



Clinically Integrated Networks and the Triple Aim: Better Health Care, Reduced Costs

Jan 07, 2022

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This article was originally [published](#) on January 6, 2022 in Westlaw Today, an imprint of Thomson Reuters.

Health care in the United States is in the midst of a slow but accelerating evolution as health care systems and providers shift their focus from treating sickness to supporting wellness. Some common phrases dropped in the health care community today include *social determinants of health*, *community wellness*, and *functional medicine*, which reveal that today's health care concerns are directed at something much more holistic than treating a sick patient's symptoms after a 15-minute medical evaluation.

Health care providers have traditionally relied upon a fee-for-service model, in which, generally, each medical service provided is billed and reimbursed. Today, however, health care providers are increasingly collaborating within various models of care that address the health care needs of an identified population and that base payment upon quality of care and improved outcomes to the health of the population as a whole.

Among such collaborations, the clinically integrated network (CIN) can be quite effective in terms of organizing health care providers to improve overall quality through performance measurement, value and efficiency. CINs represent a model of health care that integrates larger organizations like hospitals with a network of specialists and independent physicians.

In a well-designed CIN, patients continue to see their long-time primary care physicians but have access to an entire system of specialists who are integrated in a way that focuses on improving the individual patient experience and health outcomes. To achieve this, a quality CIN utilizes data-sharing structures to maintain and track a patient's entire medical history (not just billable events), which improves the quality of the data and enhances the patient experience.

Recent trends indicate CINs make a significant impact in enhancing the overall quality and cost of patient care, which payment-for-quality measures are designed to achieve when they are carefully designed and managed. Consider, for example, that one of the measures many health care professionals focus on to ensure quality is the Triple Aim of health care, a set of guidelines to help ensure that a health system is functioning as effectively as possible. CINs have become the desired vehicle by which health systems ensure they are progressing toward achieving these Aims.

The Triple Aim was developed by the Institute for Healthcare Improvement (IHI) in 2007 in order to establish priorities for a modern health care system. In 2010, it was integrated into the U.S. national strategy for health care, making it incredibly salient for all American health care organizations. The goals are simple. According to the IHI, in order to provide the highest quality of care, health care systems and providers should focus on:

- Improving the patient experience of care.
- Reducing the per capita cost of health care.
- Improving the health of populations.

The patient population a CIN manages may take various forms. For example, a CIN may negotiate with a payor to manage the health care of an identified population and receive upside and downside financial risk associated with the same; it may contract to care for one or more employers' self-insured employee populations; or it may identify a community need to address a particular underserved patient population. The point is for the CIN to identify the specific health care needs of a population, and the attendant costs in addressing those needs, and to organize in a meaningful and purposeful way to address the same to aim for quality outcomes for the individual patient and the population as a whole.

In a 2015 study published by IHI, CINs have shown they are successfully structured to meet the Triple Aim when they achieve a few markers. These markers include:

- Creating a foundation for population management of an identified population. This includes a strong governance

structure and a sense of purpose.

- Ensuring scalability as the CIN forms, develops, and grows, as the expertise of the providers in the CIN must accommodate the particular needs of the patient population.
- Establishing a learning system to drive and sustain the work over time, which most often includes (perhaps, even requires) strong and secure data sharing among providers to allow them to track patient choices and impact on their health. See Pursuing the Triple Aim: The First 7 Years, The Milbank Quarterly, June 2015, 93(2): 263–300.

The main takeaway here is that success takes time and dedication to collaborate from the top down. To achieve the Triple Aim, a CIN must strategically identify and organize around patient care goals and develop delivery models that achieve those goals at a lower cost. To do this well, a CIN must understand its target patient population's needs, analyze data to determine proper clinical responses to those needs, and monitor its providers' delivery of those clinical measures.

Health care, however, is anything but stagnant. Thus, CINs must remain acutely aware of, flexible with, and responsive to patient population needs. CINs must ensure that the most up-to-date data on each patient is immediately accessible for delivery of patient care and must utilize their clinical data to better understand and respond to the target population's health outcomes and needs. CINs need to develop structures and tools to do this.

As health care providers consider integration in a CIN, they must, first and foremost, undertake careful and attentive planning to ensure compliance with the health care regulations pertaining to referrals among health care providers. As health care providers within a CIN begin to think collectively, with a shared focus on the health needs of a particular patient population, they will inevitably need to consider and plan for referring patients to other providers within the CIN who understand the value-based goals of the CIN and the most efficacious treatment of the patient.

The patient data shared and utilized among providers in the CIN and the understanding the health care providers in the CIN gain by

analyzing the data to improve patient care and reduce costs should drive the referrals made within the CIN. Fortunately, significant regulatory reform has occurred over the last several years to recognize the movement away from fee-for-service to value-based arrangements, and referrals within a CIN that is properly structured can provide significant value to the overall health of the patients in the CIN.

The Anti-kickback Statute and the Stark Law, for instance, now provide rules to safeguard carefully designed value-based arrangements, where health care providers are able to care for and appropriately refer patients within a CIN. See 42 CFR § 411.357(aa) (Stark Law exception) and 42 CFR § 1001.952(ee) – (gg) (Anti-kickback Safe Harbors). Each regulation requires consideration of what level of financial risk is involved for the parties to the arrangement, and remuneration paid under the arrangement must be for legitimate value-based activities.

Furthermore, as physicians within a CIN consider the referrals to be made within the CIN, specifically those that are required by the CIN itself in its contract, policies and/or procedures, they need to ensure nothing can be construed as an inducement to furnish medically unnecessary items or services or, on the other hand, reduce or limit medically necessary items or services.

To guard against such inducement, the regulatory restrictions on physician referrals include:

- there can be no requirement to refer patients not part of the CIN and the value-based arrangement;
- the referral requirement must be in writing; and
- the referral requirement must not apply if the patient expresses a desire for a different provider or supplier, the insurer determines that a different provider or supplier be used or the physician determines a referral within the CIN is not in the patient's best medical interests.

Beyond considering these regulations pertaining to patient referrals, those looking to form or join a CIN need to engage experienced health care counsel to fully vet other applicable laws related to

antitrust concerns as well as to maintaining the privacy and security of the patient data. Each of these legal concerns will require a fact-specific analysis of the CIN itself and how it will operate.

As health care reimbursement moves further away from fee-for-service toward payment for quality of care and value-based outcomes, the CIN will undoubtedly be an enticing model for health care providers. By its inherent structure, a CIN can lead to innovative approaches for offering and achieving higher levels of care for patients while working to decrease costs at the same time.

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