Connected Care Partners
Our Discussion Today

- Introducing the Connected Care Partners CIN
- What is a Clinically Integrated Network (CIN) and why is the time right to join the Connected Care Partners CIN?
- How will the CCP CIN benefit each of us? What is the “give and the get”?  
  - Providers
    - Independent
    - Employed
  - Hospitals
  - Patients
- What does it mean to join? Is there a downside to joining?
- How do I get more information?
The Connected Care Partners CIN is looking for high quality providers to join

**Value Proposition**

- **Improve patient care** through clinical integration between inpatient and outpatient, and between employed and independent providers
- **Joint contracting:** the CIN structure enables employed and independent providers to join with the hospitals to contract as a group with insurers
  - Value-based contracts will reward providers for quality and high value care
- **Population health management** is possible with the large regional provider network of a CIN
  - Centralized analytic, IT, and quality improvement infrastructure
  - Support for MACRA and other value-based contracts
WHAT IS CIN
What do you see?
By shifting perspective you might see an old woman or a young woman.
WHAT IS THE ROLE & IMPORTANCE OF CLINICAL INTEGRATION IN TODAY’S HEALTHCARE ENVIRONMENT?
The US spends more on health care per-capita and as a percentage of GDP than any other country.

Health Care Spending 1980–2012

Average spend on health per capita ($US PPP)

- United States: $8,454
- Australia: $3,175

Total expenditures on health as percent of GDP

- United States: 16.5%
- Australia: 8.5%

Note: $US PPP = purchasing power parity in USD
However, life expectancy of Americans is lower than of other countries which spend less per person.

Despite outstanding breakthroughs in extending life in patients with serious illnesses, our performance is poor when compared with other wealthy countries.
Hospital Care and Physician and Clinical Services account for the largest proportion of National Health Care Expenditure.

National Health Care Expenditure, 2015

Source: National Health Expenditure Accounts (NHRA), CMS
HHS goals:

- 30% of FFS Medicare payments to be based on quality or value* by the end of 2016
  - Already achieved!
- 50% by end of 2018
  *alternative payment models such as ACOs or bundled payment arrangements*

Source: HHS Press Release, January 26, 2015
“UnitedHealth's $43 Billion Exit From Fee-For Service Medicine....earning 1-6% savings from VB contracts” (Forbes: Jan. 2015)

Advantages:
- Greater provider risk
- Prospective attribution
- Tiering / narrow network
- Referral to low cost providers
- Benefit design

Dan Schumacher - CFO
Patient Protection and Affordable Care Act - 2010

Reforming an Entire Industry Sector (17.5% GDP)

PPACA

Insurance Reform

• Expansion of coverage
• Insurance mandates
• Insurance exchanges
• Pre-existing conditions
• Medical loss ratio regs
• “Cadillac tax”

Delivery System Reform

• Payment Reform

Drives

• Org Reform

• P4P
• Bundled payments
• Shared savings

• CINs
• ACOs
• PCMH

Clinically Integrated Network
Hospitals and providers must prepare and brace for a wave of market and financial blows.

- CMS Quality Penalties
- Provider Realignment
- High Deductible Plans
- CMS VB / Bundled Payments
- CMS Payment Reductions
- Medical Home Volume Impact
- Price and Quality Transparency
- Commercial “Narrow Networks”
- Insurance Exchanges
- “Hospital-at-Home”

Clinically Integrated Network
MACRA Legislation is a “game changer” for ALL providers

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Signed into law April 16, 2015
  - Final MACRA rule, expected by November 1, 2016
- Repeals SGR, locks provider reimbursement rates at near-zero growth
  - 2016-2019: 0.5% annual increase
  - 2020-2025: 0% annual increase
  - 2026+: 0.25% annual increase or 0.75% increase depending on payment track

- New approach to paying clinicians for value and quality
- The MACRA “Quality Payment Program” Includes two paths:
  - The Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APM)
Little time for strategic planning: MACRA measurement starts 2017, with financial impact in 2019

- Medicare expects most clinicians to be in the MIPS program, initially
- CMS only expects 4.5-12% of clinicians to qualify for the APM track in 2019
- Law requires MIPS to be budget neutral
- Important dates:
  - **First measurement year starts January, 2017**
  - Payments based on year 1 performance starting in 2019
Providers in qualified APMs can earn guaranteed bonus pay while providers in MIPS have greater upside and downside.

- Medicare FFS
- MIPS Bonus
- MIPS Penalty
- APM

2015-2024:
- 0.5% annually
- 2026 and beyond:
  - 0.25% annual increase for MIPS track;
  - 0.75% increase for APM track.

Clinically Integrated Network
MIPS heavily weights quality performance, and law mandates public reporting.

Results of the Quality Payment Program will be placed on a website.

- 50% Quality
- 25% Cost
- 15% Clinical Practice Improvement
- 10% Advancing care Information (IT)

Names of clinicians in Advanced APMs
As feasible, the names and performance of Advanced APMs
MIPS scores for clinicians, including aggregate and individual scores for each performance category.

Clinically Integrated Network
Providers are Evaluating Strategies for Alignment

The Accountable Care Organization is one way in which providers are aligning.

Disparate provider units competing as the Health System or as individual providers can align as an Accountable Care Organization.
There is a high degree of overlap between CIN and ACO organizational structure.

**CIN**
- Typically created to bring together otherwise independent providers for the purposes of working on the triple aim.
- Can enter into P4P or risk contracts directly with insurers.

**ACO**
- Typically created to participate in MSSP or Pioneer ACO program.
- Providers can be part of a CIN or can all be employed within a health system.

**Common Attributes**
- Value-based contracting
- IT infrastructure to support population health
- Care management
- Focus on the continuum of care

**A CIN is not:**
- A Third Party Administrator (TPA)
- An Independent Physician Association (IPA)
- A Preferred Provider Organization (PPO)
- A Physician-Hospital Organization (PHO)
- A Health Plan or Benefits Plan
We’re shifting one business model to another, but this evolution will take time; for now, we are “living in the middle”

**FEE FOR SERVICE**
- Volume driven
- Maximize unit price / volume
- Little reward for quality
- No incentives for coordination of care
- Regulatory disincentives to collaboration

**FULL POPULATION HEALTH**
- Return to “managed” care
- Reward lower cost / higher quality
- Incentives to reduce utilization
- Coordination of care
- Lines blurred between payers and providers
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**Living in the Middle**

- We need a plan that works for both FFS and population health!

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A challenging cultural and financial shift will need to take place to go from filling the hospital to emptying the hospital.
What is the structure of the CIN, and how does it work?
Segments of the provider community are not aligned

A CIN structure can bring all providers together across the continuum of care.
An organizational structure created to integrate providers

- CIN **on same level** with hospitals and the employed medical group
- A provider-led and provider-majority Board
- Physician executive leader and dedicated operations team
What are the benefits of a CIN?
When we speak with the community, we are armed with a compelling CIN value proposition

- Clinical integration allows providers to:
  - (a) work together to improve the quality of care they provide to patients, and demonstrate that quality to current and future patients;
  - (b) enter into value-based contracts that require centralized quality improvement infrastructure and a large network of providers;
  - (c) enhance revenue through P4P and risk contracts where better management of chronic patients is rewarded
  - (d) join a network that will build the necessary analytic and IT infrastructure to be successful under MACRA and other value-based initiatives

- Clinical integration gives hospitals the ability to
  - (a) provide higher quality of care to patients in the community they serve
  - (b) align with providers in the development of clinical pathways, standardized order sets, and other performance improvement initiatives
  - (c) develop a better, more collaborative relationship with providers
  - (d) improve performance on hospital pay-for-performance measures such as readmission rates;
  - (e) position themselves at an advantage in the market based on quality.
When we speak with the community, we are armed with a compelling CIN value proposition.

- Clinical integration provides patients with:
  - (a) more coordinated and effective care management and outreach from a trusted source, their provider;
  - (b) higher quality care;
  - (c) better value for their health care dollar;
  - (d) greater stability in their relationship with their doctor and hospital, and less likelihood that they will need to choose new health care providers every year.

- Clinical integration gives employers:
  - (a) the ability to more effectively manage the health care costs of employees and their dependents through the purchase of better, more efficient health care services;
  - (b) increased employee productivity and reduced absenteeism, through the better management of chronic disease;
  - (c) lower health care costs over the long term, through the reduction of variation in provider practice patterns;
Oh, crap! Was that TODAY?
QUESTIONS?
What are the objectives of the CIN for 2016?

- Enter into a contract with Acclaim for the 13,000 employees and dependents of NMHS as the CIN’s first contract
- At the direction of the CIN committees, develop the infrastructure and capabilities to embark on quality improvement initiatives
- Through the CIN IT and Analytics Committee, select an EMR to be the preferred EMR for the CIN
- Through the CIN Primary Care Collaborative, build infrastructure to help practices develop PCMH capabilities
How do I join the CIN, and what are the requirements?
Benefits of membership in the Connected Care Partners CIN

A summary

• Work collaboratively with a large network of providers to improve patient care
• Opportunity to participate in the governance of a provider-led organization whose mission is to achieve the “quadruple aim”
  – improving the patient experience, improving the health of populations, reducing the per capita cost of healthcare, improving provider satisfaction
• Participation in CIN committees
  – IT and Analytics, Quality Improvement, Contracting, Credentials, etc
• Access to quality improvement infrastructure and expertise that can help your practice enhance performance on clinical quality metrics
  – Support for collecting and reporting of MACRA metrics
  – Guidance from the CIN primary care collaborative focused on PCMH capabilities
• Tier 1 status for (13,000) Acclaim patients starting in 2017
• Inclusion in future value-based contracts negotiated by the CIN
Payer Strategy & Contracting Committee

**Purpose:** Oversee the CIN’s contracting arrangements with payers and providers. Design Performance Incentive Plan in collaboration with Performance Improvement and Quality Committee.

- The Payer Strategy and Contracting Committee shall perform the following functions at a minimum:
  - develop and recommend payer strategy for approval by the Board of Directors;
  - develop general contracting policy guidelines and principles;
  - oversee the Company’s payer contracting and recommend contracts to Board of Directors for approval;
  - review actuarial/cost analysis;
  - recommend division of bundled funds;
  - oversee the Company’s provider contracting; and,
  - review and recommend clinical performance incentive plan (“Performance Incentive Plan”) awards in collaboration with the Performance Improvement and Quality Committee.
**Purpose:** Oversee the CIN’s gathering and analysis of performance data and practices to (1) set goals and take action, (2) identify high risk or complex patients, (3) measure and analyze the results of performance measurement activities. Design Performance Incentive Plan in collaboration with Payer Strategy and Contracting Committee.

- Will oversee an annual review of the quality of care provided by the CIN and recommend new goals to improve clinical performance and patient experience.
- The Committee shall perform the following functions at a minimum:
  - recommend clinical performance initiatives (metrics and goals) for approval by Board of Directors;
  - develop patient care protocols;
  - develop clinical performance measurement definitions and methodology;
  - prioritize and recommend performance improvement initiatives and allocation of resources to effect improvements in quality objectives;
  - monitor clinical performance reporting;
  - develop and recommend clinical performance incentive plan (“Performance Incentive Plan”) in collaboration with the Payer Strategy and Contracting Committee; and,
  - review and recommend care management systems.
**Purpose:** Develop and recommend policies, processes and procedures that (1) promote professionalism of the CIN related to patient care, collaboration, and relationships with non-CIN entities, (2) promote strategic growth and recruiting of the CIN in accordance with FTC guidelines, (3) allow the CIN to credential and onboard new participants.

- The Committee shall perform the following functions at a minimum:
  - recommend credentialing criteria and methodology for approval by Board of Directors;
  - review and recommend approval of each provider’s credentials;
  - review and recommend medical professionalism standards; and,
  - conduct provider disciplinary process and recommend disciplinary action.
Purpose: Organized to create an engaged forum for PC Providers to work together to design and deliver patient-centered ambulatory care in a manner that will increase quality, improve efficiency, and ensure timely access to primary care services.

- The Committee shall perform the following functions at a minimum:
  - Initially assist with primary care provider recruitment;
  - Chronic Disease Management: assess the variability of practice for chronically ill and assess provider, group, and system performance as compared to best practice.
  - Transitions of Care Management: assess gaps in ambulatory care delivery systems as patients are transitioned from one ambulatory care setting to another. Includes the communication between primary and specialty care;
  - Ensure optimal performance within payer contracts and VB performance models
  - Design and deliver programs to improve performance.
Purpose: Establish a shared vision and strategy to guide multi-year efforts to develop medical informatics and analytic capabilities within the NMHS CIN

- The Committee shall perform the following functions at a minimum:
  - Develop an understanding of the advantages and disadvantages of available electronic health records and health information exchange technologies to support ambulatory care within the CIN, and establish consensus on short term (1-3 year) deployment strategy
  - Achieve basic capabilities to support population health management, including the capability to share and integrate data across the major participants in the CIN as needed
  - Build a core team of human resources with expertise in medical informatics and population care analytics focused on serving the CIN