Building Clinically Integrated Network Infrastructure

May 2026

Executive Summary

Clinically Integrated Networks (CINs) offer a practical pathway for states seeking to strengthen care delivery, improve coordination and support long-term sustainability—particularly in rural and under-resourced communities. As health care systems face increasing pressure to deliver higher-quality care at lower cost, many providers lack the scale, infrastructure and resources needed to participate effectively in value-based models. CINs enable independent providers to collaborate through shared data, standardized clinical protocols and coordinated care management while maintaining local governance.

Across state-led transformation efforts, including the Rural Health Transformation Program (RHTP), there is a consistent emphasis on building the foundational elements that support clinical integration. While not always explicitly framed as CIN development, these efforts reflect a broader shift toward integrated, population-focused models of care.

This playbook provides a framework for states to support the development and maturation of CINs. It outlines core components of CINs, including governance, data infrastructure, care coordination and contracting readiness, and presents a set of actionable strategies states can use to convene stakeholders, structure funding and align policy and payment approaches. The playbook also introduces tools such as a minimum standards checklist and a maturity pathway to help states assess readiness and guide investment decisions.

CINs enable rural providers to coordinate care across regions, reducing variations in treatment and administrative burdens through standardized pathways and centralized reporting. They support value-based care readiness by pooling data for population health insights and care transitions, improving outcomes like readmission rates while preserving long term financial sustainability.

By aligning infrastructure investments, policy strategies and payment models, states can move beyond fragmented, time-limited initiatives and support the development of durable, provider-led networks that improve care delivery and sustain access over time.

- Health Policy Futures Lab and Heartland Forward

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Introduction

States are making historic investments in delivery system transformation, with a growing emphasis on regional scale, shared infrastructure, workforce extension and long-term financial sustainability. Clinically Integrated Networks (CINs) can contribute to these goals. A CIN is a group of independent health care providers that formally collaborate through shared clinical protocols, performance metrics, data infrastructure, care coordination and at times procurement, to improve quality and efficiency of care.

There are promising signs that CINs lead to improved adherence of evidence-based protocols, more standardized clinical pathways, stronger collaboration among providers and improved information sharing across settings.

To ensure that provider-initiated CINs translate into durable system change rather than time-limited programs, states can play a critical role in establishing clear expectations for what constitutes a CIN and how networks progress toward readiness. Rather than building CINs directly, states can define the core capabilities that distinguish CINs from informal collaborations, providing existing partnerships and efforts the necessary resources to scale their networks.

This playbook provides a framework for states to support the development of CINs by establishing minimum standards for governance, data infrastructure, care coordination, contracting and financial sustainability. It also introduces a structured pathway for network readiness, enabling states to distinguish between early-stage collaborations and networks that are operationally prepared to coordinate care and participate in value-based payment models.

Rural Health Transformation Program (RHTP) investments can be leveraged as a mechanism to build the infrastructure required for this progression. By aligning funding, technical assistance and program requirements with stages of network readiness, states can support providers in developing the capabilities needed for clinical integration and long-term sustainability. Over time, this approach helps ensure that investments in coordination and infrastructure evolve into durable, integrated networks that continue to deliver value beyond the initial funding period.

CINs are defined by the ability of providers to collectively improve quality, manage care and demonstrate value across a population.[1] In practice, these networks are built over time through shared and sustained investment before advancing into contracting and value-based payment. Particularly in rural settings, sustainability often depends on a combination of grant funding, operational revenue, shared savings and contracting strategies rather than a single funding source.[2]

For states, this framework provides three immediate resources to support the development of CINs:

- A minimum standards checklist that can be used in certification, grant eligibility and procurement
- A readiness and maturity model that allows infrastructure funding to be tiered and sequenced
- A pathway for aligning infrastructure investments with long-term payment and sustainability strategies

This playbook is informed by a review of academic literature, policy research and media reports, followed by outreach to academic experts and industry leaders to gather insights on real-world implementation, operational challenges and successful CIN models; this process ensures the framework is both evidence-based, analytically rigorous and grounded in practical, real-world application for states. These insights were used to refine and validate the framework, ensuring it reflects both policy guidance and current practice.

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[1] Health IT Playbook. The Office of the National Coordinator for Health Information Technology Health IT Playbook. https://playbook.healthit.gov/playbook/glossary/.
[2] Better together: Rural hospital high-value networks. The Rural Monitor. https://www.ruralhealthinfo.org/rural-monitor/rural-hospital-high-value-networks.

The Case for CINs

CINs offer a compelling path forward for small or rural hospitals, clinics and independent physician groups that want to remain locally governed while adapting to a health care environment increasingly defined by scale, data capabilities and value-based payment models. Many smaller providers face growing pressure from rising technology costs, complex reporting requirements, workforce shortages and declining margins. CINs provide a way to collaborate and share infrastructure without requiring full organizational consolidation or acquisition. This creates a middle path allowing independent providers to preserve their identity and community relationships while gaining access to capabilities typically associated with larger health systems.

Access to Shared Data and Analytics Infrastructure

One of the most immediate advantages of a CIN is access to shared data and analytics infrastructure. Participation in modern reimbursement models requires the ability to track quality metrics, identify care gaps, analyze utilization patterns and benchmark performance. Developing these capabilities independently can be prohibitively expensive for smaller, rural organizations, in areas where these resources are most critical. CINs often provide shared population health tools, performance dashboards and clinical decision support resources that allow participating providers to improve care delivery and meet payer requirements without building these systems alone. This shared infrastructure can accelerate quality improvement initiatives and support more consistent performance across the network.

Participation in Value-Based Payment Models

CINs also enable participation in value-based payment arrangements that reward improvements in outcomes, care coordination and cost efficiency. Small providers often lack sufficient patient volume, actuarial expertise or financial reserves to independently assume performance risk or negotiate favorable contracts. By aggregating covered lives across multiple organizations, CINs create sufficient scale to participate in shared savings contracts, bundled payments and other alternative payment models. Participation in these arrangements can diversify revenue streams and position providers for continued relevance as reimbursement structures evolve.

Strengthened Care Coordination and Local Retention of Services

Another important benefit is strengthened care coordination allowing for more services to remain local. Rural hospitals and clinics frequently lose patients when referrals move outside their community, reducing continuity of care and affecting financial sustainability. CINs can help formalize referral pathways, improve transitions of care and connect patients to specialists through telehealth or shared care management programs. These capabilities improve the patient experience while helping maintain appropriate service volume within local communities.

Standardization of Clinical Practice and Performance Improvement

Smaller organizations with overworked staff often have limited resources to continuously develop and implement best practices across service lines. CIN participation allows providers to align around standardized care processes that reduce unnecessary variation, improve quality performance and support compliance with regulatory expectations. Benchmarking performance against peer organizations can also create constructive accountability and encourage continuous improvement.

Workforce Support and Reduction of Professional Isolation

CINs frequently provide forums for clinical collaboration, continuing education opportunities and shared access to specialty expertise. Currently, participants in similarly-situated CINs use active Slack channels and listservs to help each other solve problems or find information. Participation in a CIN can also reduce professional isolation and support workforce sustainability. These connections can enhance professional satisfaction and support recruitment and retention of clinicians in under-resourced areas.

Strengthened Contracting Position with Payers

CINs may also strengthen contracting positions with payers. Individually, small providers often have limited negotiating leverage and may face administrative burden

when contracting independently. A clinically-integrated structure can support participation in performance-based contracts. Collective performance improvement efforts can enhance credibility with payers and employers seeking higher-value networks.

Financial Sustainability and Strategic Positioning

While CIN participation does not guarantee cost savings, it can improve strategic positioning by enabling access to shared savings opportunities, reducing duplicative infrastructure investments and improving patient retention within aligned referral networks.

Over time, CIN infrastructure can also serve as a foundation for participation in Accountable Care Organizations (ACOs), employer contracting arrangements and other collaborative models focused on population health management.

CINs provide a structured way for small or rural providers to strengthen their long-term viability while preserving independence. By combining shared infrastructure with local governance, CINs can help small hospitals, clinics and physician groups adapt to industry changes without sacrificing the relationships and community presence that make them essential components of the health care system.

The Difference Between CINs and Coordinated Care Organizations (CCOs)

A CIN and a Coordinated Care Organization or Coordinated Care Network (CCO) both aim to improve how health care providers work together, but they differ significantly in their level of structure, accountability and strategic purpose. Both models seek to improve patient care across multiple providers and settings, yet a CIN represents a deeper and more formal level of collaboration designed to measurably improve quality and efficiency of care. A CCO, by contrast, typically emphasizes communication and care transitions without necessarily requiring the shared infrastructure and performance management systems associated with clinical integration.

How Coordination Differs from Clinical Integration

A CCO generally focuses on improving the patient experience by strengthening relationships among providers and facilitating smoother transitions across the continuum of care. Common activities may include improving referral pathways, aligning discharge planning processes, supporting care navigation and enhancing communication between primary care providers, specialists and hospitals. These networks can play an important role in reducing fragmentation and improving continuity of care, particularly in rural or under-resourced areas where access to specialty services may be limited. However, coordinated care arrangements often rely on voluntary collaboration and may not require formal governance structures, shared clinical performance metrics or robust data analytics capabilities.

How the CIN Structure Adds Governance and Accountability

A CIN builds upon coordination by introducing a more structured framework for improving clinical performance and managing population health. CIN participants typically agree to adopt shared evidence-based clinical protocols, track performance on standardized quality measures and participate in continuous improvement processes supported by data infrastructure. CINs commonly include formal governance mechanisms and participation expectations encouraging providers to modify practice patterns based on network performance results. This level of integration enables participating organizations to work collectively toward measurable improvements in outcomes, cost efficiency and care consistency.

CINs v. CCOs: Data Infrastructure and Performance Measurement

Another important distinction between CINs and CCOs is the role each model plays in payment and contracting strategy. By aggregating patient populations and demonstrating meaningful clinical integration within value-based payment arrangements, CINs can provide the scale and infrastructure needed to manage financial risk and meet payer expectations for accountability. Coordinated care models, while beneficial for improving communication and care transitions, are not typically structured to support joint contracting or population-level financial accountability.

CINs v. CCOs: Role in Payment and Contracting

In practical terms, coordinated care arrangements may represent an earlier stage of collaboration, helping organizations build trust and establish working relationships across providers. Identifying these existing arrangements can assist states in identifying opportunities to expand to the CINs through existing collaboration efforts. Over time, some networks evolve from coordination-focused activities into more formal clinically integrated structures as participants invest in shared data capabilities, adopt common clinical standards and pursue opportunities for joint performance improvement. The distinction between the two models is therefore less about terminology and more about the depth of alignment, the degree of shared accountability and the level of infrastructure supporting care delivery improvement.

Evolution from Coordination to Integration

For small or rural hospitals, clinics and independent physician groups, understanding the difference between CINs and CCOs can help clarify strategic options for collaboration. A coordinated care approach may offer a lower-complexity starting point for improving relationships and patient transitions, while a CIN may offer a more comprehensive framework for long-term sustainability in an environment increasingly shaped by value-based reimbursement and expectations for measurable quality performance.

Current CIN Landscape

CINs have emerged across a range of markets, often developing in response to the need for coordinated care delivery and participation in value-based payment arrangements. While there is no comprehensive national registry of CINs, and definitions and structures vary across markets, they are typically formed by health systems, physician groups or regional provider collaboratives and are often aligned with accountable care organizations or other value-based initiatives. Some CINs have evolved from earlier transformation efforts, including federally-supported models and grant-funded infrastructure investments.

Common Characteristics of Existing CINs

Across research and interviews with organizations actively operating CINs, several common characteristics emerge:

- Formation starts with a convener that has sufficient administrative capacity. The convener recruits other participants and begins the process of incorporation.
- A core group of committed, active CEOs leads the initial phase.
- An LLC or 501c(3) that houses the entity and centralizes infrastructure is established. Each entity has equal power, usually with one vote per member.
- Strong participation agreements, governance frameworks, data sharing agreements and antitrust compliance documentation is put in place.
- Subcommittees are established to address clinical, financial and legal issues.
- Shared clinical standards, performance measurement and continuous improvement across providers are established.
- Aggregated data and visibility into quality, utilization and cost, often across multiple EHR systems is essential.
- Financial alignment mechanisms including participation in value-based payment, and in many cases support for collective contracting strategies, is required to collectively reap shared savings.

Key Qualities of an Effective CIN

While CINs vary in structure, effective networks often demonstrate several critical capabilities:

- **Clinical integration first:** Shared protocols, quality measurement and performance improvement are established before advancing into contracting and payment models.
- **Centralized, scalable infrastructure:** A shared platform for data, care coordination and operations supports providers in functioning as a more coordinated and accountable system.
- **Provider alignment and participation:** Strong engagement across participating providers, including frontline staff, is essential for adoption and sustained performance.
- **Contracting and financial strategy:** The ability to translate clinical performance into financial outcomes through value-based payment and payer negotiations supports long-term sustainability.
- **Adaptability to local context:** Successful CINs are designed to operate within local market conditions, particularly in rural areas where providers face resource constraints and fragmented care delivery environments.

How CINs Can Contribute to State Delivery System Transformation and Rural Health Goals

CINs can play a particularly important role in helping states achieve health delivery system transformation goals in rural communities. Many state reform efforts focus on improving access to care, strengthening financially vulnerable rural providers, expanding behavioral health capacity, improving maternal health outcomes and advancing value-based care. Rural hospitals, clinics and independent physician practices are essential to achieving these goals, yet they often lack the scale, infrastructure and workforce capacity needed to fully participate in emerging care models. CINs offer a practical pathway for rural providers to collaborate, share resources and improve care delivery while maintaining local independence and community presence.

Preserving Access to Care in Rural Communities

One of the most pressing challenges facing states is preserving access to care in rural areas where hospitals and clinics operate on thin margins and face workforce shortages. CINs can help stabilize rural delivery systems by enabling providers to pool resources and invest jointly in care management infrastructure, data analytics and specialty partnerships that would be difficult to develop independently. Through shared infrastructure, rural providers can improve care coordination, strengthen referral relationships and maintain more services locally. This can reduce the need for patients to travel long distances for routine or follow-up care, improve patient experience and support the financial viability of community-based providers.

Supporting Participation in Value-Based Payment Models

States are also increasingly focused on advancing value-based payment models within Medicaid and other public programs. Rural providers often face barriers to participation in these models due to small patient populations, limited analytics capabilities and financial risk constraints. CINs allow rural providers to aggregate patient populations across multiple organizations, creating sufficient scale to participate in shared savings arrangements, population health initiatives and other performance-based payment models. By enabling participation in these models, CINs can help ensure that rural providers are not left behind as payment systems evolve toward greater accountability for outcomes and cost performance.

Improving Coordination for High-Need Populations

Improving care coordination for patients with chronic conditions, behavioral health needs and maternal health risks is another priority for many states. Rural communities often experience higher rates of chronic illness, maternal morbidity risk and limited access to behavioral health specialists. CINs provide a structure for rural providers to collaborate on shared care protocols, transitions of care processes and referral pathways that improve continuity of care. CIN infrastructure can support telehealth consultation arrangements, shared care management services and coordinated approaches to managing high-need populations. These capabilities can help reduce avoidable hospitalizations, improve disease management and expand access to specialty expertise in communities where provider supply is limited.

Integrating Behavioral Health and Primary Care and Supporting Maternal Health Improvements

States are also working to better integrate behavioral health and primary care, which is an effort particularly important in rural areas where behavioral health workforce shortages are acute. CINs can help organize providers around collaborative care models that incorporate behavioral health screening, referral coordination and shared treatment planning. Similarly, CINs can support maternal health improvement initiatives by facilitating alignment around evidence-based prenatal and postpartum care pathways and improving coordination between obstetric providers, primary care clinicians and community-based supports, such as doulas and community health workers.

Reducing Administrative Burden

Administrative complexity is another barrier facing rural providers, who often operate with limited staff capacity to manage reporting requirements across multiple payers. CINs can help reduce administrative burden by creating shared approaches to quality measurement, performance reporting and care management processes. Alignment around common measures and shared analytics platforms can allow rural providers to focus more attention on improving care delivery rather than navigating duplicative reporting systems.

Aligning with Telehealth and Digital Health Investments

CINs can also complement state investments in telehealth expansion, health information exchange infrastructure and rural health transformation initiatives. By organizing providers around shared clinical improvement goals, CINs create a framework for making effective use of interoperable data systems and virtual care technologies. This alignment can ensure that state investments in digital health infrastructure translate into meaningful improvements in access and care coordination for rural populations.

Maintaining Local Governance and Community-Based Care

Importantly, CINs allow rural providers to collaborate while maintaining local governance and responsiveness to community needs. Many rural communities value maintaining local control over health care services and preserving trusted relationships between patients and providers. CINs offer a way to strengthen the capabilities of rural providers without requiring consolidation into distant health systems that may not fully understand local needs.

By supporting collaboration among rural hospitals, clinics and independent physicians, CINs can help states advance delivery system transformation goals related to access, quality, affordability and health equity. They provide a pathway for rural providers to participate in value-based care, strengthen coordination across settings and adopt evidence-based practices while preserving the community-based care infrastructure that is essential to the health of rural populations.

Impacting Total Cost of Care (TCOC)

High functioning CINs drive down total cost of care (TCOC) by fostering internal competition among providers for patient referrals, using transparent cost and quality data to direct volume toward high performers. This merit-based system reduces leakage, redundancies and unnecessary utilization while aligning incentives for value over volume. CINs deploy shared analytics platforms to score providers on metrics like episode costs, readmissions and Healthcare Effectiveness Data and Information Set (HEDIS) rates, creating provider "report cards" visible network-wide. Referrals flow to lowest-cost, highest-quality options (e.g., low-acuity cases stay local), with financial incentives like shared savings distributed based on performance.

Implications for States: Enabling Sustainable, Integrated Networks

Across many state initiatives, including RHTP proposals, there is a clear focus on strengthening provider alignment, expanding data infrastructure and improving care coordination. While these efforts are not always labeled as CIN development, they reflect the foundational components of clinical integration. States play a critical enabling role in this process. Rather than building or operating networks directly, states establish the conditions under which provider-led networks can form, mature and sustain themselves over time. This includes aligning funding with infrastructure development, supporting shared capabilities such as data systems and care management and creating pathways for participation in value-based payment models. When these elements are aligned, CINs can evolve from early-stage collaborations into durable systems that improve quality, strengthen provider sustainability and support long-term care coordination beyond initial funding periods.

State Role in Supporting CINs

CINs are still a relatively nascent model and states have an opportunity to play a constructive role in supporting their development without imposing formal regulatory structures that could inadvertently slow innovation or limit participation. Rather than creating new licensure frameworks or prescriptive requirements, states can help catalyze CIN formation by reducing barriers, supporting shared infrastructur, and encouraging voluntary alignment around common standards.

Convening Stakeholders

One of the most effective roles states can play is to help convene stakeholders and build shared understanding of the CIN model. Many small providers are not yet familiar with the operational or legal components of clinical integration and may lack trusted partners to help organize collaborative efforts. States can act as neutral conveners by bringing together hospitals, physician groups, community health centers and payers to identify opportunities for collaboration and align on shared priorities such as chronic disease management, maternal health outcomes, behavioral health integration or rural specialty access. State leadership can help create momentum and signal that collaboration across providers is aligned with broader health system goals.

Supporting Infrastructure Through Funding

States can also support CIN development through targeted grant funding (including RHTP funds) that helps providers invest in the foundational infrastructure required for clinical integration. Grant programs can help offset the upfront costs associated with building interoperable data systems, developing shared clinical protocols or implementing population health tools. Strategic investment at the early stages can accelerate readiness for value-based payment participation and improve the long-term sustainability of small providers.

Promoting Alignment and Reducing Fragmentation

States can play an important role in helping to promote consistency and reduce fragmentation of care by encouraging alignment around common quality measures and coordination approaches. While states should avoid rigid definitions of CIN structures, they can help standardize key elements such as core performance domains, priority clinical areas and data reporting approaches. Aligning quality priorities across Medicaid programs, state employee health plans and other state purchasing strategies can reduce administrative burden on providers and create clearer incentives for collaboration. States can also support voluntary learning collaboratives that allow emerging CINs to share best practices and refine governance approaches.

Providing Data Access and Technical Assistance

Medicaid programs can serve as an important catalyst by creating pathways for CINs to participate in or care coordination initiatives. States can encourage managed care organizations to work constructively with provider networks that demonstrate meaningful collaboration around quality improvement and care management. Technical assistance programs can help smaller providers understand how CIN participation aligns with broader state priorities related to access, cost containment and population health improvement.

Leveraging Medicaid and Managed Care

States can further support CIN maturation by helping clarify how CINs can align with existing initiatives such as Medicaid, RHTP, multi-payer alignment efforts, health information exchange investments and telehealth expansion strategies. Ensuring that CIN development complements rather than duplicates existing infrastructure can improve efficiency and encourage broader participation. States can also facilitate access to data resources, including Medicaid claims data or all-payer claims databases, which can help networks identify opportunities for improvement and measure progress.

Maintaining a Supportive, Non-Prescriptive Approach

Importantly, the role of states should be supportive rather than prescriptive. CINs emerged and benefit from flexibility, evolving based on local market conditions, provider relationships and community needs. Overly rigid regulatory frameworks could discourage participation or limit innovation in governance and care delivery approaches. A balanced state role focuses on reducing friction, encouraging voluntary alignment and providing resources that help providers collaborate effectively while maintaining independence.

By acting as conveners, funders and facilitators of shared learning, states can help accelerate the responsible development of CINs without imposing unnecessary administrative burden. This approach allows states to support improved care coordination, stronger rural provider sustainability and greater preparation for value-based payment models, while preserving the adaptability needed for CINs to mature as an effective and scalable model of collaboration.

Recommended State Actions to Support CINs

States can support CIN development through a combination of convening, targeted investment and alignment of payment and policy strategies. The following section outlines specific actions states can take to operationalize support.

Convening Stakeholders

Identify Priority Regions and Use Cases

States can begin by identifying geographic areas or clinical priorities where collaboration could have the greatest impact. In rural areas, CIN formation is often most relevant where there are:

- financially vulnerable rural hospitals
- limited specialty access
- high rates of chronic disease
- maternal health access gaps
- behavioral health workforce shortages
- fragmented referral patterns
- long travel distances for care States can use Medicaid data, hospital financial reports and workforce shortage designations to identify communities where CINs could improve sustainability and access.

Focusing convening efforts around clearly defined use cases—such as improving maternal outcomes, expanding specialty access through telehealth or strengthening post-acute care coordination—can help align stakeholders around shared goals.

Map Key Stakeholders Across the Care Continuum

Effective CIN convenings include representation across the care delivery system. Mapping existing relationships and referral patterns can help identify natural collaboration clusters.

Provide Education on the CIN Model

Many providers are unfamiliar with CIN structure and requirements. Educational resources can reduce uncertainty and allow providers to make informed decisions about participation. States can support educational sessions that address:

- what constitutes clinical integration
- governance models used in CINs
- legal considerations
- infrastructure requirements
- relationship to ACOs and value-based payment
- examples from other states or regions

States can partner with rural health associations, hospital associations or technical assistance organizations to deliver this education.

Convene Initial Listening Sessions

States can host structured listening sessions to understand provider needs and readiness for collaboration. Listening sessions signal that the state is facilitating rather than directing CIN development.

These sessions often surface practical needs such as shared analytics tools, telehealth partnerships or care management resources.

Facilitate Multi-Stakeholder Design Workshops

Once interest is established, states can facilitate working sessions focused on defining:

- shared clinical priorities
- initial population focus (e.g., diabetes, maternal health, behavioral health)
- data sharing needs
- care coordination opportunities
- governance considerations
- infrastructure gaps
- timeline for development

Workshops help translate general interest into actionable collaboration plans. States can use neutral facilitation to ensure balanced participation among hospitals, physicians and clinics.

Provide Planning Grants or Technical Assistance

Small and rural providers often lack resources to evaluate CIN participation independently. States can support planning through:

- seed grants for feasibility analysis
- legal consultation funding
- data infrastructure assessments
- readiness evaluations
- governance design support

Even modest funding can accelerate progress by allowing providers to dedicate staff time to planning activities. Technical assistance providers may include universities, rural health resource centers or quality improvement organizations.

Align CIN Development with Existing State Initiatives

States can increase momentum by connecting CIN discussions to existing programs such as:

- Medicaid value-based purchasing initiatives
- rural health transformation programs
- telehealth expansion efforts
- health information exchange investments
- federally integrated/coordinated care models
- maternal health improvement initiatives
- behavioral health integration programs

Alignment helps stakeholders see CIN participation as reinforcing rather than duplicating existing work.

Encourage Participation from Medicaid Managed Care Plans

Managed care plans often play an important role in supporting coordination infrastructure. States can encourage plans to:

- participate in stakeholder convenings
- share data insights
- align quality priorities
- explore value-based arrangements with emerging networks

Plan participation can increase the likelihood that CIN infrastructure supports meaningful payment reform opportunities.

Establish Ongoing Learning Collaboratives

States can sustain momentum by creating peer learning environments where emerging CIN participants can share:

- governance approaches
- data strategies
- clinical improvement initiatives
- contracting experiences
- operational challenges

Learning collaboratives can help reduce duplication of effort and accelerate maturation of CIN structures. Participation may include both early-stage and more developed networks.

Maintain a Supportive but Non-Prescriptive Role

States can foster CIN development most effectively by:

- encouraging voluntary participation
- avoiding rigid structural requirements
- supporting locally driven priorities
- allowing flexibility in governance models
- focusing on removing barriers to collaboration

Maintaining flexibility allows CINs to evolve in ways that reflect local market dynamics and provider relationships.

Provide Targeted Grant Funding (Including RHTP funds)

Funding should focus on building durable capabilities—such as data sharing, care coordination and quality measurement—that allow providers to collaborate effectively and participate in value-based care. The following steps provide a practical framework for states looking to structure CIN funding in a way that promotes meaningful delivery system transformation without imposing rigid regulatory structures.

Define the Policy Goals for CIN Funding

States should clearly articulate that CIN funding is intended to advance delivery system transformation goals such as improving rural access to care, strengthening financially vulnerable providers, improving care coordination and supporting participation in value-based payment models. Clarifying the purpose of funding helps ensure that grants support long-term infrastructure development rather than short-term financial relief.

Identify Eligible Collaborations

States should establish baseline expectations for participation without creating overly prescriptive definitions. Eligible applicants should demonstrate collaboration across multiple provider types, such as rural hospitals, physician groups, federally qualified health centers, behavioral health providers and other community-based organizations. The emphasis should be on meaningful collaboration and shared clinical improvement goals.

Use a Phased Funding Approach

States should consider staged funding to support networks at different levels of readiness:

- Planning phase: stakeholder convening, governance design, readiness assessments
- Implementation phase: shared data platforms, care management infrastructure, clinical protocols
- Performance phase: expansion tied to demonstrated progress in care coordination and value-based participation

A phased approach reduces risk and supports thoughtful development.

Require a Clear Use Case

Applicants should identify the delivery system challenge the CIN is designed to address, such as improving maternal health outcomes, strengthening behavioral health integration, reducing avoidable hospital transfers, improving chronic disease management or expanding access to specialty care in rural areas. Funding should be tied to solving a defined care delivery problem.

Evaluate Infrastructure-Building Potential

States should prioritize applications that build shared, durable assets such as interoperable data systems, analytics capacity, quality measurement capabilities and shared care management resources. Selection criteria should focus on the potential to create meaningful clinical integration rather than organizational size or existing sophistication.

Prioritize Rural and Under-Resourced Providers

Because rural providers often face greater resource constraints, states should consider set-asides, enhanced scoring or technical assistance support for networks serving rural or under-resourced communities. Ensuring rural participation is essential to achieving statewide delivery system transformation goals.

Require Governance and Sustainability Plans

Applicants should describe how participating providers will make decisions, manage shared infrastructure and sustain CIN activities after grant funding ends. Sustainability may come through payer participation, shared contributions from member organizations or alignment with Medicaid value-based payment initiatives.

Tie Funding to Measurable Milestones

States should structure awards around achievable milestones such as establishing governance structures, implementing shared data platforms, adopting common quality measures, launching care coordination programs or entering value-based payment arrangements. Milestones should focus on real progress toward clinical integration rather than process compliance.

Align CIN Funding with Existing State-Funded Initiatives

States should coordinate CIN grants with existing funding efforts such as Medicaid transformation initiatives, RHTP funding, telehealth expansion, health information exchange investments and rural health strategies. Alignment helps avoid duplication and ensures that CINs reinforce broader system transformation efforts.

Provide Technical Assistance Alongside Funding

Many providers, particularly in rural markets, will need support related to governance design, legal considerations, interoperability planning and measure selection. Pairing funding with technical assistance can improve the likelihood that CINs develop durable and effective infrastructure.

Treat CIN Funding as a Catalyst for Long-Term Transformation

States should view CIN funding as an early-stage investment in collaborative delivery system capacity. Over time, successful CINs should demonstrate improved care coordination, stronger quality performance and readiness to participate in value-based payment models. The goal is to help providers build sustainable capabilities that support long-term system transformation.

Together, these steps allow states to encourage thoughtful CIN development while maintaining flexibility for local innovation and ensuring that funding supports meaningful improvements in care delivery, particularly for rural communities.

Promote Consistency and Reduce Fragmentation

States can help ensure that CINs develop in ways that strengthen collaboration rather than create additional fragmentation. Because CINs are still emerging, variation in quality measures, data standards and care coordination approaches could create unnecessary administrative burden for providers, particularly small and rural organizations with limited capacity. States can play a constructive role by encouraging alignment around core elements of clinical integration while maintaining flexibility for local innovation.

Align Core Quality Measures Across Programs

States can reduce fragmentation by aligning priority quality measures across Medicaid, state employee health plans and other transformation initiatives. Consistent measures, such as those focused on chronic disease management, maternal health, behavioral health integration and avoidable utilization, allow CIN participants to focus improvement efforts more effectively and reduce duplicative reporting requirements.

Promote Common Data Standards and Interoperability

Encouraging the use of shared data standards, participation in health information exchanges and consistent reporting approaches can reduce technical barriers to collaboration. Alignment on interoperability helps ensure that CIN participants can exchange information efficiently, particularly in rural markets where IT resources may be limited.

Support Shared Infrastructure

States can invest in infrastructure used across multiple CINs, such as health information exchanges, telehealth platforms, analytics tools and quality reporting frameworks. Shared infrastructure reduces duplicative investment and helps smaller providers participate in CINs.

Encourage Alignment Around Care Coordination Priorities

States can promote consistency by identifying priority clinical areas where coordination is particularly important, such as maternal health, behavioral health integration, chronic disease management, transitions of care and post-acute coordination. Shared focus areas can accelerate learning and improve comparability of results across regions.

Facilitate Learning Collaboratives

Peer learning collaboratives allow emerging CINs to share governance approaches, implementation strategies and data solutions. These forums help spread best practices and reduce the need for each network to develop processes independently.

Provide Model Governance and Participation Frameworks

States can offer optional templates for participation agreements, governance structures and data sharing expectations. Model frameworks can reduce legal costs and accelerate development while still allowing networks flexibility to adapt to local needs.

Align Expectations Across Medicaid Managed Care Plans

States can encourage managed care organizations to adopt consistent expectations related to quality improvement and value-based payment participation. Alignment across plans reduces complexity for CIN participants and strengthens incentives for collaboration.

Encourage Multi-Payer Alignment Where Possible

Consistency is strengthened when Medicaid, commercial payers and employer purchasers promote similar quality priorities and care coordination expectations. States can facilitate dialogue across payers to promote aligned signals to providers.

Maintain a Supportive but Flexible Approach

States can encourage convergence around best practices without imposing rigid requirements that might discourage participation. A balanced approach promotes consistency while allowing CINs to evolve based on local provider relationships and community needs. Through these steps, states can help reduce fragmentation, lower administrative burden and support more coordinated care delivery, particularly in rural areas where aligned infrastructure can significantly improve access, sustainability and quality of care.

Catalyzing Value-Based Payment Arrangements

What States Can Do to Catalyze Value-Based Care Arrangements in CINs

States can play a significant role in accelerating value-based care arrangements within CINs, particularly in rural markets where providers often lack the scale, capital and infrastructure needed to independently assume performance risk. CINs create a platform for providers to collaborate on quality improvement and population health management, but state policy and purchasing strategies can help create the conditions that make value-based participation feasible and attractive. By aligning incentives, reducing administrative barriers and supporting early-stage infrastructure development, states can help CINs transition from collaborative structures into vehicles for accountable, outcomes-focused care delivery.

Align Medicaid Payment Models with CIN Capabilities

States can design Medicaid value-based purchasing programs that recognize and support clinically integrated provider networks. This may include shared savings arrangements, care coordination payments or bundled payment models that reward collaboration across hospitals, physicians, behavioral health providers and community-based organizations. When Medicaid incentives align with CIN capabilities, providers have a clearer pathway to participate in alternative payment models.

Encourage Managed Care Plans to Contract with CINs

States can signal to Medicaid managed care organizations that clinically-integrated provider networks represent strong partners for value-based contracting. States may encourage plans to work with CINs on shared savings arrangements, performance incentives or care coordination initiatives that leverage the network's ability to manage population health. Encouraging plan participation helps ensure that CIN infrastructure translates into meaningful payment opportunities.

Provide Upfront Infrastructure Funding

Participation in value-based payment requires investment in analytics, care management, data sharing and quality reporting capabilities. States can use grant funding, including RHTP resources, to help CIN participants build the infrastructure needed to track performance, identify care gaps and manage financial accountability. Early-stage funding can help rural providers overcome initial barriers to participation.

Support Multi-Payer Alignment

States can convene Medicaid, commercial payers and employer purchasers to encourage alignment around core quality measures and payment approaches. When multiple payers promote similar expectations related to outcomes and care coordination, CIN participants receive clearer signals and stronger incentives to invest in value-based capabilities. Multi-payer alignment can reduce fragmentation and accelerate delivery system change.

Use State Purchasing Power to Reinforce Value-Based Approaches

States can incorporate value-based expectations into contracts for state employee health plans or other public purchasing arrangements. Aligning purchasing strategies across programs can create consistent incentives for providers to participate in CINs supporting accountability for cost and quality performance.

Offer Technical Assistance to Support Contract Readiness

Small and rural providers often need support in contract design, risk adjustment, attribution methodologies and performance measurement. States can provide technical assistance or partner with external experts to help CIN participants develop the skills needed to negotiate and manage value-based payment arrangements.

Encourage Gradual Risk Progression

States can design programs that allow CINs to begin with lower levels of financial risk and gradually increase accountability as infrastructure and experience grow. Starting with shared savings or care coordination payments can allow providers to develop confidence and capability before taking on more advanced risk arrangements.

Align Quality Measurement with State Health Priorities

States can promote value-based arrangements that focus on priority clinical areas such as maternal health, behavioral health integration, chronic disease management and avoidable hospital utilization. Alignment between payment incentives and priority population health needs ensures that CIN activities support broader transformation goals.

Reduce Administrative Complexity

Variation in reporting requirements and contract structures can discourage participation in value-based models. States can work to align quality measures, reporting timelines and performance benchmarks across programs to reduce administrative burden on CIN participants, particularly smaller providers with limited staffing capacity.

Connect CIN Development to Broader Transformation Initiatives

Value-based care arrangements are most effective when aligned with complementary initiatives such as telehealth expansion, health information exchange investment, rural health transformation programs and workforce development efforts. Coordinating these initiatives can help ensure that CINs have the infrastructure needed to manage population health effectively.

Promote Transparency Around Performance and Learning

States can facilitate learning collaboratives or data-sharing initiatives that allow CINs to understand performance trends and identify improvement opportunities. Shared learning environments can accelerate adoption of effective care models and support continuous improvement across networks.

By aligning payment incentives, supporting infrastructure development and reducing barriers to participation, states can help CINs evolve into effective platforms for value-based care. These efforts are particularly important in rural areas, where clinically integrated collaboration may be essential to sustaining access to care while improving quality and managing costs.

State Evaluation Checklist: Minimum Standards for CINs

1. Formal Governance and Legal Structure

A CIN must have a clearly defined governance and legal structure that enables coordinated decision-making and accountability across participating providers.

- Defined legal entity or formal governance body with decision-making authority
- Participation agreements that outline roles, responsibilities and expectations for all members
- Authority to establish and enforce participation standards, including quality and performance requirements
- Governance models that ensure representation across participating providers and promote alignment of incentives

In many successful models, a dedicated CIN management entity provides operational infrastructure, administrative support and contracting capability while preserving shared governance across participating providers. Rather than relying on a single "anchor" health system, these structures are designed so that all members, regardless of size, have an equal voice in key decisions and a proportional stake in network performance.

2. Multi-Provider Participation and Network Scope

CINs must include a sufficient breadth of providers to enable coordination across a defined population and care continuum.

- Participation across independent providers and organizations, not limited to a single system
- Representation across care settings, including primary care, specialty care, hospitals and behavioral health
- Defined geographic region or target population that the network is accountable for
- The scope and composition of the network should support meaningful coordination of care and allow for performance measurement at the population level.

3. Shared Data and Performance Infrastructure

A CIN must have the ability to aggregate, analyze and act on data across participating providers.

- Infrastructure to aggregate clinical and/or claims data from multiple sources
- Network-wide reporting on quality, utilization and cost
- Performance dashboards and tools to monitor provider performance and identify variation

Shared EHR systems are not required; many networks operate across multiple platforms and rely on interoperability solutions such as data aggregation layers, direct messaging or reporting tools.

High-functioning networks often provide standardized templates, dashboards and reporting tools to support consistent implementation and enable providers to act on performance data.

4. Clinical Integration and Care Coordination

Clinical integration is the defining feature of a CIN and requires more than collaboration; it requires coordinated, measurable improvement in care delivery.

- Adoption of shared, evidence-based clinical pathways across providers
- Centralized or coordinated care management infrastructure
- Ongoing monitoring of adherence to clinical standards and performance improvement
- Some networks formalize clinical integration through structured quality programs or accreditation frameworks, enabling consistent implementation of best practices.

In practice, successful CINs invest in implementation support, including structured training, clinical "boot camps" and ongoing education to ensure providers can adopt and sustain shared care models.

5. Care Management and Between-Visit Infrastructure

CINs must support care beyond episodic encounters, particularly for patients with chronic conditions or complex needs.

- Chronic care management programs
- Remote patient monitoring and other tools to support ongoing care
- Coordination of care across providers and settings between visits

These capabilities enable longitudinal care management, improve outcomes and are foundational for participation in value-based payment models.

6. Referral and Network Management Capability

A CIN must have visibility into and influence over how patients move across the health care system.

- Ability to track patient movement across care settings, including referrals and transitions
- Visibility into cost, quality and performance of referral partners
- Mechanisms to influence or guide referral patterns based on value

In many markets, especially rural settings, a significant portion of care occurs outside local providers. Effective CINs actively manage these referral pathways to improve quality, control cost and ensure continuity of care.

7. Value-Based Payment and Contracting Readiness

To achieve long-term sustainability, CINs must be able to translate clinical integration into financial alignment.

- Ability to contract collectively with payers or participate in shared savings arrangements
- Financial mechanisms to distribute savings, manage risk and align incentives across providers
- Systems to monitor cost, utilization and financial performance

In more advanced networks, these capabilities may also support negotiation with payers or referral partners, enabling providers to align reimbursement with performance and improve financial sustainability.

CIN Maturity and Readiness Pathway

CINs typically develop over time, progressing through stages of increasing capability and coordination. This pathway can help states assess readiness and align support accordingly:

- *Emerging Network*
  Early-stage collaboration among providers, often supported by initial funding or partnerships, with limited formal infrastructure.
- *Operational CIN*
  Established governance, shared data systems and care coordination models that support clinical integration across providers.
- *Value-Based Ready Network*
  Demonstrated ability to contract with payers, manage cost and utilization and sustain operations through aligned financial incentives.

Federal transformation models often emphasize replicability, requiring networks to demonstrate that clinical integration and performance improvement can be scaled across multiple providers and regions.

Financing Pathways for CIN Infrastructure

In practice, CIN sustainability is achieved through a combination of funding sources rather than a single revenue stream:

- **Grant funding** to establish initial infrastructure and operations
- **Billable services** such as care management and remote patient monitoring
- **Shared savings** from participation in value-based payment models
- **Contracting revenue** from payer negotiations
- **Shared Services** to improve pricing for services, goods and commodities purchased as a network

This blended approach is particularly important in rural settings, where providers often lack the financial capacity to support network infrastructure independently. Over time, these financing pathways enable networks to transition from grant-supported initiatives to sustainable, integrated systems of care.

Many CINs evolve from grant-funded transformation models (e.g., CMMI initiatives) into formal accountable care or shared savings arrangements over time, with infrastructure established during early phases supporting later participation in value-based payment.

Many networks are structured to minimize or eliminate direct participation costs for rural providers, recognizing that financial barriers can limit engagement and long-term sustainability. This blended model is especially important in rural settings.

CINs may also improve financial sustainability by increasing negotiating leverage with commercial payers, particularly in markets where providers are historically under-reimbursed.

Antitrust Considerations

CINs must pay careful attention to antitrust rules because they bring together otherwise independent providers to collaborate in ways that can affect competition. Under U.S. antitrust law, competitors are generally prohibited from jointly negotiating prices or engaging in collective actions that could reduce competition or increase costs for purchasers. Because many CIN participants are independent entities that might otherwise compete with one another, their collaboration must demonstrate that it produces meaningful benefits for patients and payers, not simply increased market leverage.

Antitrust considerations are particularly relevant when CINs seek to negotiate value-based contracts with payers on behalf of participating providers. Joint negotiation among independent providers could raise concerns about price-setting or reduced competition if it is not supported by genuine clinical integration. For this reason, CINs are typically structured to demonstrate that participating providers are actively working together to improve quality, coordinate care and manage costs through shared clinical protocols, performance measurement systems and accountability mechanisms. These activities show that collaboration is designed to improve care delivery rather than merely consolidate negotiating power.

Federal antitrust guidance recognizes that clinical integration can create efficiencies that benefit patients, such as improved coordination of care, reduced duplication of services and better management of chronic disease. When providers are sufficiently integrated—for example, by using shared data infrastructure, implementing common care pathways and monitoring performance across the network—joint contracting may be viewed as reasonably necessary to support these improvements. In this context, the CIN structure helps demonstrate that collaboration is tied to improving quality and efficiency, not simply increasing prices.

Previous federal antitrust guidance from the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) Antitrust Division included “safety zones” that

identified circumstances in which activities such as joint contracting, information sharing and clinically or financially integrated provider networks were less likely to face antitrust enforcement scrutiny when they demonstrated meaningful clinical or financial integration that improved quality and efficiency of care.[3] These frameworks emphasized core elements of clinical integration, including:

- Adoption and enforcement of evidence-based care pathways
- Participation standards tied to quality and cost performance
- Measurement and reporting of provider compliance
- Investment in shared infrastructure, including data and care management resources
- Continuous improvement in quality and efficiency

In 2023, both agencies withdrew the Statements of Antitrust Enforcement Policy in Health Care. This action did not change underlying antitrust law or prohibit clinically integrated arrangements. Instead, enforcement now relies on a case-by-case analysis informed by existing statutes, enforcement history and market-specific factors. DOJ and FTC are seeking public input for additional guidance on collaborations among competitors.[4] The removal of predefined "safe zones" places greater emphasis on demonstrating meaningful clinical integration. This process creates an opportunity for stakeholders to inform future guidance on provider collaboration, particularly in areas such as governance, data sharing and care coordination.

What Does Not Qualify as a CIN

Not all provider collaborations meet the threshold of clinical integration. The following structures, while valuable, do not qualify as CINs in the absence of additional capabilities:

- **Informal provider collaboratives:** Partnerships without defined governance, accountability or shared performance expectations.
- **Single-system networks without independent providers:** Organizations operating within a single health system that do not demonstrate coordination across independent entities.
- **Time-limited grant programs:** Initiatives that lack a pathway to sustainability beyond the funding period.
- **Data-sharing arrangements without accountability:** Efforts that exchange information but do not use data to measure performance, enforce standards or drive improvement.
- **Networks lacking contracting capability:** Collaborations that are unable to participate in value-based payment arrangements or align financial incentives across providers.

These distinctions are critical for states seeking to differentiate between early-stage collaboration and true clinical integration.

[3]Statements of Antitrust Enforcement Policy in Health Care. U.S. Department of Justice and the Federal Trade Commission. https://www.ftc.gov/system/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf.

[4]DOJ withdraws long-standing health care antitrust policy statements. HUB | K&L Gates. https://www.klgates.com/DOJ-Withdraws-Long-Standing-Health-Care-Antitrust-Policy-Statements-2-15-2023.

Indicators of Weak or Incomplete Network Infrastructure

Not all regional collaborations are positioned to function as CINs. The following indicators may suggest that a network lacks the infrastructure or alignment needed to support clinical integration and long-term sustainability:

- **Lack of governance or accountability:** Absence of a defined governance structure, decision-making authority or mechanisms to enforce participation standards and performance expectations.
- **Limited provider participation:** Insufficient representation across independent providers or care settings, limiting the network's ability to coordinate care across a defined population.
- **No shared data infrastructure:** Lack of systems to aggregate, analyze and report on quality, utilization and cost across participating providers.
- **No pathway to value-based payment:** Inability to participate in or prepare for shared savings or other value-based payment arrangements, limiting financial sustainability.
- **Formed solely for grant funding:** Networks established primarily to access funding, without a clear plan for sustaining operations, infrastructure or participation beyond the grant period.

These indicators can help states identify gaps in network development and target support toward building the capabilities required for clinical integration and long-term viability.

Emerging Foundations for CINs in Heartland RHTP Roadmaps

Across the eight heartland states reviewed—Arkansas, Kansas, Kentucky, Indiana, Missouri, Louisiana, Tennessee and Oklahoma—explicit references to "CINs" are relatively limited within the Rural Health Transformation Program (RHTP) proposals. However, many states are investing in the structural components that underpin CINs, including regional provider coordination, shared data infrastructure and support for value-based care. Rather than establishing formal CIN entities, most proposals emphasize regional coalitions, hub-and-spoke delivery models, health information exchange expansion and practice transformation initiatives that enable providers to collaborate more effectively across rural health systems. Taken together, these approaches suggest that states are laying the groundwork for clinically-integrated delivery systems by building the governance, technology and care coordination infrastructure needed to support integrated, population-focused care, even if they do not formally use CIN terminology.

Looking Ahead: A Pathway Toward CINs

As states implement transformation programs, many are building the foundational elements of CINs. Over time, these efforts can evolve into formal networks capable of sustaining care coordination and participating in value-based payment models.

Questions for State Leaders

As states evaluate regional collaborations and infrastructure investments supported through RHTP, several key questions can help assess whether these efforts are positioned to evolve into sustainable, integrated care networks:

- *Do regional collaborations have formal governance structures?* Is there a defined entity or governance model with clear roles, decision-making authority and accountability across participating providers?
- *Do providers share data and performance systems?* Are there mechanisms in place to aggregate, analyze and report on quality, utilization and cost across participating organizations?
- *Are care coordination models in place?* Do providers have the operational capacity to coordinate care across settings, including between visits and across the continuum of care?
- *Can the network participate in value-based payment?* Does the collaboration have the infrastructure and contracting capability to engage in shared savings or other value-based payment arrangements?
- *Is there alignment across participating providers?* Are providers working toward shared clinical standards, performance goals and care models, with engagement beyond executive leadership to frontline staff?
- *What additional steps are needed for full integration?* What gaps remain in governance, infrastructure, data or financial alignment that would need to be addressed to support a fully integrated network?
- *What experiences can integrated networks share to inform federal guidance on collaborations among competitors?* How can lessons learned from existing networks help shape future policy, particularly related to clinical integration and antitrust considerations?

These considerations can help states assess whether the infrastructure and partnerships developed through RHTP could evolve into sustainable, integrated care networks that continue to support rural health systems beyond the initial transformation period.

Closing

CINs represent a scalable model for advancing health care delivery system transformation while preserving provider independence and local accountability. As states continue to invest in infrastructure, care coordination and value-based care, CINs provide a pathway to ensure these efforts translate into sustained improvements in quality, access and cost performance.

The opportunity for states is not to build networks directly but to create the conditions under which they can succeed. By aligning funding, reducing fragmentation and supporting shared capabilities, states can enable providers to collaborate more effectively and participate in evolving payment models.

Over time, the success of these efforts will depend on whether infrastructure investments lead to durable systems that can operate beyond initial funding periods. CINs offer a mechanism to achieve this transition—moving from isolated programs to integrated, performance-based models of care that are better equipped to meet the needs of patients and communities.