreement is the vehicle for setting expectation and later enforcing expectation, it should be written clearly and concisely so each party knows its obligations to the other and the remedy and recourse should those obligations not be met. Significant legal ramifications can be involved in the coordination of health care for payment, therefore the Participation Agreement should serve in an evidentiary capacity for the intent of the parties going into the arrangement.

ACKNOWLEDGMENT



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