PREMIER

Ready, Risk, Reward:

Aligning for Success with the Second Generation of Clinically Integrated Networks

This white paper provides an in-depth look at the future of clinically integrated networks (CINs), providing a blueprint to health systems seeking to accept added levels of risk and effectively implement value-based payment models.

Executive Summary

Clinical integration has long been a goal of many healthcare providers in order to improve quality, coordination and efficiency. Historically, establishing these integration vehicles was a risky endeavor, as creating cooperative financial and care agreements across competing provider types required compliance with a range of anti-trust and anti-collusion laws. However, the state-of-play for clinical integration was radically changed with the passage of the The Patient Protection and Affordable Care Act (ACA), which includes a range of new payment models designed to incent clinical integration (see callout below) and establishes operating rules for how these models can be managed legally.

WHAT IS A CLINICALLY INTEGRATED NETWORK (CIN)?

A network of high-quality, high-value organizations that provide a coordinated continuum of services to a defined population. CINs are held accountable for outcomes, health status and financial performance. Attributes of CINs, include:

- *Interdependence across provider types to collaborate, share information and build physician affinity*
- *Care coordination across the continuum, including primary, specialty and post-acute care*
- *Evidence-based clinical protocols across a wide range of diseases and conditions that lead to appropriate utilization and clinical effectiveness, as well as provider accountability for compliance*
- *Infrastructure to provide appropriate performance monitoring and training, clinical decision support, etc.*
- *Measurable high-quality, cost-effective outcomes, as well as feedback and processes to improve performance*
- *Professional management of the network to provide centralized services, including payer contracting*

The concept of CINs gained popularity with the passage of the ACA, with its focus on driving population health and value-based care, as opposed to volume-based payment that incents greater consumption – and greater healthcare spending. In the law, Congress recognized that without clinical integration across the continuum, care givers would still operate in silos and fly blind when it comes to care delivered outside of their individual setting, directly contributing to duplication of services, inefficiencies, poor care coordination and wasteful costs. Because of this, regulations were re-written and legal waivers have been granted to CINs, enabling hospitals, health systems, employed physicians, and independent physicians to work together to optimize care delivery.

Due to the incentives inherent in the ACA[1], the number of clinically integrated networks nationwide has grown exponentially, from just a handful in the late 1990s, to more than 900 today, covering more than 32 million people[2]. FTC-compliant clinical integration models can take a variety of forms, including hospital-physician models, academic practice plans, employed physician groups, independent physician groups and others, and can range in size from local, to state-based or regional multi-state networks. Uniting all efforts, however, is a shared commitment to accelerate organizational transformation to provide better, more efficient and integrated care for patients and communities, while assuming greater financial risk and increased accountability for total care costs and quality.

While growth remains positive, and providers participating in CINs agree that building clinical integration is essential to improving quality and efficiency, the pace of change may not be happening quickly enough to demonstrate value and success. Environmental factors — including the economic climate, evolving payment models, shifting patient and workforce demographics, political and regulatory pressures and disruptive new competitors in healthcare—are coalescing to pressure providers to either form high-value CINs in areas where they do not yet exist, or to optimize performance, accelerate assumption of risk and increase accountability in areas where they do exist.

For instance, mega-deals by CVS and Aetna, Humana and Kindred, as well as the ongoing provider acquisitions by insurance goliath UnitedHealthcare, are having an impact on the competitive environment in many communities. Emerging players such as Amazon and Apple are also raising questions, and may be planning to disrupt traditional healthcare delivery models. Taken together, these moves are forcing providers that have not appropriately organized to answer the call being brought by these disrupters with large CINs of their own in order to attract and retain top clinical talent, scale costs and better serve patients. In highly-competitive markets such as these, providers without the mechanisms to form and lead high-performing CINs risk an existential crisis.

Similarly, independent physicians are entering the game, either organizing CINs of their own or joining existing networks to take advantage of positive payment adjustments and bonuses made possible with MACRA. Some large-scale group practices and physician organizing

entities are forming physician-led CINs that are leaving hospitals and health systems out of the network altogether or commoditizing their participation based almost exclusively on price. Still other physicians are looking to join an existing health system CIN in order to take advantage of streamlined reporting and performance improvement efforts that CINs bring to the table[3]. Organizations must be able to either compete with the former, or offer arrangements that are attractive to the latter, in order to take advantage of this trend.

In markets where progressive health systems had the foresight to form CINs to weather future competitive challenges, the data[4] suggests that performance has been tepid, and movement toward more advanced CIN capabilities has been slow to materialize. Because all participants in the Medicare Shared Savings Program (MSSP) are deemed clinically integrated networks from a legal standpoint, performance in this program serves as an effective proxy to illustrate the point. According to the latest data set available on MSSP participant performance, only 33 percent of participants were able to achieve shared savings, suggesting that many of these existing CINs need to be revamped in order to achieve optimal performance.

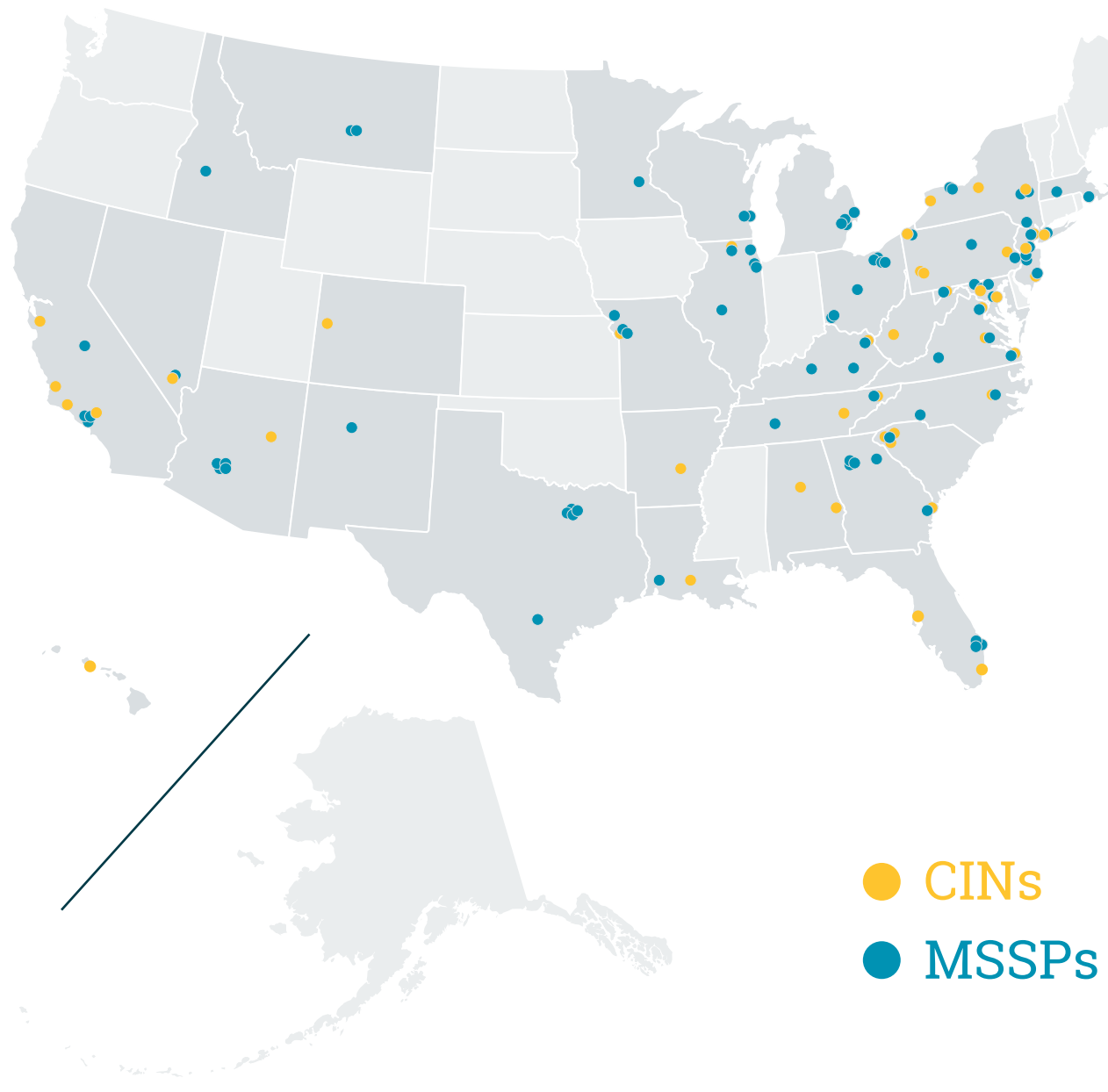
At the same time, 83 percent of 2018 MSSP participants are participating in Track 1, a shared savings model with no downside risk. This means very few of today's CINs are prepared to take on the added financial and operational risk that public payers, commercial insurers and employers are increasingly demanding. Based on the most recent CMS data, more than 140 Track 1 ACOs representing more than 3 million Medicare fee-for-service lives[5] are entering their final performance year in one-sided risk and will need to transition to two-sided risk for performance year 2019, change their delivery system, or leave the program altogether. In addition, if health systems want to optimize performance within MACRA and capitalize on bonus payments offered through the program, their CINs also must move up the risk continuum to assume downside risk in order to qualify as an advanced alternative payment model (APM).

To achieve success in this accountable new healthcare world, health systems must either form or step up their CINs to deliver increasing levels of value. This will require deliberate investments that solidify

physician engagement across larger geographies, effective deployment of infrastructure capable of managing larger patient populations and implementing new models of care to generate financial return.

Since 2012, Premier has provided strategic guidance and implementation support for health systems looking to create CINs, either building, operationalizing or reconfiguring 40 such programs servicing more than 1 million covered lives. This white paper outlines lessons learned over the past six years, and offers a blueprint for future success.

FIGURE 1: Premier's National CIN/MSSP Practice Map



Public Policies Incenting Clinical Integration

PAYING FOR QUALITY

HOSPITAL READMISSION REDUCTION PROGRAM (HRRP)

- *The Hospital Readmission Reduction Program is an initiative that puts a certain percentage of payment at risk, with penalties assessed on providers that have the highest rates of readmissions (top 25 percent) within 30 days of discharge.*
- *Conditions assessed include heart bypass surgery, heart failure, pneumonia, COPD, total hip replacement, total knee replacement and heart attack.*

MEDICARE ACCESS AND CHIP AUTHORIZATION ACT (MACRA)

- *MACRA sunsets historical physician payment updates and requires all physicians to participate in either a Merit Based Incentive Payment System (MIPS) tied to quality, efficiency and care improvement activities, or an advanced alternative payment model (APM) that puts provider payment at risk.*
- *Clinicians in MIPS have an escalating percentage of payment at risk (4 percent in 2019, 5 percent in 2020, 7 percent in 2021 and 9 percent in 2022 and beyond), with bonuses and penalties meted out based on performance.*
- *Clinicians in Advanced APMs are able to earn up to 5 percent bonus payments on Part B revenue, subject to volume and patient count minimums.*
- *Physicians participating in Track 1 MSSPs (one-sided risk) are provided several MACRA/MIPS benefits, including streamlined reporting and automatic credit in improvement areas.*

ACCOUNTABLE CARE ORGANIZATIONS (ACO)

MEDICARE SHARED SAVINGS PROGRAMS (MSSP)

- *Track 1: This is a shared savings only arrangement if it meets overall quality and spending benchmarks for its patient population and doesn't include any penalties if savings are not obtained – meaning limited risk. More than 80 percent of MSSP participants are in this tracak in 2018.*
- *Track1+: This track is a two-sided risk model that limits shared savings to 50 percent, but also caps losses at 30 percent.*
- *Track 2: This track includes some downside financial risk. Participating ACOs could face between 5 to 15 percent of total losses over the three performance years—along with a higher 60 percent rate for the ACO share in savings.*
- *Track 3: The third track allows ACOs to earn up to 75 percent of generated savings and qualify for specific legal waivers in exchange for accepting higher downside risk of up to 15 percent of all Medicare Part A and Part B payments.*

NEXT GENERATION ACO

- *Next Generation ACO participants can choose capitated payment, meaning CMS would pay ACOs a lump sum for the duration of care for each patient, making providers responsible for any and all care that patients need, even if it exceeds the capitated amount.*
- *This high-risk, high-reward payment model builds upon the Pioneer ACO Model and MSSP. Unlike other models, the Next Generation ACO model includes prospectively set benchmarks and pilots certain patient incentives, including increased access to telehealth and care coordination services.*

BUNDLED PAYMENTS

BUNDLED PAYMENTS FOR CARE IMPROVEMENT

- *The Center for Medicare and Medicaid Innovation's Bundled Payments for Care improvement (BPCI) initiative, which began on Oct. 1, 2013, tests four bundled payment models: retrospective acute hospital stay only, retrospective acute care hospital stay plus post-acute care (PAC), retrospective PAC only and prospective acute care hospital.*
- *More than 2,100 acute care organizations participate in this initiative.*
- *Participants are given flexibility in selecting clinical conditions to include in the episode, based on a list of diagnosis-related group options.*

BUNDLED PAYMENTS FOR CARE IMPROVEMENT – ADVANCED

- *Slated to begin in October of 2018, BPCI Advanced is a voluntary program to test retrospective bundled payment across 29 inpatient and three outpatient clinical episodes.*
- *Participants are given flexibility in selecting one or more clinical conditions to include in the episode, based on a list of diagnosis-related group options.*
- *Episodes are evaluated from the date of inpatient or outpatient admission, through 90 days, and payment is tied to quality performance, as well as cost savings in excess of CMS-determined a target price.*
- *Model qualifies as an advanced alternative payment model under MACRA.*

First-Generation CINs: A Focus on Building and Learning

Early adopters of the CIN model worked as pioneers to form legal entities capable of providing centralized contracting, infrastructure and management of a high-value ecosystem of care providers. Common characteristics of early stage CINs typically include:

HEALTH SYSTEM LEADERSHIP

Most first-generation CINs are organized and funded by a community or integrated health system, which has the relationships, the infrastructure and the financial resources necessary to coordinate community care givers and manage the overall network. In most cases, the CIN is set up to function as a lean start-up entity to minimize the incremental expense to the health system. Leadership structures tend to be part-time efforts, as participants straddle the demands of the CIN, while simultaneously managing core legacy operations.

GOVERNANCE

Although organized by the health system, most first-generation CINs create governance structures where physicians are heavily represented, occupying the majority of board seats. Most established structures where 75 percent or more of the participants were physicians, with the majority of those representing primary care practices that serve as the cornerstone of efforts to optimize population health, coordinate patient care across settings and avoid costly care and complications.

CONTRACTING

Most first-generation CINs are experimental efforts, designed to test the strength of the overall concept as a strategy for improving quality and reducing costs. As such, contracting tends to be small scale, often limited to a single value-based payment program, like MSSP or bundled payment, or a single one-sided risk arrangement with a commercial payer tied to less than 10 percent of the value of the contract. The overwhelming majority of early CIN contracts are upside only, meaning that savings are shared if benchmarks are achieved, but no financial penalties accrue during

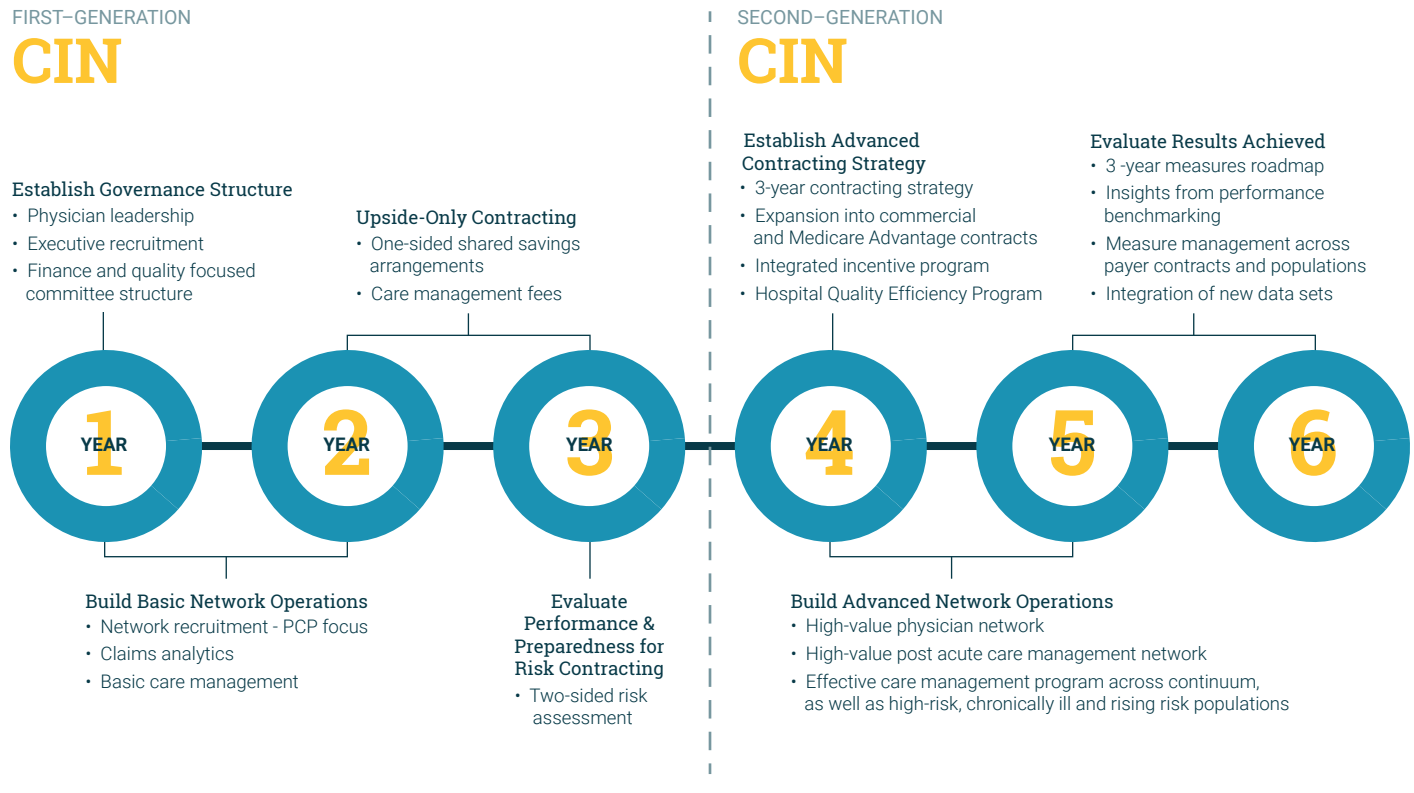
this early stage of trial and error. Moreover, first-generation contracts typically maintain traditional roles for both payers and providers, with the provider occasionally adding basic care management components.

INFRASTRUCTURE AND MANAGEMENT

First-generation CINs invest in infrastructure basics, such as claims analytics to identify high-risk patients and to monitor in- and out-of-network utilization, cost and quality performance measurement systems to evaluate the outcomes of network participation, and common electronic medical record systems to ensure efficiency and standardized care across participants. Early stage CINs also make some investments in care management, often in the form of centrally created care protocols that are pushed out to participants virtually.

In most cases, healthcare providers without experience in value-based payment should begin by experimenting in a first-generation CIN model to build their core capabilities, gain experience and learn how to manage a population using claims data. Prior to expanding the reach or risk taken on by the CIN in the second-generation of contracting, CINs must first shore up their existing network to ensure optimal cost and quality performance.

FIGURE 2: TIMETABLE FOR MOVING FROM FIRST TO SECOND-GENERATION CIN CONTRACTS



As shown in Figure 2, this is a process that usually takes about three years to operationalize and perfect.

While some CINs have produced positive results in early years, many also face challenges that delay creating value for both the sponsoring health system and participating physicians.

On the positive side, first-generation CINs are almost universally effective at increasing physician engagement and enhancing quality performance. The typical physician-led governance structure allows physicians to learn to lead and take ownership of the quality measurement and improvement processes, resulting in enhanced patient care, particularly in the primary care setting. In addition to increased quality, many newly-established CINs excel at identifying opportunities to lower cost and keep patients within the network through access to claims and utilization data.

On the other hand, realizing financial gains through a first-generation CIN can be more elusive. As noted previously, only about one-third of existing CINs are achieving shared savings today, suggesting that many of these first-generation CINs are not structured appropriately for longer-term sustainability. Even among those CINs that achieved both quality and financial success in government demonstration programs, many have faced challenges in scaling these efforts to commercial value-based arrangements due to a lack of payer engagement in many local markets.

Though an increase in physician engagement is often one of the first benefits of a CIN, these improvements are typically limited to primary care physicians (PCPs), or those focused most heavily on population health initiatives. While integrating the PCPs is an important first step, the CIN must eventually broaden the scope to include specialists and other providers that have an impact on the total per capita cost of care. This can be a challenge as CINs work to adopt models and incentives that are inclusive and attractive to the individual players.

Operational challenges also affect developing CINs. Care management models that typically focus on inpatient discharge planning, disease management and nursing outreach to patients often fail to deliver the high-trust relationships that are needed for population health management. Further, many early CINs experience difficulty in the

appropriate use of claims data. Many report that commercial payers are not providing timely, comprehensive, unblinded claims data. Even in cases when that data is available, CINs struggle to integrate multiple data formats from federal and commercial payers, and deploy analytics to risk stratify and target highest-risk patients.

Despite mixed results and uneven financial performance, public policies and a new competitive environment may drive more providers to accelerate plans to develop and deploy second-generation CINs. For instance, value-based care programs that require a CIN in order to optimize performance (MSSP and BPCI Advanced being just two examples) are proliferating and continually driving CINs to accept ever higher levels of financial risk and accountability. Second, many more commercial payers are expressing interest in creating value-based care contracts with providers, and are increasingly narrowing their networks to only include CINs or others that share a mission to jointly improve quality and reduce costs, with proven results to back it up. This was most recently seen in the Orlando market, where Disney contracted directly with a limited number of providers to offer care for employees, bypassing insurer networks altogether[6]. Last, as physicians begin to organize in order to avoid MACRA penalties and capture bonus payments, many more provider types are looking to align with a CIN in order to spread their risk and help fund their quality reporting and improvement initiatives, creating competition for the top talent.

Because of these realities, many CINs are looking to establish enhanced capabilities to ensure greater value, stronger physician partnerships and the ability to manage ever-increasing levels of risk.

Second-Generation CINs: Assessing Requirements

Moving to the second-generation of CIN contracting requires enhanced operational capabilities that can ensure a financial return on value-based contracts that are increasingly tied to two-sided risk. This evolution builds upon the basic infrastructure of the earlier CINs, but layers on advanced contracting strategies, integrated incentives and compensation alignment, robust performance reporting capabilities, a greater focus on clinical appropriateness of services, and an increased level of provider engagement to produce a differentiated, high-performing network.

FIGURE 3: OPERATIONAL CAPABILITIES NEEDED FOR SECOND-GENERATION CIN CONTRACTS

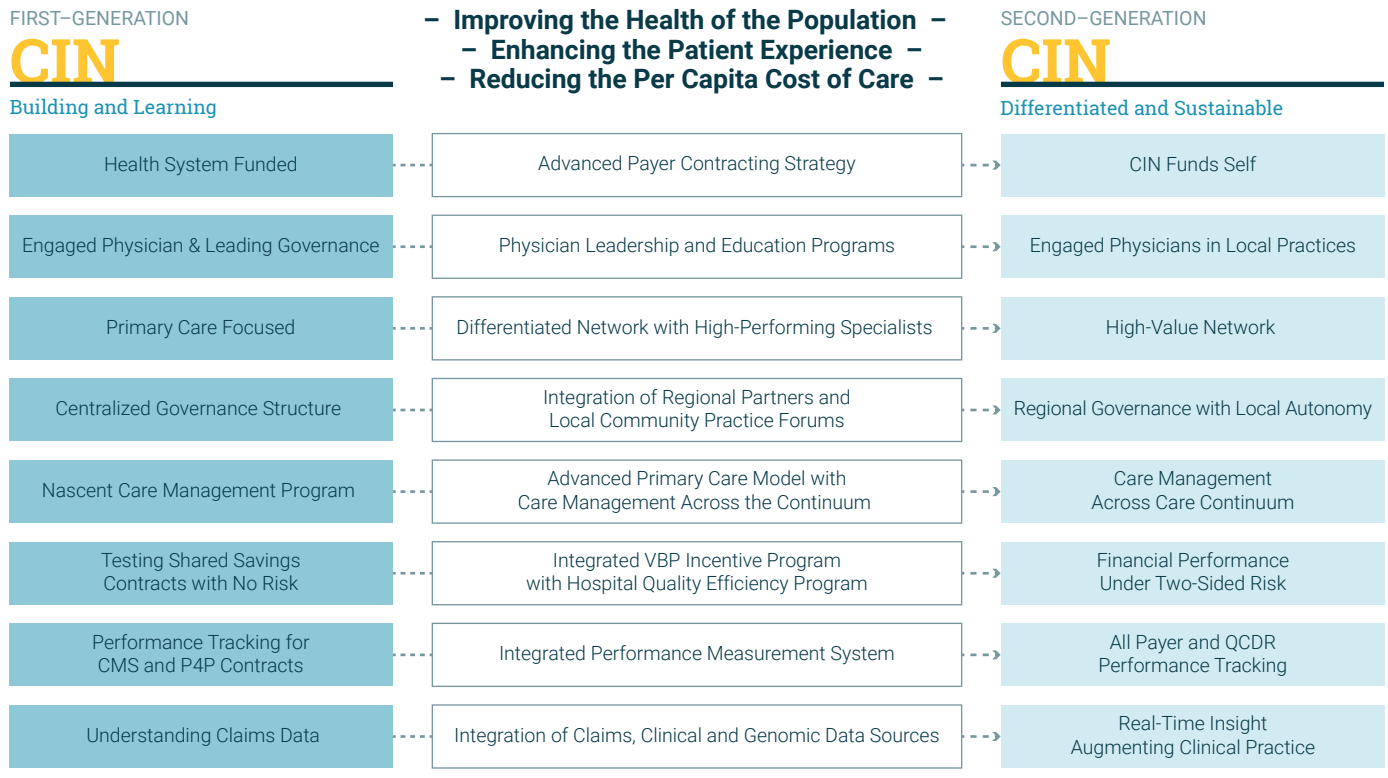


Figure 3 shows the core capabilities characteristic of this second-generation model, as well as several recommended strategies for moving up to higher levels of risk and performance. An advanced CIN should be capable of increasing quality across the continuum of care, improving utilization management, bending the cost curve, and increasing patient and physician satisfaction. A transition to a larger, more advanced CIN requires an alignment of both internal organizational readiness, as well as an optimized market environment to create the burning platform for change.

Timing, however, is paramount. While organizations may feel pressured to move into second-generation contracting right away, experience and careful observation shows that running too far, too fast can be a recipe for failure. Success in one-sided risk arrangements should be a precursor, as missteps can be even more profound and costly in the second-generation environment, where a larger percentage of contracts carry two-sided risk and hold a larger number of providers accountable for cost, utilization and quality results. Failure to optimize clinical and financial performance prior to moving into the second-generation of contracting can compromise competitive positioning, lead to significant financial losses and call into question the future viability of the network.

Action Steps To Implement Second-Generation CINs

For organizations considering a move into second-generation CINs, extensive work is required to ensure readiness and future success. Premier has developed a formula for optimizing CIN performance to ensure consistent financial and quality gains that are necessary prior to expanding into additional value-based contracts or two-sided risk models. Following this formula, Premier CINs typically perform 57 percent better on average in achieving shared savings payments through value-based contracts with Medicare, all while outpacing peers in clinical quality scores. What follows are Premier's recommendations to help CINs perform at the highest level, while developing the more advanced capabilities needed to grow and take on added levels of financial and clinical outcomes risk.

COMPETITIVE POSITIONING

Before rushing into second-generation contracts, CINs should first conduct a market scan to determine whether conditions are favorable for movement. In some crowded metro markets, CINs may be in direct competition with other provider networks, necessitating a more aggressive timetable in order to remain viable and answer scale with scale. CINs should also evaluate the impact of public policy on their strategy, which in many cases is forcing a

move up the risk continuum on a compressed timetable. For instance, CINs in the MSSP with expiring one-sided risk (upside-only) contracts may need to accelerate capabilities in order to avoid being forced out of the program within the next year. Similarly, MACRA impact should be evaluated, which will begin to influence physician choices within the next three years. Health systems that do not move into second-generation value-based contracts will miss out on the opportunity to capture up to 5 percent in bonus payments for their employed physicians starting in 2019, and could lose top clinical talent to a competitor if this opportunity is not addressed.

PRIMARY CARE NETWORK

In most value-based contracts, patient attribution is tied to the primary care physician (PCP). Therefore, it's important for the CIN to have a robust PCP network in order to ensure enough attributed lives to attract payers to the contracting table, and for fixed costs to be spread to a larger population of beneficiaries. In addition, as the network moves into two-sided risk arrangements, the CIN will invariably give rise to decreased utilization of some hospital and post-acute care services. By connecting with PCPs and engaging them in the network, health systems can mitigate the losses—and possibly benefit— from utilization compression over time, chiefly through increased referrals and market share as the provider of choice in the area. To continue to attract additional PCPs to the network, CINs should offer a range of attractive incentives, including quality value-based contracts that offer performance bonuses to participants, shared performance improvement infrastructure that removes the reporting and monitoring burden from the physicians and shifts it to the CIN, integrated claims analytics and utilization management reports, performance improvement toolkits, and care management support and infrastructure.

BROAD BUY-IN AND PROPER CULTURE

The CIN may be organizationally ready to move forward, but if the willingness to do so is not demonstrated by both the leadership and participants, the effort risks failure. Broad-based agreement to accept additional financial risk is necessary from all CIN participants to avoid creating the perception of "forced" movement before all are ready. Aligning the compensation models with this risk is imperative. Similarly, leadership across the CIN must rally behind a common culture of continuous cost and quality performance improvement in order to ensure future success.

To accomplish this, the CIN should offer a scalable education and leadership development program that provides network participants with the clinical, business and leadership skills necessary for the shift to value-based care, integrating both virtual and in-person forums to promote community and clinical interdependence. Participants also should be given the opportunity to shape the path ahead by providing input on structures, evidence-based pathways, quality initiatives, compensation and incentives through short surveys.

FINANCIAL VIABILITY

Before moving into second-generation contracts, CINs should be generating performance results that yield shared savings payments in one-sided risk arrangements that can offset the operational costs of the CIN. As a first step, many CINs expand their risk contracts to Medicare Advantage and their own employee health plan due the size of the premium, the fact that the health system is already at risk for employee costs, and the applicability of CIN capabilities to these types of plans. To further optimize the flow of finances, however, CINs need to model the financial impact of all contracts on the network to identify missed opportunities and potential for improvement. In addition, CINs should model and have adequate cash on hand to provide financial incentive payments to network participants, which may need to be paid out quarterly to incent rapid cycle change, even though shared savings payments usually aren't distributed for 14-18 months into the contract.

DATA SHARING AND DATA INSIGHTS

To optimize financial performance, CINs should have confidence that the providers in their current network are providing the highest-quality outcomes, at the lowest appropriate cost. To avoid subjective evaluations, CINs should ensure they have access to timely, complete claims data set. Data should be used to determine the cost of care among attributed patients, in- and out-of-network utilization and referral patterns and individual clinician outcomes. In many early contracting exercises, providers found that they either had too little data from payers to assess performance and manage improvement efforts, or data that was too lagged to proactively intervene. Data and data sharing gaps need to be identified and eradicated before expanding into additional and higher-risk contracting endeavors that put more dollars and patients into the risk pool.

MEASUREMENT EVALUATION

In many early contracts, metrics tended to be negotiated on a "one-off" basis with the individual payers. As a result, many CINs have contracts in place that have contradictory or competing measures that incent different behaviors depending on the individual payer. Since the second-generation CIN is predicated on scale, getting to a standardized set of performance metrics that can satisfy the needs of multiple payers is essential to avoid measure proliferation, measure fatigue and suboptimal performance[7]. Prior to expanding into additional, higher-risk contracts, the CIN should carefully examine all applicable performance metrics in use today, and standardize around measures that clinical participants agree have proven most effective at evaluating performance and incenting improvement. Ideally, the standard measure set should be a "develop once, use many times" model that not only satisfies private payers, but can also be used for federal quality reporting, and the requirements of professional societies and credentialing bodies that govern the physician participants. These metrics should be integrated into the provider's compensation models, as well.

PAYER PARTNER OPPORTUNITIES

Before moving full scale into a second-generation CIN, leadership must be sure of their ability to compete and win a plurality of value-based contracts with commercial payers and local employers. This is predicated on demonstrably favorable cost, utilization and quality results, as well as payer's appetite for change and ability to implement a risk model – and not all are ready. The CIN may believe in moving ahead, but without partners willing to go along, they may find themselves standing alone. If conditions are favorable, CINs should leverage their demonstrated value to create tiered benefit designs jointly with payers and large employers that incent in-network utilization and steer more attributed lives to the CIN.

CONTRACTING

A single, effective model for successful value-based contracting has not emerged, meaning there's tremendous variation in the terms of contracts nationwide — even within the same CIN. One large health system in the Midwest inventoried their first-generation contracts and found the technical quality varied based upon which negotiator developed each individual contract. This is a mistake that cannot continue in second-generation efforts. Best practice is to standardize the contracting function to a single

team of interdisplinary negotiators based on terms and conditions that experience has shown are attainable, valuable and able to generate financial returns. The negotiating team should include finance, quality and clinical experts. The system mentioned earlier converted all contracts to consistent, second-generation arrangements, and implemented a consistent care management model across the continuum to generate significant financial success.

ASSESS AND REFINE GOVERNANCE MODEL

Governance of the second-generation CIN needs to be centralized to provide effective management, contracting and infrastructure investment plans, while also allowing for local customization and provider flexibility. While it is critical to have a significant primary care presence in governance and leadership, composition should be more inclusive than first-generation models, including the perspectives of specialists, post-acute care clinical leadership and regional/community partners. For larger CINs that cover multi-state regions and diverse patient populations, it is often necessary to allow local provider communities to form customized structures supporting quality initiatives tailored to local needs, as well as their own methods for distributing performance incentives.

MANAGING OUT-OF-NETWORK REFERRALS AND VOLUME

Critical to current and future financial performance is the CIN's ability to attract providers and patients to the network–and keep them engaged. Patients should be incented to leverage in-network services with tiered benefit design, as well as quality outcomes and a consumer-centric focus that measures and rewards patient engagement. This may include more convenient care access points, high-touch services, and use of electronic tools such as e-visits and Skype visits. Physicians also play a role in preventing leakage, and should be incented to encourage patients to remain in-network. Data can play a major role in this effort, proving to referring physicians that clinical quality, utilization and costs are better managed in-network than out -of -network. To ensure ongoing adherence, however, successful CINs should measure unblinded referral leakage utilizing claims data across the continuum, and control outmigration with participation requirements that mandate in-network utilization.

PARTICIPANT EVALUATION CRITERIA

First-generation CINs were heavily focused on optimizing primary care as a core strategy for providing lowest-cost treatment and avoiding expensive condition complications. In more advanced contracts, controlling the overall medical expense across the continuum is vital. As such, specialists need to be involved in implementing value-based care in the network, as well as other settings of care. Prior to moving into second-generation contracts, the CIN must develop an equitable process for evaluating these partners for in-network inclusion, leveraging public data sets such as star ratings, readmission rates, patient satisfaction scores, clinical appropriateness criteria, etc., to ensure only those with demonstrably positive outcomes are selected for inclusion.

BEGIN EXPANSION EFFORTS

With value criteria in place, a high-value network of providers should be created to differentiate the CIN with commercial payers and employers. An important area to include in this effort is post-acute care, where the creation of a preferred referral network can have a significant impact on total Medicare costs (estimated between 5-10 percent of total medical costs). As providers are recruited into the network, they need continued support for performance improvement, including performance metrics, infrastructure, education and clinical resources. Physicians also should be educated to guide patients to in-network resources and/or appropriate settings. For instance, appropriate patients should be steered toward home care, where patient satisfaction is often higher, as opposed to an inpatient skilled nursing facility, where costs can balloon to $12,000 or more a day[8]. As the network grows, CINs should consider forming regional or statewide partnerships with providers in adjacent service areas, and developing a tiered system to identify providers the network is willing to engage with for risk-contracting in order to cover a broader geographical area.

ENHANCE CARE MANAGEMENT

Over time, care management through the CIN needs to be integrated and streamlined. Across the network, leadership is needed to assess existing workflows, technologies and employee competencies, and make necessary adjustments to move away from traditional hospital case management in favor of population health management across the continuum. In many cases, this can be accomplished through advanced

primary care, with care managers assigned to individual physicians leveraging existing models such as the patient-centered medical home (PCMH). Using this structure, the CIN has an established pathway to institute a standardized approach to care delivery (access, integrated behavioral health, team-based care), including transitions of care.

ROADMAP FOR FUTURE GROWTH

CINs contemplating the second-generation of value-based contracts need to be guided by a three-year contracting roadmap. Strategic areas that need to be developed include a contracting strategy that lists target payer partners with whom the CIN can build new value -based arrangements for growth. CINs also need to plan for how operations and governance structures will shift over time to accommodate larger geographic regions, particularly as the network expands to additional providers across the continuum and into adjacent service areas. Lastly, financial models need to be created to demonstrate growing ROI over time. Models should consider infrastructure requirements that may need to be funded through the CIN to ensure competitiveness, staffing and workforce needs, as well as evolving measurement capabilities. CINs should also contemplate new, additional information sources such as genomic sequencing, social determinants of health or patient-reported outcomes.

KLAS names Premier Inc. Best Strategy, Growth and Consolidation Consulting Firm for the second year in a row in its 2018 Best in KLAS: Software and Services report.
As the leader in strategy, growth and consolidation consulting, Premier received high marks for helping healthcare organizations navigate through complex mergers, acquisitions and growth of their enterprises. This work streamlines decision-making, reduces operational redundancies, integrates physicians and independent practices within the health system, enhances integration between providers and payers and improves their ability to leverage growth strategies. Thank you to all of our members who were surveyed by KLAS for ranking us #1 again in customer satisfaction.

Conclusion

While the industry is still at the beginning of true system integration and value-based care and payment incentives, the tipping point for CINs is fast approaching. Organizations that prepare early will be well positioned to take advantage of the changing market environment and the financial opportunity that risk contracts present. Though the path to a high-performing CIN that's ready to take on multiple at-risk contracts is neither simple nor easy, a deliberate, systematic strategy to evolve value-based care capabilities is a critical success factor for sustainability moving forward.

AUTHORS

Tony Malcoun, vice president of population health advisory services, Premier Inc.

Joe Damore, FACHE, vice president of population health management, Premier Inc.

FOR MORE INFORMATION, PLEASE CONTACT:

Tony Malcoun
tony_malcoun@premierinc.com.

REFERENCES

1 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

2 David Muhlestein, Robert Saunders, and Mark McClellan, "Growth Of ACOs And Alternative Payment Models In 2017," Health Affairs, June 28, 2017, https://www.healthaffairs.org/do/10.1377/hblog20170628.060719/full/

3 http://www.modernhealthcare.com/article/20180203/NEWS/180209972

4 CMS, Medicare Shared Savings Program Results file

5 CMS, Medicare Shared Savings Program Results file

6 http://www.orlandosentinel.com/health/os-disney-oh-fh-insurance-20180202-story.html

7 http://www.iha.org/sites/default/files/resources/iha-pbgh_commercial_aco_measurement_benchmarking_initiative_2017.pdf

8 http://www.nejm.org/doi/full/10.1056/NEJMp1315607#t=article