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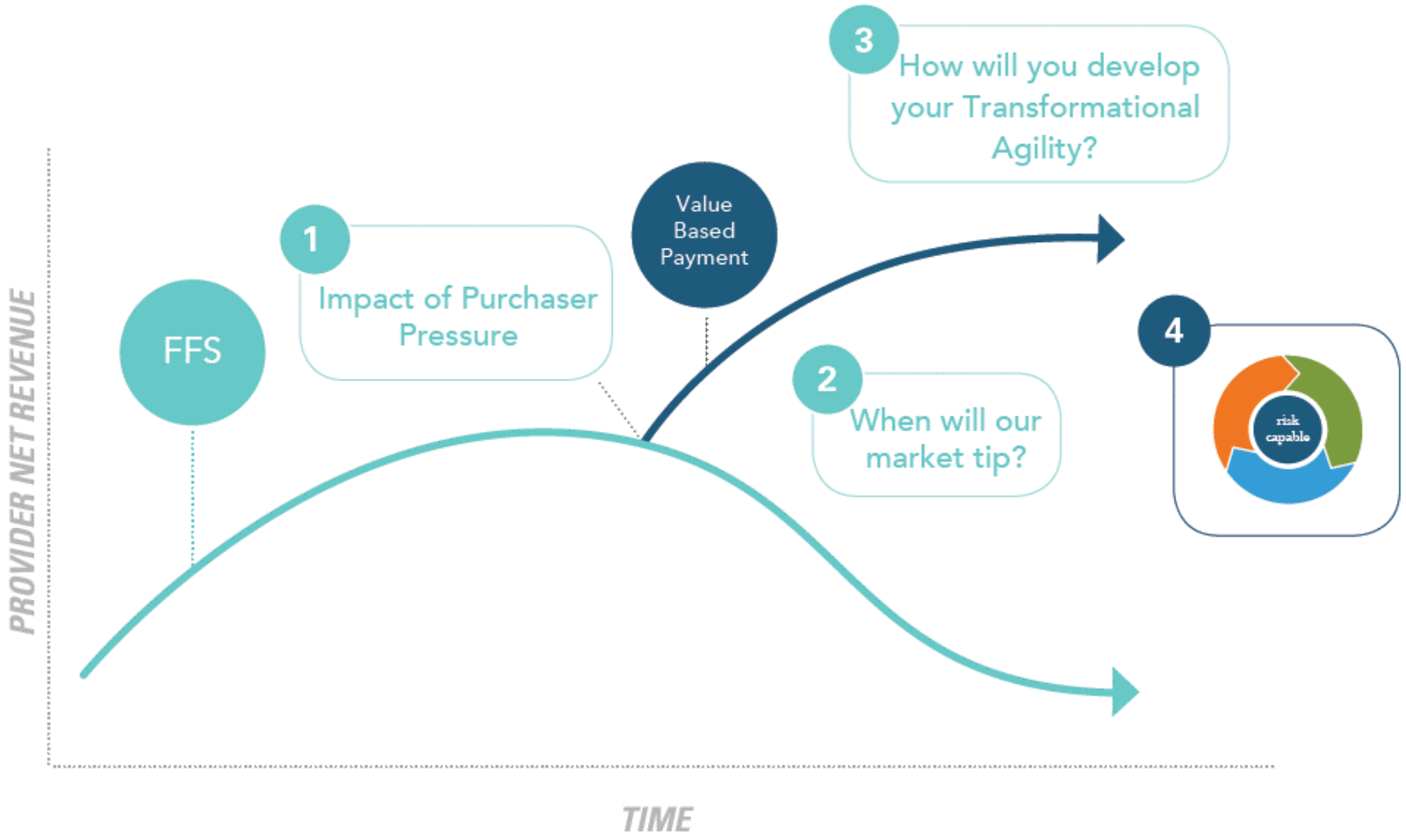
Clinical Integration

Kevin Locke, Principal, DHG Healthcare
Michael Strilesky, Principal, DHG Healthcare

Agenda

- Accelerators for CIN Development
- Overview of CINs
- Financial Considerations for Networks
- Value and Risk-Based Contracts
- Legal Considerations
- Q&A

The Tipping Point: Volume to Value



Accelerators: CMS

"HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs…."

– **HHS Press Release, January 26, 2015**

"Entities furnishing DHS face the predicament of trying to achieve clinical and financial integration with other health care providers, including physicians, while simultaneously having to satisfy the requirements of an exception to the physician self-referral law's prohibitions if they wish to compensate physicians to help them."

- CMS, Physician Fee Schedule Proposed Rule, July 2015

Accelerators: Provider and Payer Economics

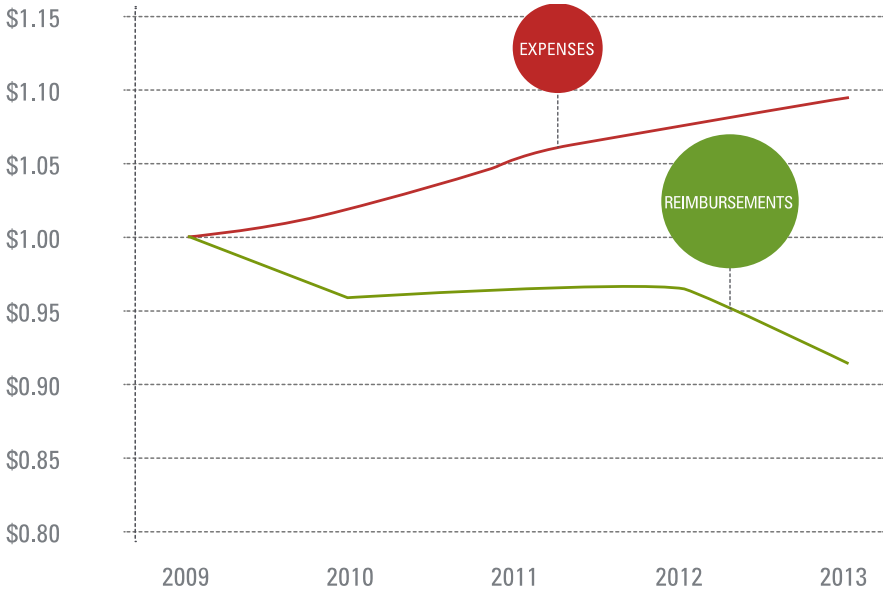
Provider Expenses vs. Reimbursement

- In 2009, what would have cost a provider $1.00 cost them $1.09 in 2013.
- In 2009, services a provider would have been paid $1.00 for, were only reimbursed $0.91 in 2013.

State Budget Constraints

- On average, 26% of a State's budget is allocated to Medicaid
- Increased prevalence of state budget shortfalls has spiked interest in improving Medicaid delivery

EXPENSES VS. REIMBURSEMENTS



NOTABLE STATE-LEVEL REFORM

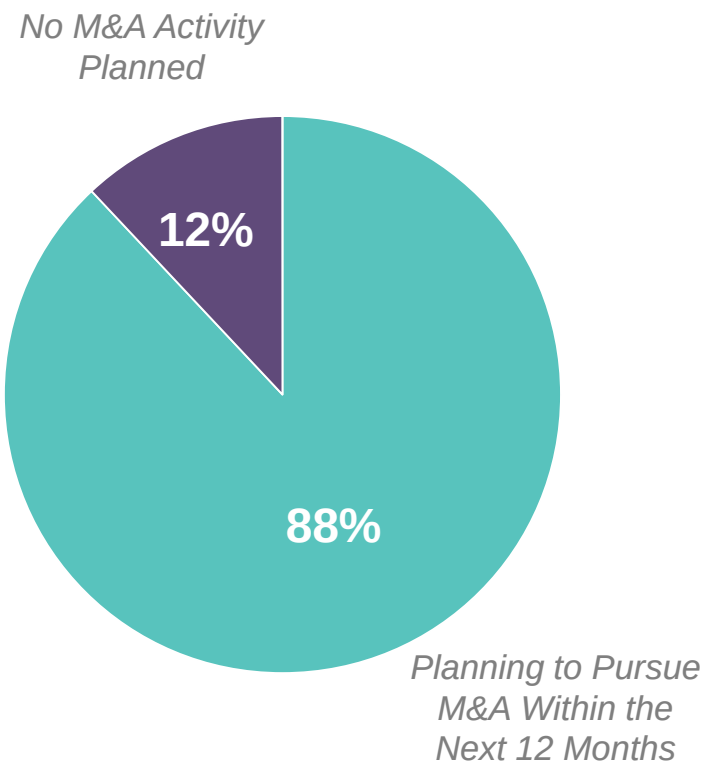
State	Reform Model	Scope
TN	Episodic Bundles, (PCMH coming soon)	Commercial & Medicaid
AR	Mandatory PCMH	Medicaid
AL	RCOs	Medicaid
OR	CCOs	Medicaid
IL	Alliance for Health Innovation Plan	All Payers

Source: Consumer Price Index & CMS Reimbursements Data

Accelerator: Consolidation

Consolidation

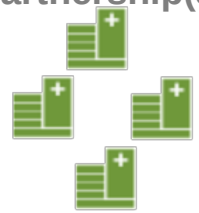
- When 189 hospital leaders were asked, 88% stated they had plans to pursue M&A within the next 12 months



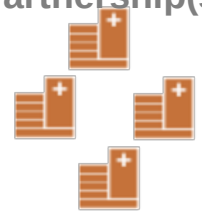
Reasons for Consolidation

- Providers seeking Partners for both proactive and reactive reasons

Proactive Partnership(s)



Reactive Partnership(s)



Proactive Drivers

- Mission, Vision, Values, Culture
- Market Opportunity
- Access to Capital
- Quality, Outcomes, Care Gaps
- Cost Structure
- Payer / Reform Preparedness
- Access to Care / Community Need
- Perception / Brand

Reactive Drivers

- Exclusion from Payer / Employer Network
- Changes in Referral Patterns
- Unsustainable Financial Model
- Changes in Competitive Landscape
- Impact of Healthcare Reform
- Changes in Technology

Source: Consumer Price Index & CMS Reimbursements Data

Accelerators: Payment and Volume Risk

Shifting Risk to Providers & Consumers

Increasing Consumer Choice / Power

- Clear plan comparison on exchange platforms
- Easy for individuals to switch plans annually
- Variable individual premium contribution, high deductibles
- New and increased choices for provider access

RETAIL CLINICS

- minute clinic — *900+ Locations*
- Walgreens healthcare clinic — *400+ Locations*
- The Little Clinic — *125+ Locations*

Estimated to be nearly 3,000 retail clinics in the US by the end of 2015

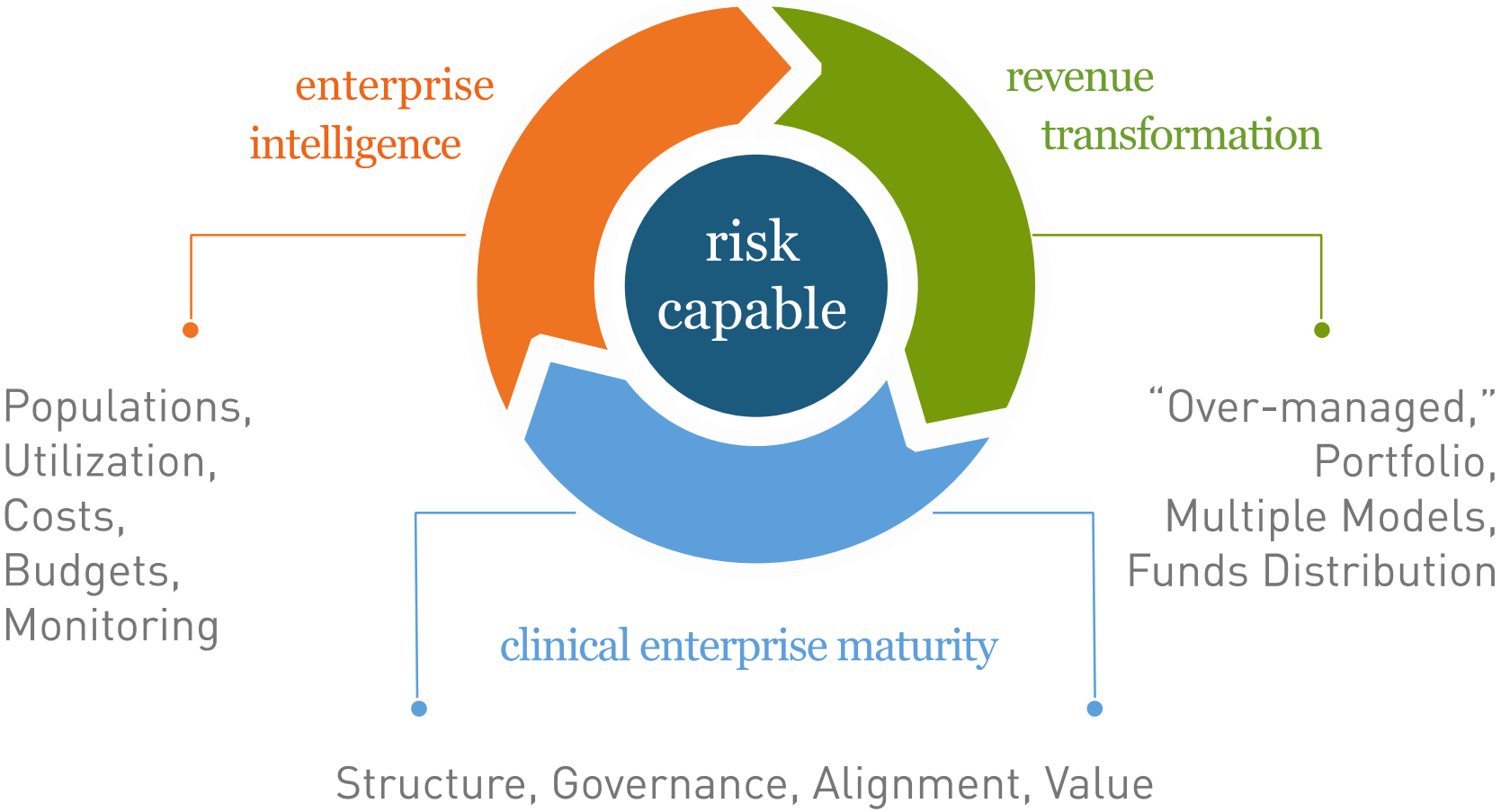
Source: Consumer Price Index & CMS Reimbursement Data

Accelerator: The Tipping Point is Here

The movement towards value has already started for physicians and hospitals

Patient-centered care	→	***PCMH***
Evidence-based care	→	***P4P***
Effective use of health IT	→	***MU***
Patient satisfaction	→	***HCAHPS / CG-CAHPS***
Care coordination	→	***PMPM***
Bundled payments	→	***BPCI/CCJR***
Total cost of care	→	***MSSP***

Provider Response: Risk Capability



Provider Response: Clinical Integration

A **Clinically Integrated Network (CIN)** is a **selective** partnership of physicians collaborating with hospital(s) and other providers to **deliver evidence-based care**, **improve quality** and **efficiency**, manage populations and **demonstrate value** to the market. Once these objectives are met, the network may contract on behalf of participants

CIN GOALS

IMPROVE QUALITY
- Consistent Performance Metrics
- Evidence-based Protocols
- Defined Provider Expectations

ENHANCE ACCESS
- Emphasis on Prevention
- Use of Telehealth and Virtual Tools
- Expanded Provider Availability

CREATE EFFICIENCIES
- Utilization Review
- Right Time, Right Place
- Decrease Spend per Beneficiary
- Care Coordination

CIN OUTCOMES

DELIVER VALUE
- Improve Performance
- Pursue Contracts that Reward Value

**“The future is already here –
it’s just not evenly distributed”**

William Gibson

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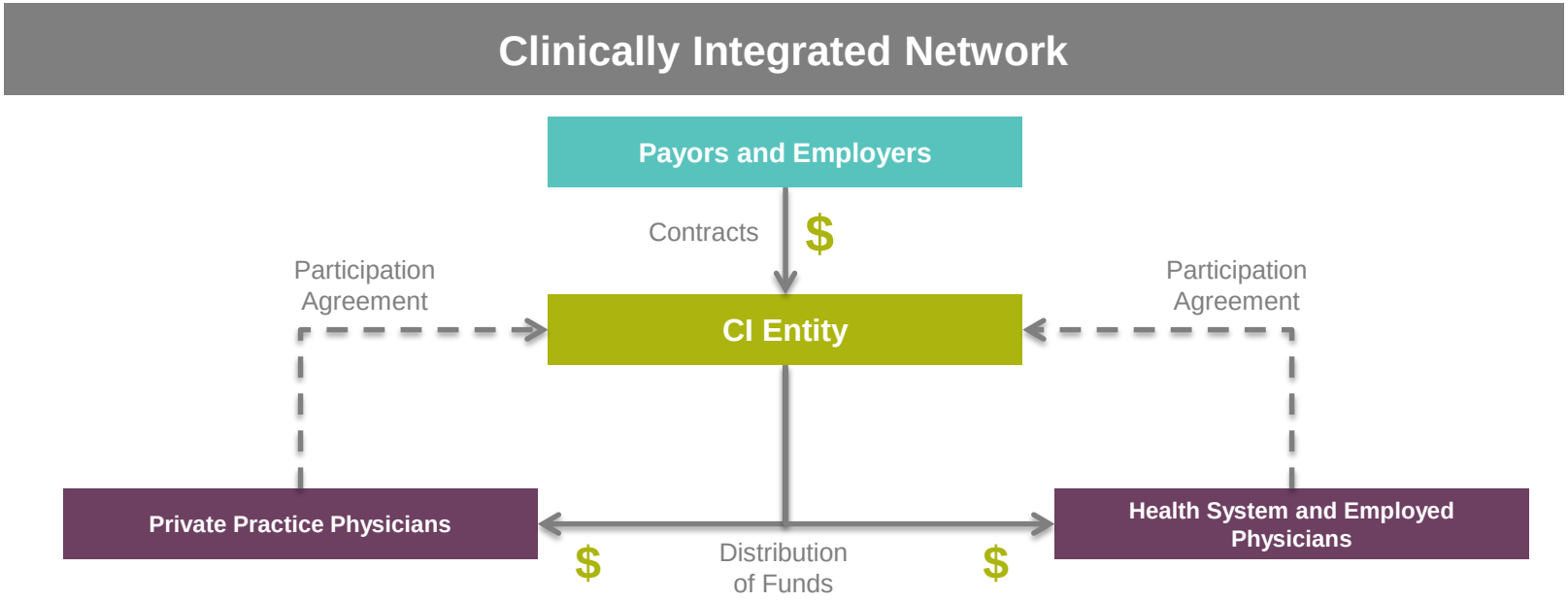
Clinically Integrated Networks (CINs)

CIN: Definition

A **Clinically Integrated Network (CIN)** is a selective partnership of physicians collaborating with hospitals to **deliver** evidence-based care, improve quality, efficiency, and coordination of care, and **demonstrate** value to the market.



WHAT IT'S NOT

- **Physician employment**
- **Hospital-led initiative**
- **Mechanism to gain negotiating leverage over payors**

CIN: Advantages

HOSPITALS & HEALTH SYSTEMS

- Care coordination “inside” network
- Alignment with independent and employed PCPs and specialists
- Demonstrate quality to earn enhanced reimbursement, sustain rates

PHYSICIANS

- Defining what “Quality” is
- Increased input and decision making
- Share in performance based incentives
- Maintain independent practice

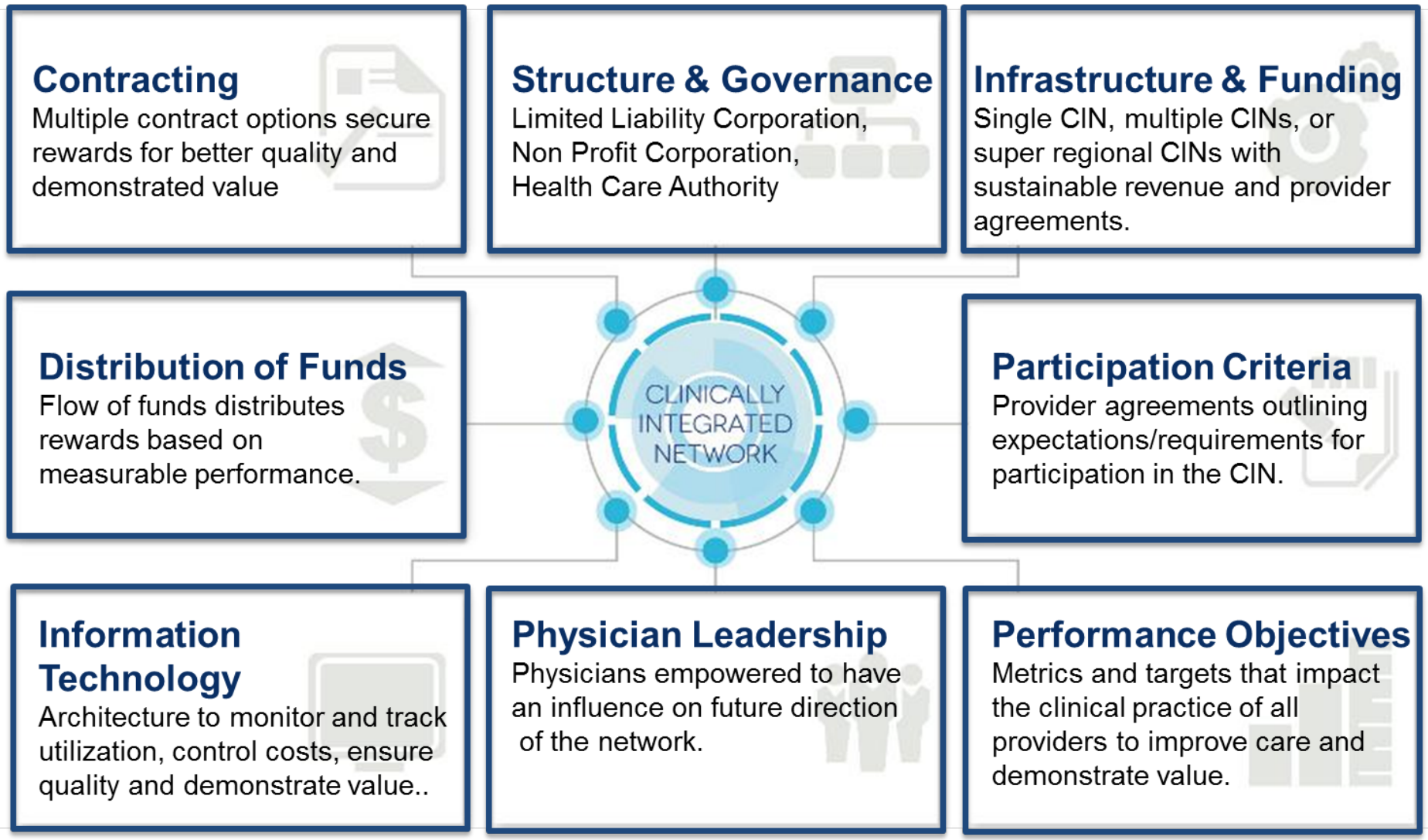
PAYORS & EMPLOYERS

- Reduced cost and enhanced value
- Better management of high-cost chronic patients
- Shift of risk to providers

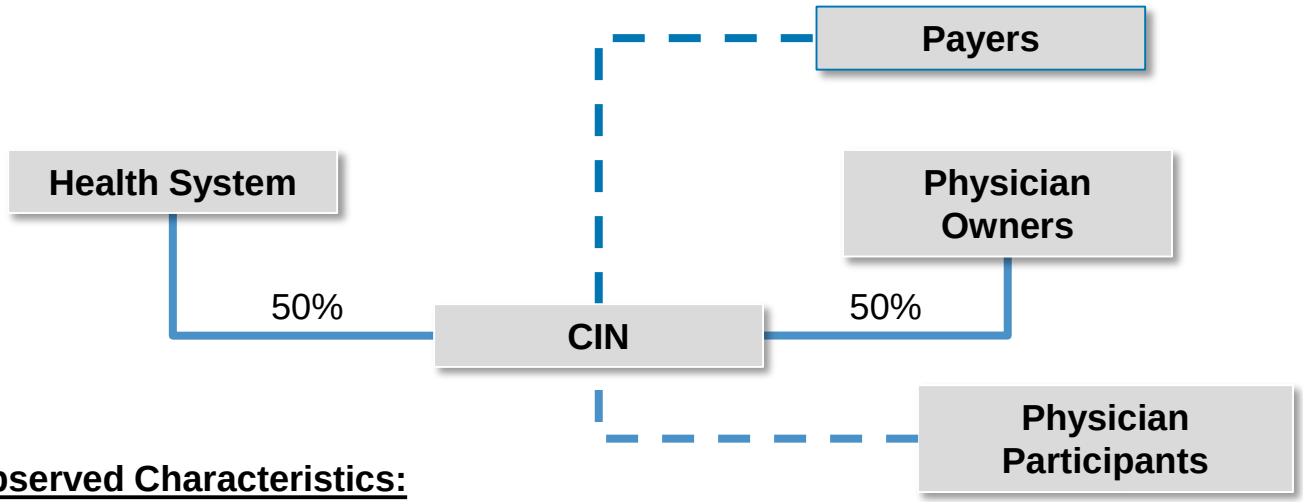
PATIENTS & COMMUNITIES

- Improved coordination and efficiency of care
- More information and control of care
- Higher satisfaction
- Lower cost and higher value

CIN: Key Components



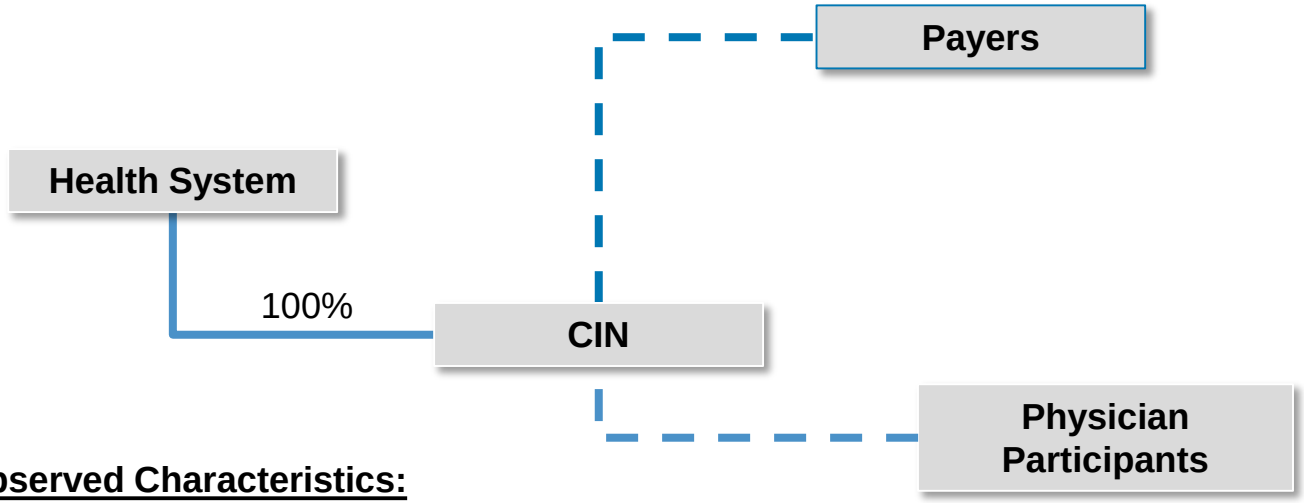
Infrastructure: Joint-Venture LLC Model



Observed Characteristics:

- Physicians can elect Board Members
- Participation Fees will be different for Owners than for Participants
- All physicians will sign the same Membership Agreement
- Active participation is required to achieve performance goals
- Profit distribution to owners only, based on company's profits
- Performance rewards will be available to Owners and Participants based on performance

Infrastructure: Subsidiary LLC Model



Observed Characteristics:

- Physicians can nominate Board Members, that are approved by Health System
- Participation Fees are typically the same for all Physician Participants, assuming all physicians sign the same Participation Agreement
- Active participation is required to achieve performance goals
- Distribution pool developed at the discretion of Health System, factoring in overhead costs for the network
- Networks can create rewards to physicians

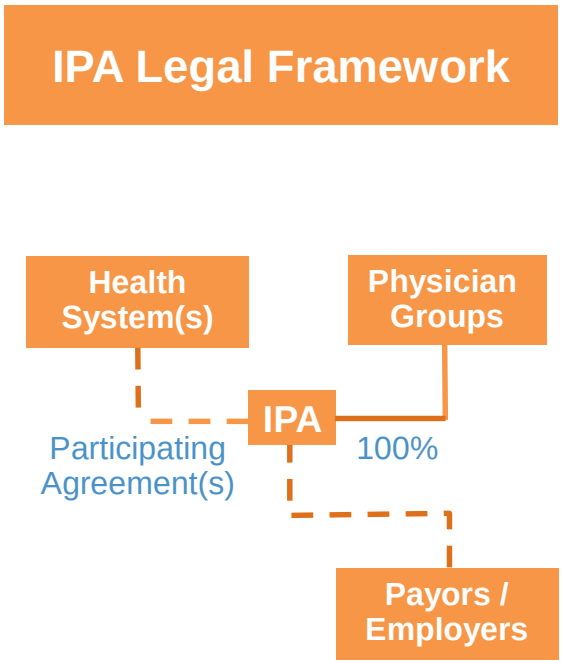
Infrastructure: Expectations

Regardless of the infrastructure / model, all networks work to ensure the following:

1. **Health System maintains "Reserved Powers" that include…**
   Budget, Capital, Dissolutions or Mergers, Not-for-Profit Status
2. **Critical issues have support of the Physicians**
   Ex. No contract should be approved unless the physicians agree it's a good idea
3. **Committees and Management support the activities of the Network**
   Management (along with Executive Committee) will be accountable for day-to-day operations
4. **Physicians are meeting Participation Criteria and Performance Objectives of the Network**
   Failure to meet network requirements, and associated penalties are the same in either model

Physician Owned Networks

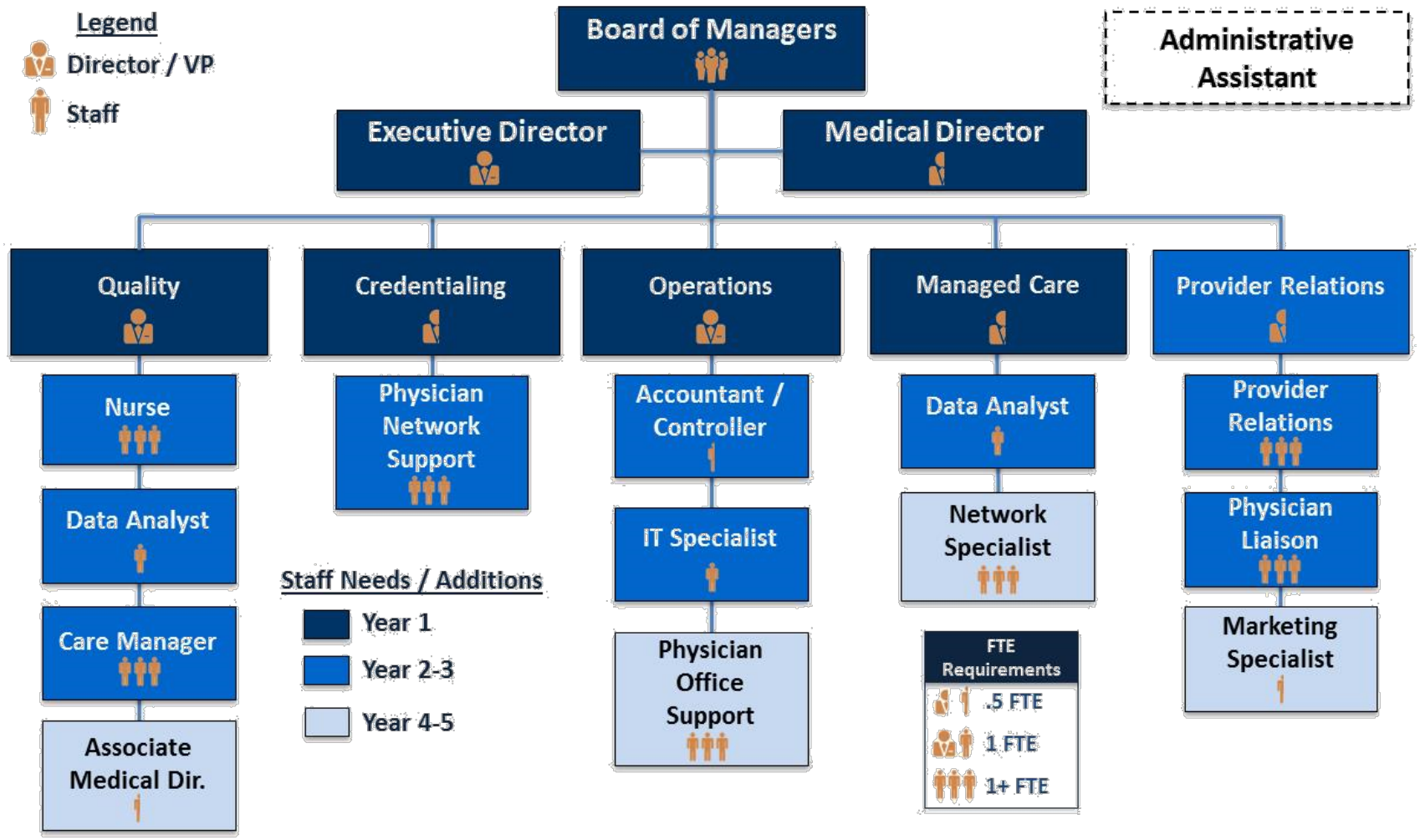
Overview: A CIN comprised entirely of physicians would be structured using the framework of an Independent Practice Association (IPA). Physician groups would **capitalize a subsidiary LLC or the existing IPA** to fund CIN infrastructure.



Network Characteristics:

1. Similar Operating Agreement and Governance Model as CINs
2. Participation Fees are typically the same for all Physician Participants
3. Distribution pool developed at the discretion of IPA, factoring in overhead costs for the network
4. Focus of network could be PCP or multi-specialty depending on contracting strategy
5. Typical objectives is to "commoditize" hospitals in the market and extract bonus payments from payers

Infrastructure: Organizational Structure



Infrastructure: Care Management

The Clinical Care Focus

- **Implementation through a suite of services/products that will assist organizations in moving from a fee for service focus to a population health management focus**
- **Six Areas of Focus Built Around the Triple Aim:**

Focus on Population Stratification and Management

Focus on Evidence Based Guidelines

Focus on Care Management Strategies

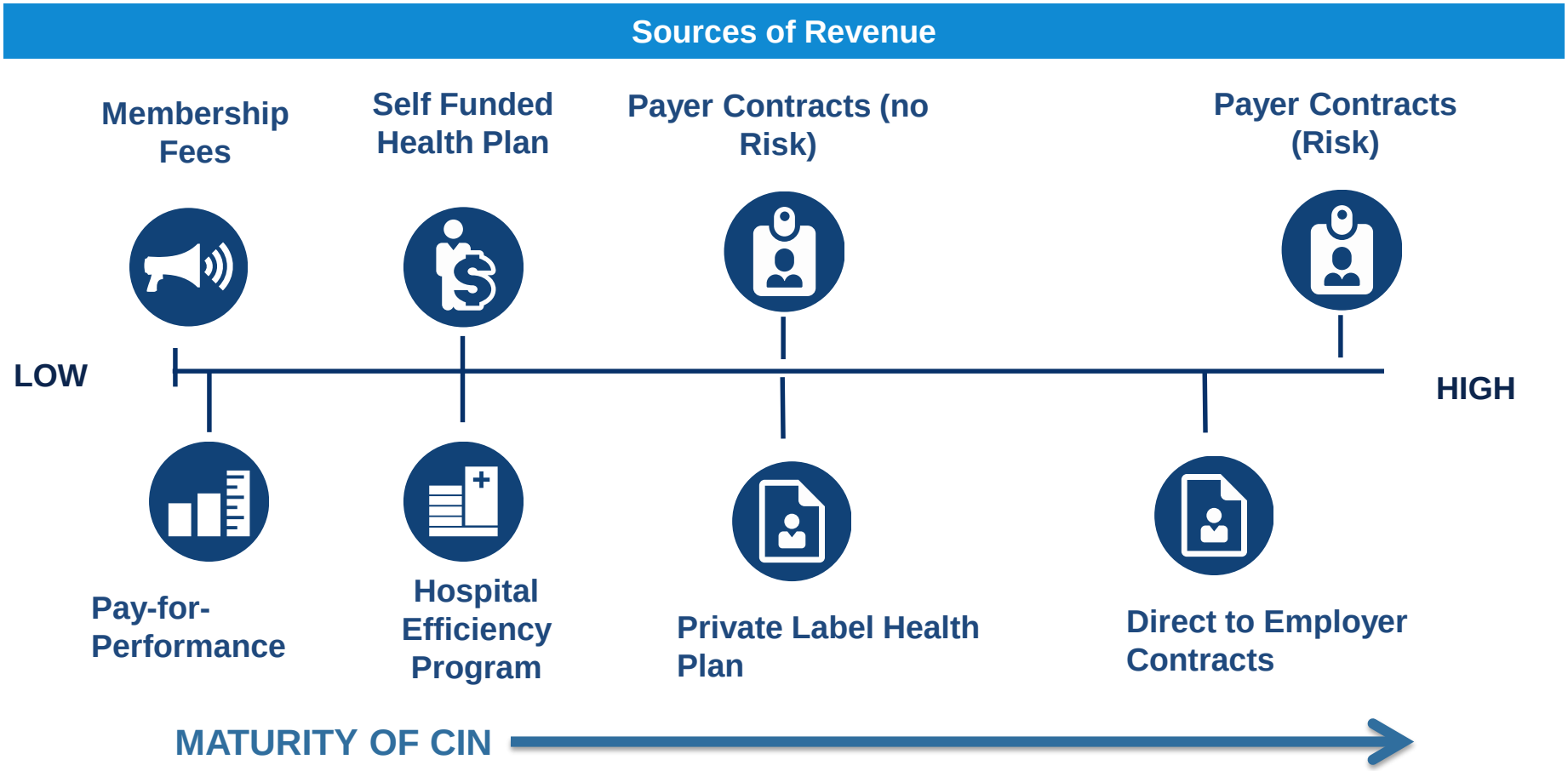
Focus on Data Management and Outcomes Measurements

Focus on Access to Care and Patient Engagement

Focus on Continuum and Alignment of Care

Funding: Aligned with Start-Up and Contracting

The CIN is a separate business entity with a distinct identity, mission, and vision, dedicated leadership and staff, sustainable sources of revenue to offset operations.



Participation Criteria for Physicians

Participating Physicians (Independent & Employed)

Physician Leadership	Information Technology	Quality Improvement	Contracting
▪ Board and committees ▪ Participate in educational programs ▪ Provide leadership and oversight over network initiatives	▪ Implement the preferred network IT platform ▪ Share clinical information and claims data	▪ Follow guidelines and protocols ▪ Achieve network defined measures and performance ▪ Agree to corrective action plans and process improvement initiatives	▪ Participate in jointly negotiated contracts

Performance Objectives

Metrics and targets designed to meaningfully impact the clinical practice of all network physicians, and to align their conduct with hospital initiatives, so as to improve quality and demonstrate value across the entire continuum of care.

Examples of Performance Improvement		
Element	**Description**	**Examples**
Variance & Cost Reduction	Minimize variable physician performance not related to patient characteristics	• Minimize orthopedics supply chain cost • Staffing and productivity opportunities
Unnecessary Care Reduction	Reduce avoidable, unproductive and duplicative services	• Prostate cancer screenings for elderly patients • Reduce Readmissions
Clinical Restructuring	Ensure treatment in most optimal setting with most appropriate level of provider	• Early step down from an IP to SNF bed • Partnerships with a local retail clinic to offer non-urgent care
System Optimization	Shift focus to upstream, preventative care with emphasis on CI and population health	• Disease-based medical homes • Patient engagement strategies using telehealth

Source: Sg2 Analysis

Physician Leadership

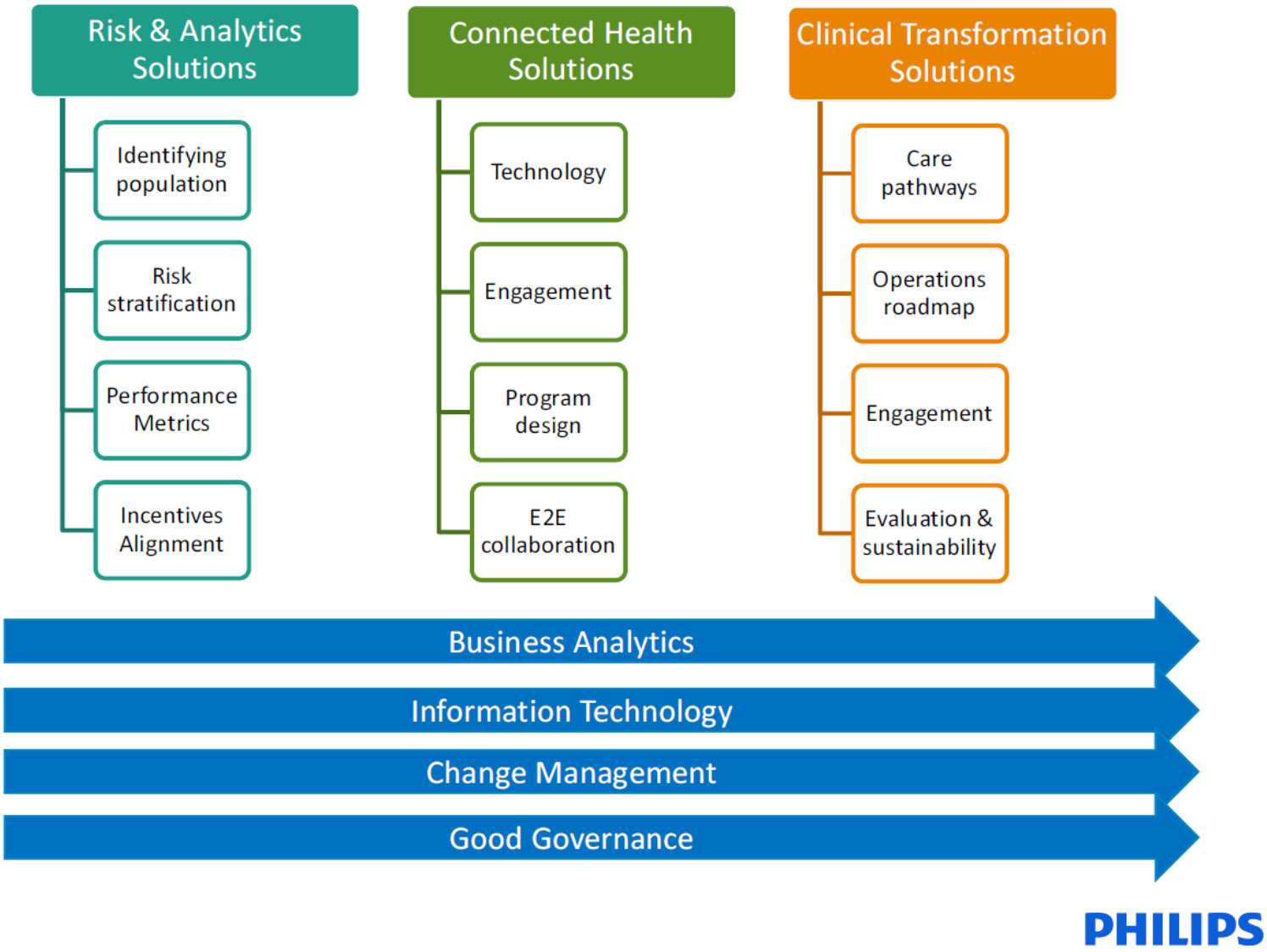
Board Composition
Physician Chair

Managing Board
Physician, Hospital, Community Representation

Committees
Chaired by Physicians

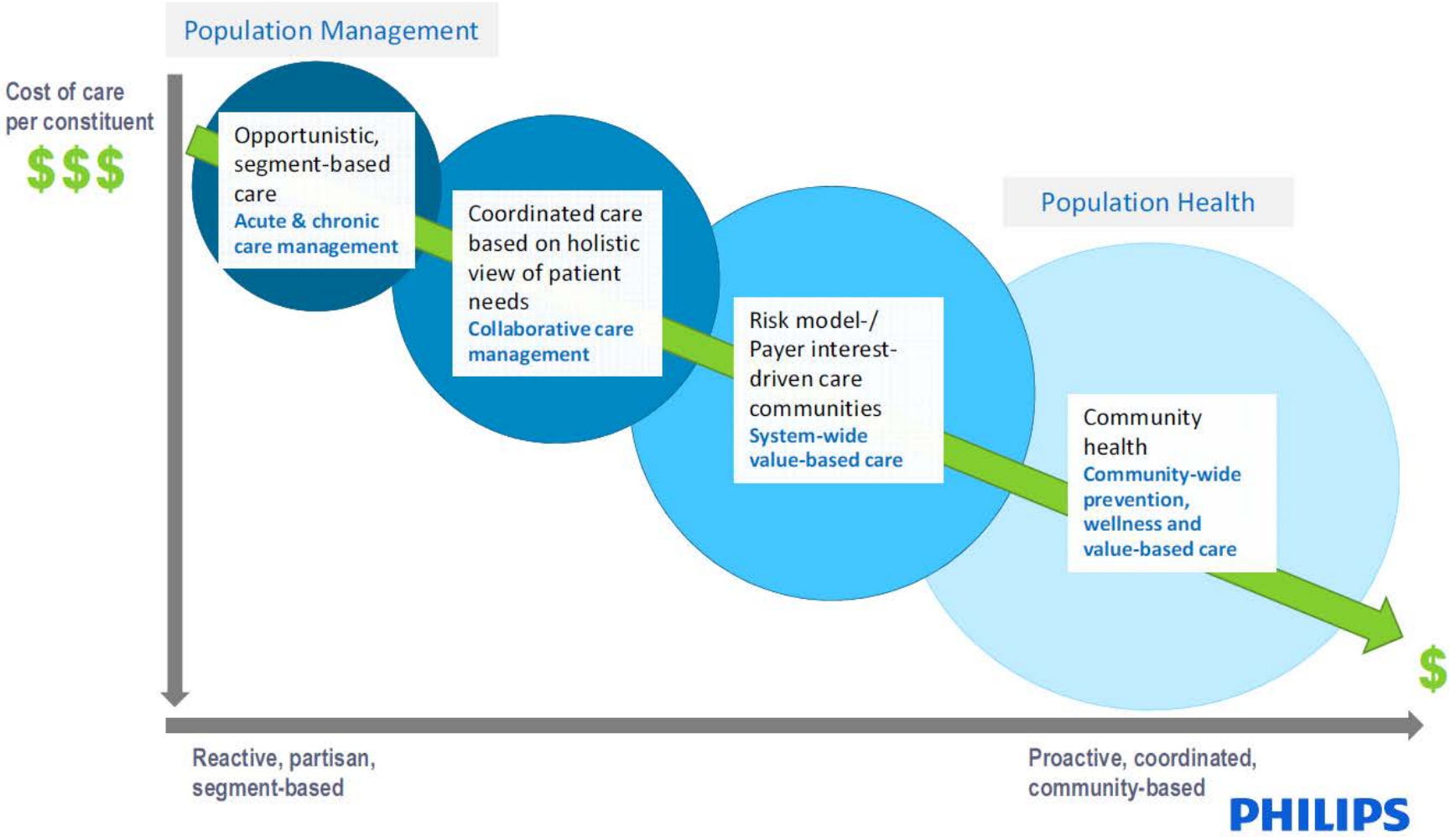
- **Charters outline roles of each physician-led committee**
- **Communication & Education designed to engage medical staff**
- **Membership & Operations will hold physicians accountable for performance below thresholds**

IT Connectivity for Population Health



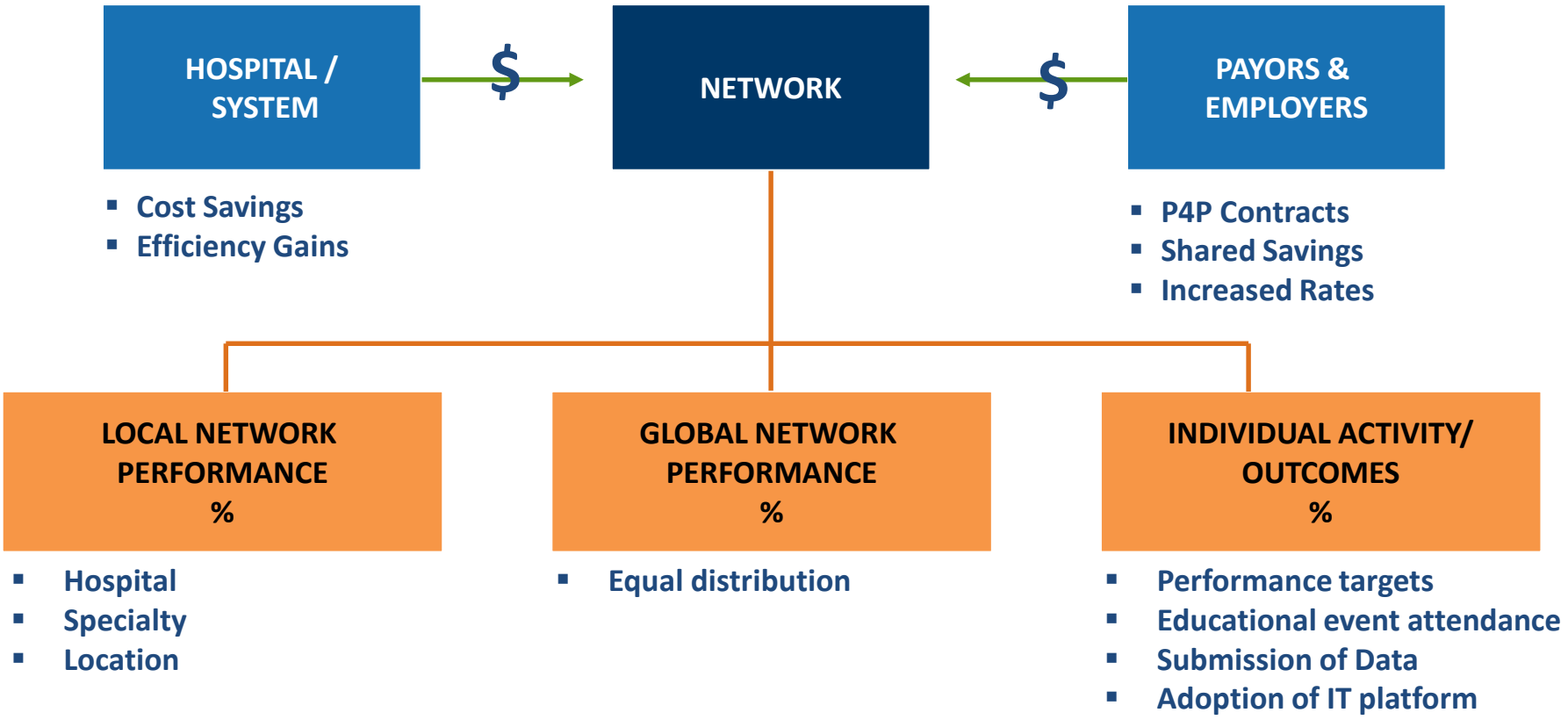
PHILIPS

Developing the Population Health Model



Distribution Framework

Overview: The CIN establishes an organized plan to link performance on defined gradients to eligibility for incentive payments.



Physician Performance Measurement Options

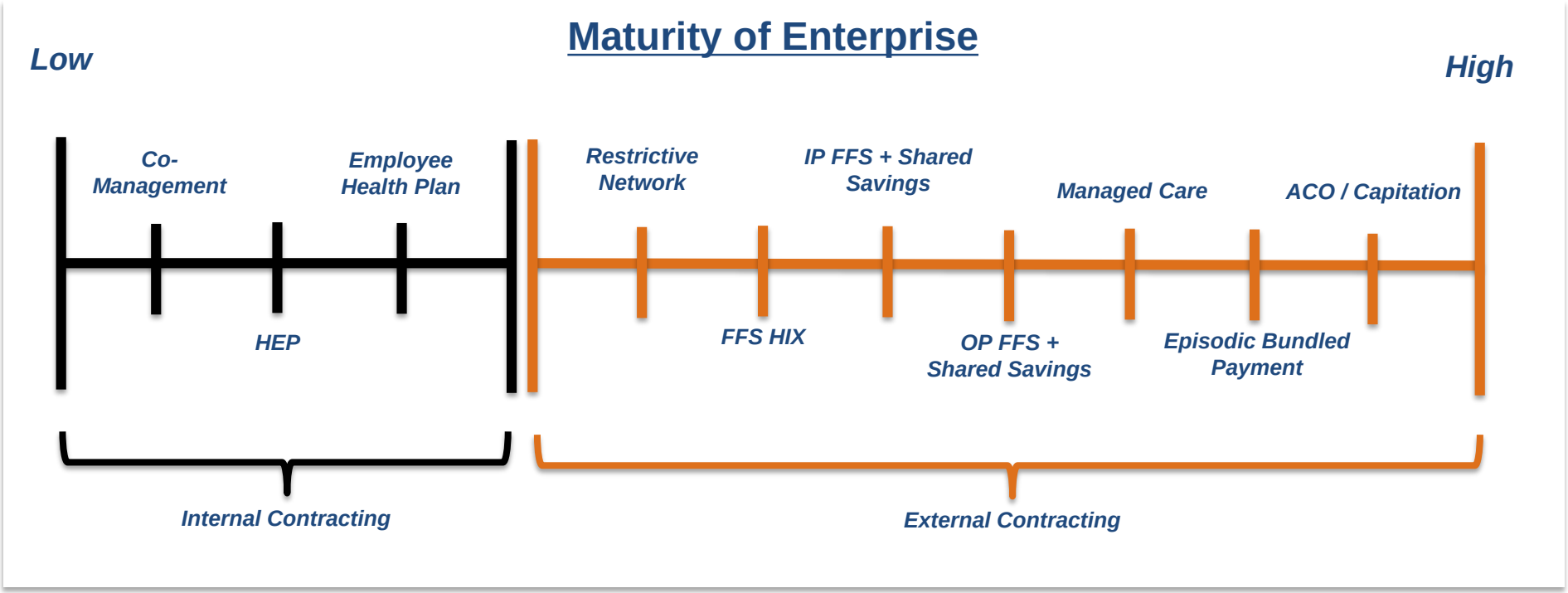
Options	Definition
Service Line Performance	Based on group performance categorized either by hospital and/or system.
Global Performance	All members compliant with CIN standards receive an equal distribution
Individual Performance	Based on each physician's performance across the selected participation criteria
Performance Thresholds	Payout to CIN can be based on the achievement of targets selected across each metric
Hourly Requirements	Based on time spent working on CIN initiatives

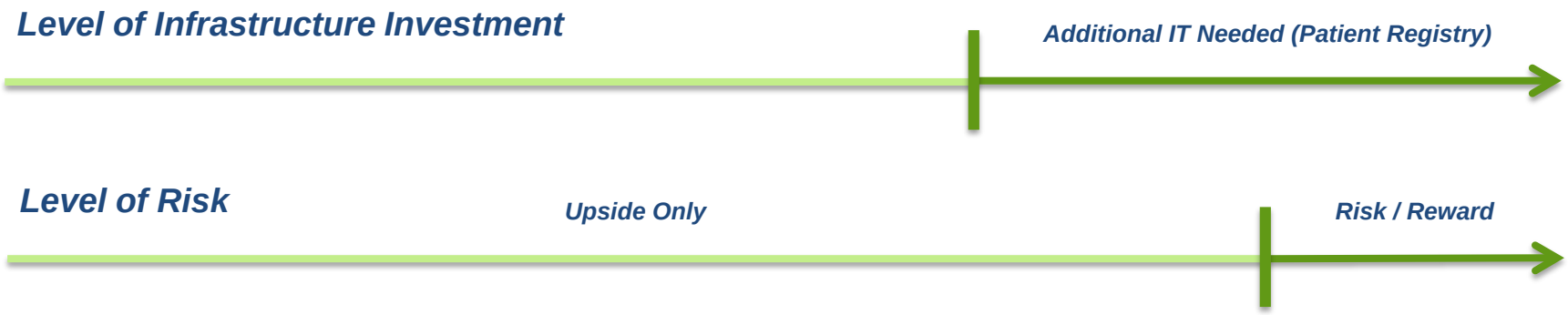
Fair Market Value

Fair Market Value (FMV) firms evaluate the commercial reasonableness of compensation that is transferred between providers. Typical circumstances to receive a FMV Opinion include the validation of:

1. Compensation between Hospital and CIN
2. Downstream compensation formula between Hospital-owned CIN and individual physicians
3. Performance targets, benchmarks and processes that do not include funds from third party payers

Contracting Continuum of Options





Network Contracting Comparisons

MESSENGER MODEL

Back and forward counter offers passed from payer to network (the "messenger") for individual provider to consider OR standing offer power of attorney

CLINICALLY INTEGRATED NETWORK

Jointly Negotiated Contracts based on:

- Interdependence and Cooperation
- IT/Data Sharing
- Quality
- Cost Effectiveness
- Care Coordination
- Population Health
- Remedial Actions

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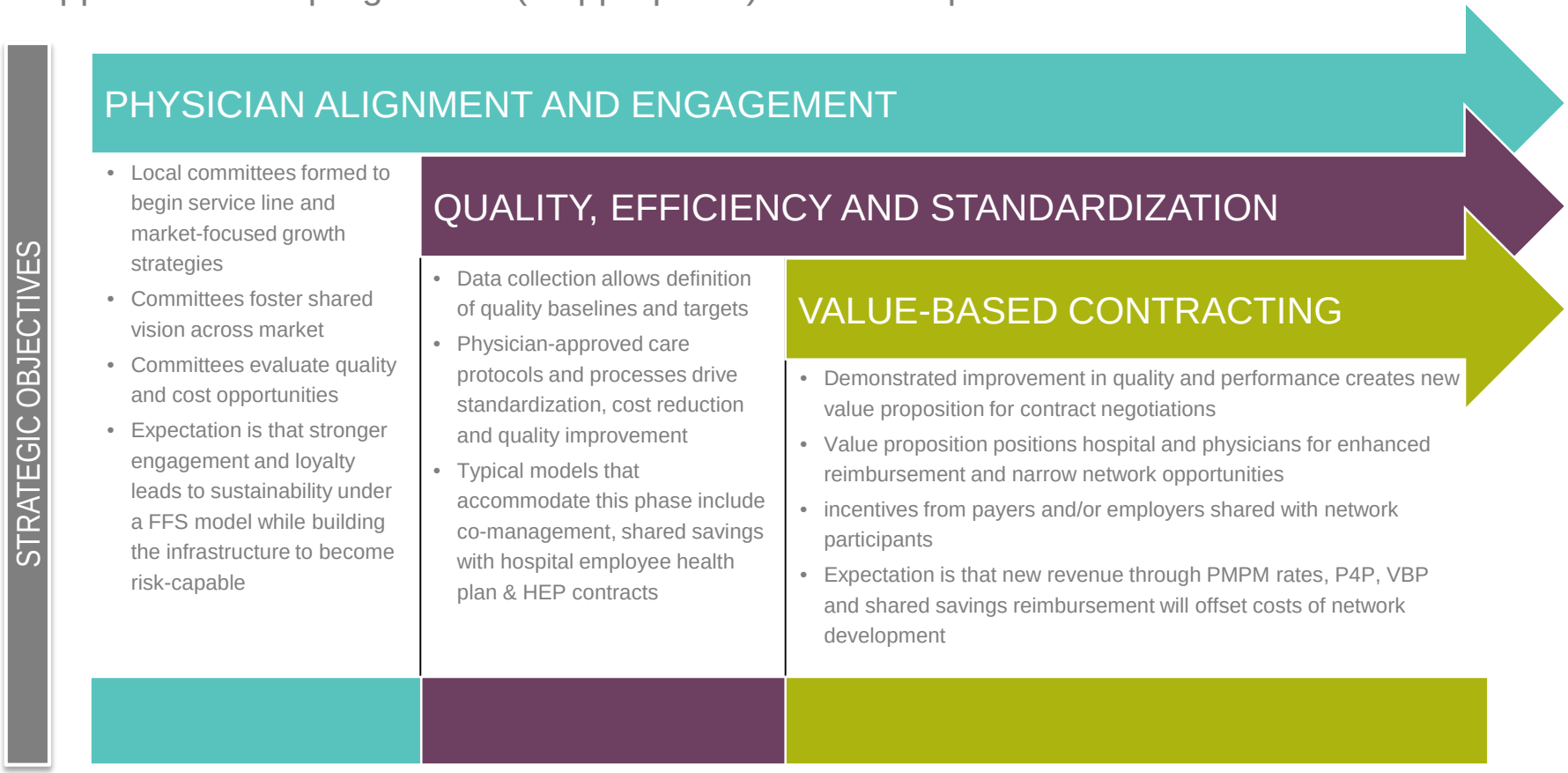
The Phases of Network Maturation

- Network maturation should follow a systematic process paced to market opportunities, allowing the hospital and its physicians to prepare for the future while remaining focused on short-term initiatives
- While the phases of maturity are sequential, unique local dynamics will dictate how a market approaches the progression (if appropriate) from each phase to another



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Financial Considerations for Networks

Financial Considerations for Networks

- Complexities in creating reliable forecasts and capital plans
- Federal and state uncertainties – “stroke of the pen” risk
- Operationalizing risk capability across multiple domains
- Articulating and demonstrating ROI on major current investments
- Compliance requirements across multiple providers
- Alignment around measurable participation criteria: quality, certifications, clinical protocols, payment incentives
- Accelerating transformation across the industry landscape
- Identifying and deploying the “right” tools to monitor progress and changes
- Continuous evaluation: measuring, reporting and adjusting

“Big Rock” CIN Decisions

- How BIG (in terms of network participants) should we be?
- What is our contracting strategy this market?
- How much can we afford to invest on a go forward basis?
- Do we have the leaders (physician and administrative) to lead this network?
- What is our approach to integrate clinical and financial information?

Network Metrics for Management Professionals

Metric	Measurement
Participants	# of Physicians / Providers / Facilities
Covered Lives	“Belly Buttons”
Access	Drive Time to PCPs
Quality Metrics - Acute	Hospital Compare Metrics
Quality Metrics – Ambulatory	HEDIS, PQRS
Value-Based Agreements	# of Contracts
Employer Relationships	# of Contracts / Wellness Clients
Revenue at Risk	% of Total Revenue tied to VBP

Assumptions for Developing a CIN Proforma

Revenue Assumptions

CIN's *typically* earn revenue from the following sources:

- Shared Savings payments from contracts, if successful
- Care Management fees from contracts
- Membership Dues from participating physicians / hospitals

Based on the CIN's objectives, the network will pursue contracts that target defined populations in the region:

Target	Lives	Year
Hospital Employee Health Plan	3,500	2016
Medicare Advantage Plans	8,000	2016
MEWA with local businesses	6,000	2017
School System	17,000	2017
Large Employer	20,000	2018

MEWA = Multiple Employer Welfare Arrangements

5 Year Proforma – *Sample of Revenue*

	Rounded (000)				
	2015	**2016**	**2017**	**2018**	**2019**
Revenue					
Dues	$ -	$ 80,000	$ 150,000	$ 200,000	$ 300,000
Care Management Fees	126,000	215,000	525,000	959,000	852,000
Shared Savings	-	-	366,000	1,517,000	2,404,000
	126,000	**295,000**	**1,041,000**	**2,676,000**	**3,556,000**

Revenue Considerations:

1. ***ALL*** contracts agree to use CIN (and pay a PMPM fee) for care management services
2. Physicians and other network participants who join CIN will need to pay ***Annual Dues***
3. ***Shared Savings payments*** are based on lowering healthcare costs and/or improved outcomes for the managed lives

5 Year Proforma – *Sample of Expenses*

Expense Considerations:

1. ***Salaries*** include CMO, Executive Director and Analyst to supplement existing leadership teams
2. ***Care Management and G&A expenses*** are based on existing resources, with growth in care managers as new contracts are signed
3. ***IT costs*** allocated to CIN based on proportion of covered lives to ACO
4. ***Outside services*** include CI accreditation, legal and FMV support

Rounded (000)

	2015	2016	2017	2018	2019
Revenue					
Dues	$ -	$ 80,000	$ 150,000	$ 200,000	$ 300,000
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Expenses					
Salaries and Benefits	788,000	812,000	1,068,000	1,422,000	1,465,000
General & Administrative	200,000	206,000	212,000	219,000	225,000
Care Management	126,000	204,000	473,000	815,000	682,000
Information Technology	64,000	122,000	235,000	464,000	387,000
Outside Services	120,000	124,000	127,000	131,000	135,000
	1,298,000	**1,468,000**	**2,115,000**	**3,051,000**	**2,894,000**

5 Year Proforma – *Sample*

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	1,298,000	**1,468,000**	**2,115,000**	**3,051,000**	**2,894,000**
Net Income	**$ (1,172,000)**	**$ (1,173,000)**	**$ (1,074,000)**	**$ (375,000)**	**$ 662,000**

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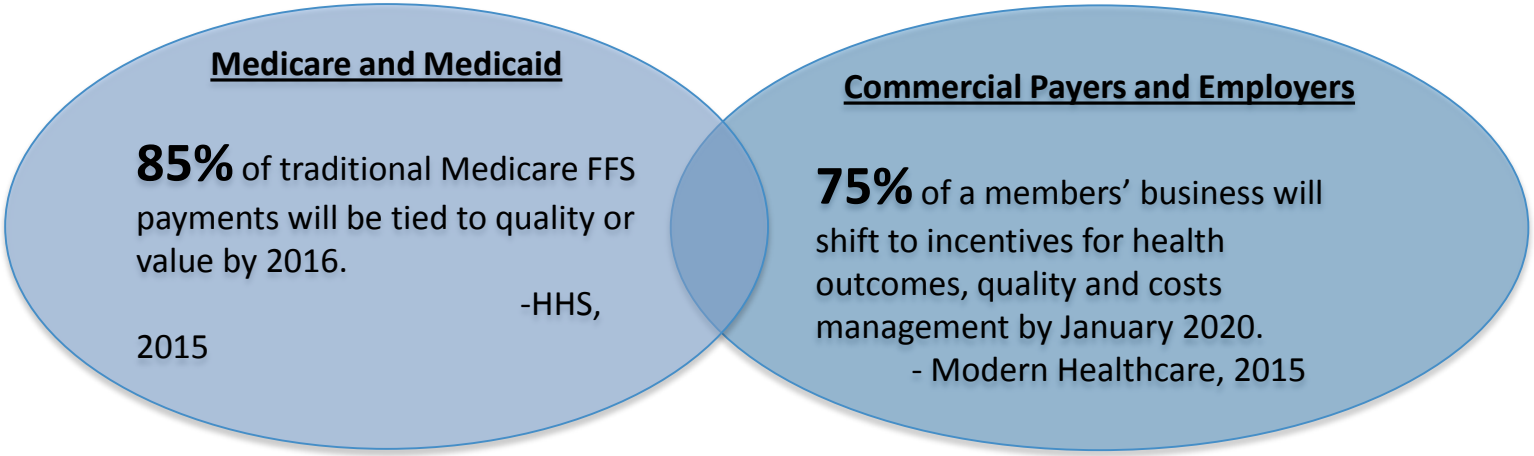
Value-Based and Risk-Based Contracting

Value-based Contracting Options

Definition: A provider agreement with a payer or employer with the following characteristics:

1. A clear set of goals and indicators
2. Organized efforts to collect data on the progress of the selected indicators
3. Rewards or penalties based on performance



In reference to The Healthcare Transformation Task Force which includes Ascension, Aetna, Caesars Entertainment Corp. and Pacific Business Group.

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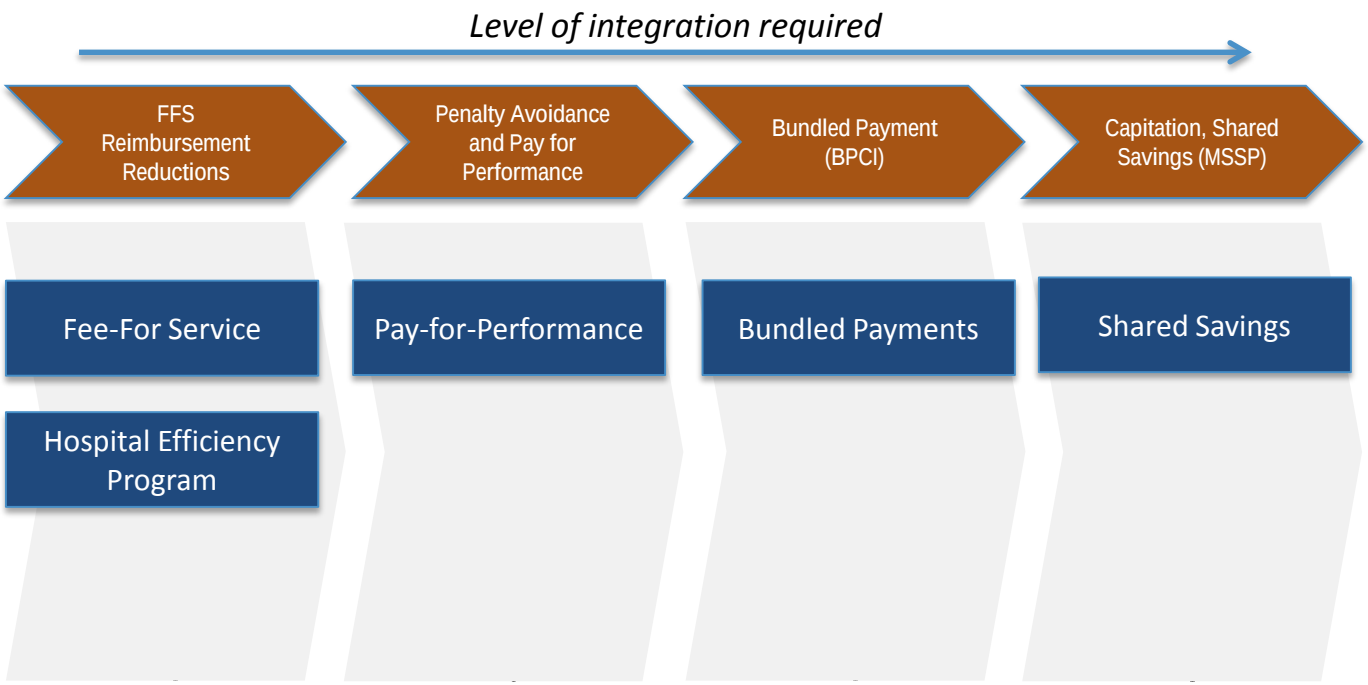
Value-based Contracting Alternatives



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Pay-for-performance based contracts

Pay-for-performance (or per-member-per-month PMPM) contracts are typically defined by a select number of evidence-based guidelines that have direct payments for compliance. They typically involve process-based metrics, which identify gaps in care for defined populations.

Performance Management

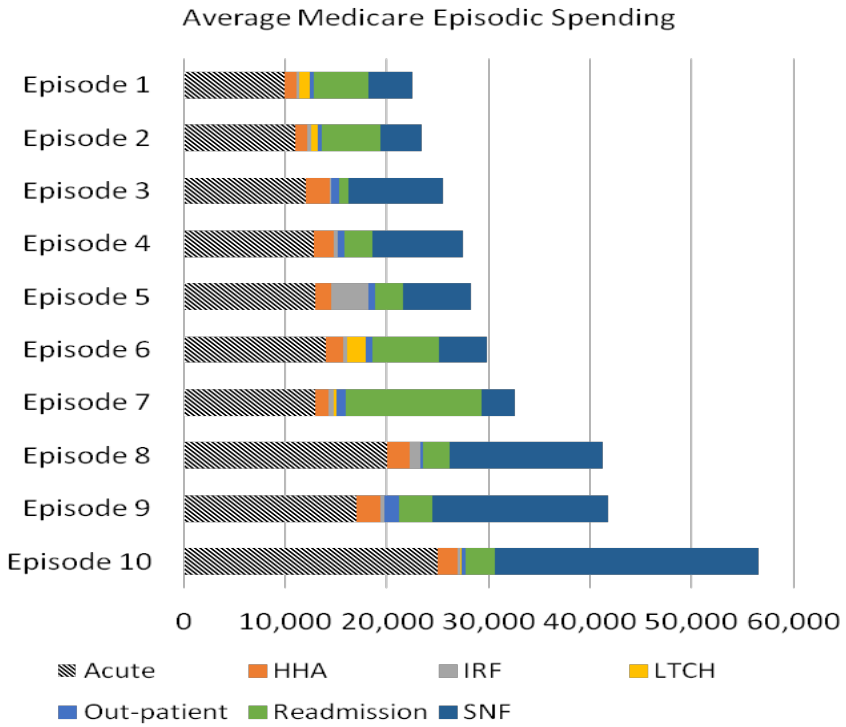
Category	Description	Target	Payment
Body Mass Index	***Defined population:*** Assigned members between 18-74 years of age who had an OP visit ***Criteria:*** Organization must calculate and document patients height, weight and BMI in the patient's chart and submit a claim with the specific diagnosis code indicating such services were provided	> 61%	$3.00 PMPM
Breast Cancer Screening	***Defined population:*** Assigned female members from 40-69 years of age ***Criteria:*** Organization must ensure that each eligible woman has had a mammogram during the measurement year or the prior year to screen for breast cancer	> 70%	$2.50 PMPM

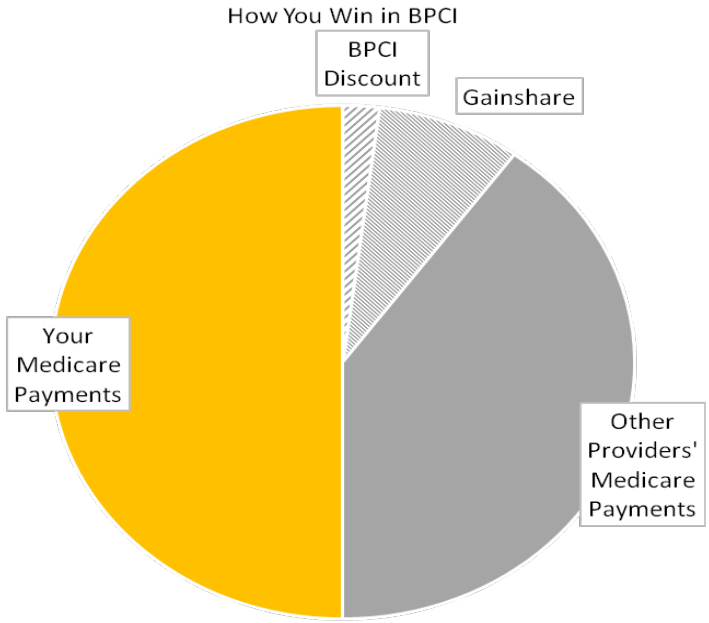
How You Win:

- Utilize an integrated legal entity as the vehicle for change
- Define the patient population that your organization is managing
- Identify the high-risk patients that represent performance metrics
- Agree to receive clear, simple and accurate dashboards with third-party on a regular basis
- Align incentives with all providers involved in the care for the defined patient population

Bundled Payments – Medicare

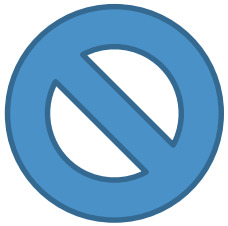
Medicare Bundled Payments, formally called **Bundled Payments for Care Improvement (BPCI)** has been gaining popularity since inception in 2011; currently more than 6,000 organizations are participating or evaluating participation today. BPCI makes a single provider responsible for Medicare expenditures for an episode of care, including expenditures by any Medicare providers.





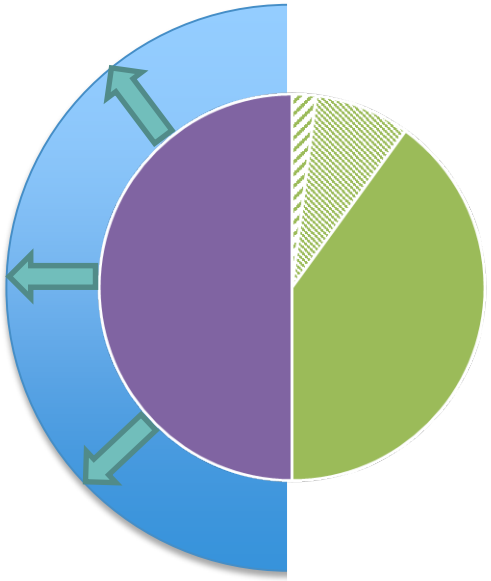
Bundled Payments – Commercial

Commercial bundled payments share principles in common with Medicare bundled payments, including taking episodic risk beyond a providers' direct sphere of responsibility, financial incentives/disincentives, and quality measurements.



The best episode of care from a commercial insurers' perspective is **an episode that never happens**. It is avoided by identification, treatment, and management.

How You Win in Commercial Bundles



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Shared Savings

Shared savings contracts are regularly scheduled FFS payments in addition to opportunities for bonus payments based on the achievement of quality targets and decreased expenditures.

Performance Management

☑ **Quality and Efficiency Metrics**

Metrics	Baseline	Target
30-Day Readmission Rate	%	%
HEDIS Measures	%	%

☑ **Cost Metrics**

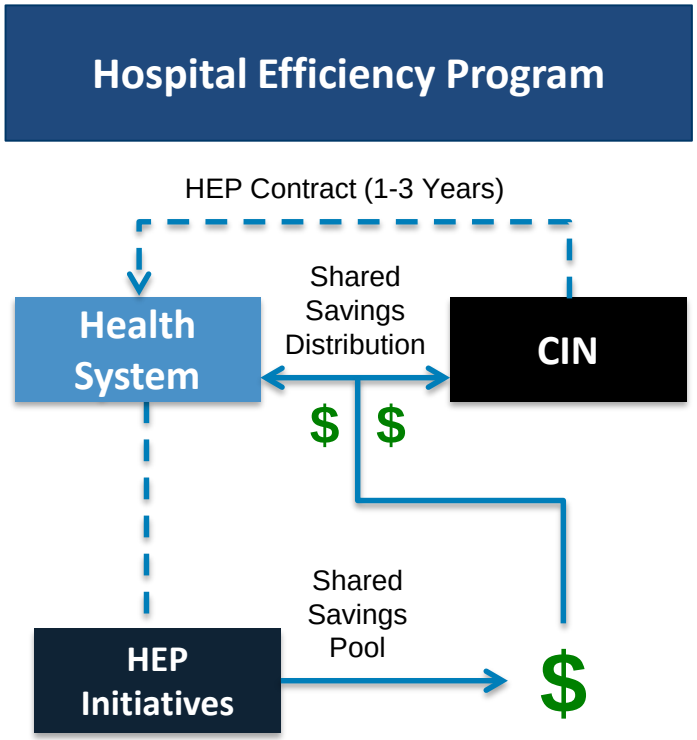
Key Metrics	Baseline	Target 1	Target 2
Admissions Trend	**#**	**1% Reduction**	**3% Reduction**
Total Payout		**$50,000**	**$100,000**
ER Visits	**#**	**1% Reduction**	**3% Reduction**
Total Payout		**$50,000**	**$100,000**

How You Win:

- Utilize an integrated legal entity as the vehicle for change
- Define the patient population that your organization is managing
- Identify the high-risk patients that represent performance metrics
- Agree to receive clear, simple and accurate dashboards with third-party on a regular basis
- Align incentives with all providers involved in the care for the defined patient population

Hospital Efficiency Program (HEP)

A **Hospital Efficiency Program** is an agreement between the hospital and the CIN to improve quality and reduce costs within the hospital. Payments and targets are defined in advance and if achieved are allocated back to the CIN for distribution to network physicians. Areas of focus are defined via a set of initiatives and metrics, each with its own predefined baseline and performance targets.



BENEFIT TO STAKEHOLDERS

Physicians

- Increased quality and efficiency through standardization
- Receive payment for demonstrated efficiencies and care coordination in various initiatives

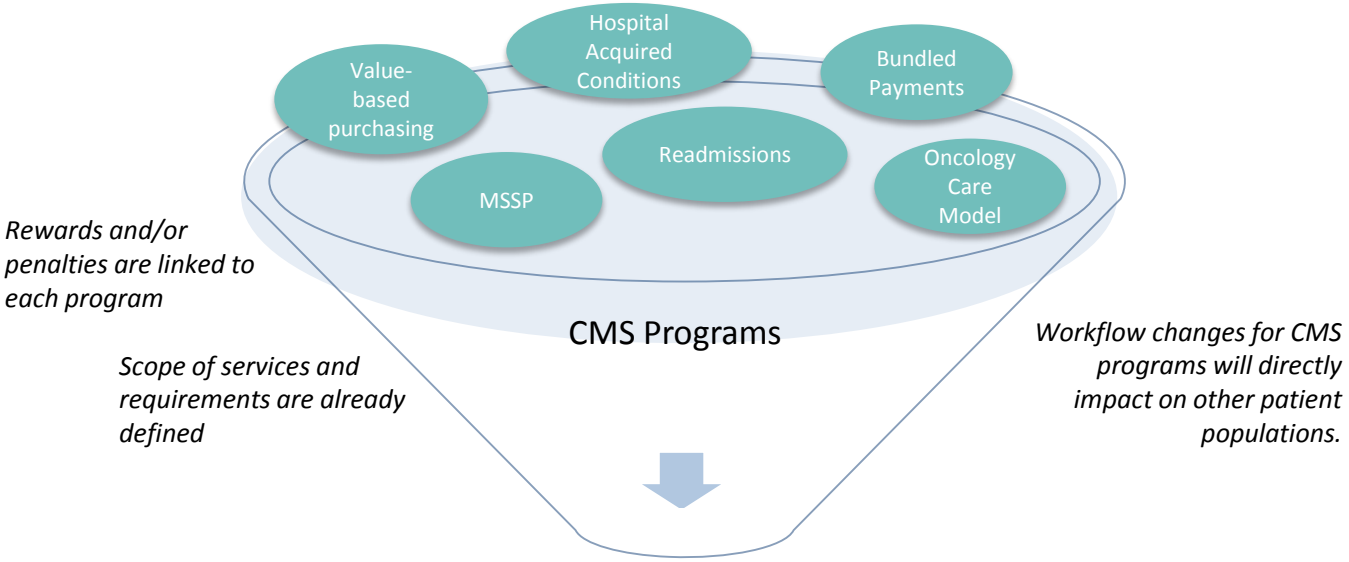
Markets and Hospitals

- Reduce expenses in the "system" and gain efficiencies
- Establish a sense of urgency to reduce waste

WHAT IT'S NOT

- Traditional Gainsharing

Align CMS criteria to other performance-based contracts



What is stopping you from creating the same type of performance-based contracts with commercial payers and employers?

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Legal Considerations

Legal Issues Affecting Alignment Structures and CINs

Issue	Concerns
Antitrust – Market Concentration and Integration	Impact on competition by: • Too many providers/exclusivity in market • Competitor joint action without integration
Federal Fraud and Abuse – Stark, Antikickback and Civil Monetary Penalties	• Physician financial and referral relationships • Hospital incentives/payments to reduce care • Beneficiary inducement
Tax Exempt Organization Concerns	Use of charitable assets • Private inurement, private benefit • Excess benefit transactions
HIPAA, Privacy and Confidentiality	• HIPAA privacy and security • State confidentiality and restricted records
State Law Issues	• State/Medicaid fraud and abuse provisions • Medical practice and licensure • Peer review • Business of insurance and any willing provider • Form of entity and tax considerations

Clinical Integration – Legal/Antitrust Definition

Concern with collective negotiation of fees by independent providers (hospitals, physicians, networks, etc.) who are not "integrated"

Acceptable "integration" may be via:

- Financial risk sharing (e.g., financial withhold or capitation)
- Clinical Integration

Focus: Whether the network of providers is sufficiently "integrated" to permit collective negotiation of fees

Clinical Integration – Blended Operational and Legal Definitions

- Clinically Integrated Networks involve arrangements in which:
  - Physicians participate in active and ongoing programs to evaluate and modify practice patterns
  - Create a high degree interdependence and cooperation, in order to
  - Control costs and ensure the quality of services
  - Agreements concerning price and other terms are reasonably necessary to obtain significant efficiencies
  - Joint contracting is necessary to the end goal; not end of itself

Clinical Integration Criteria

Key Elements from FTC Advisory Opinions:

- Structural goal is care coordination with rigorous medical management of clinical practice
- Development and implementation of evidence based or other clinical protocols
- Performance reporting, corrective action procedures
- Focused management of high cost, high risk patients
- Health Information Technology/EHR use promotes network objectives
- Data collection, evaluation and performance/outcome benchmarking
- Provider financial and time commitment to program (e.g., committee service and staff training)
- Ultimate ability to terminate non-compliant providers if remediation efforts are unsuccessful i.e., provider selectivity is important

Valid plan to implement clinical integration can suffice . . . but the plan needs to be implemented.

- Norman PHO FTC Advisory Opinion

CINs: FTC Perspective

FTC REGULATION	DEFINITION OF CLINICAL INTEGRATION	INDICIA *(PROBABILITY)* OF CLINICAL INTEGRATION
Price Fixing: unreasonable control of market pricing **Market Power:** monopolization of a market and constraint of competition	➢ An ***active and ongoing program*** to ***evaluate and modify practice patterns*** by providers ➢ A network of ***select providers*** based on predefined performance and accountability criteria ➢ A high degree of ***cooperation and interdependence*** *(coordination, standardization)* in providing care ➢ A commitment ***to reduce costs, improve quality and increase efficiency***	➢ Use of **common information technology** to ensure exchange of all relevant patient data ➢ Development and adoption of **clinical protocols** ➢ **Care review** based on the implementation of protocols ➢ **Mechanisms** to ensure compliance with initiatives

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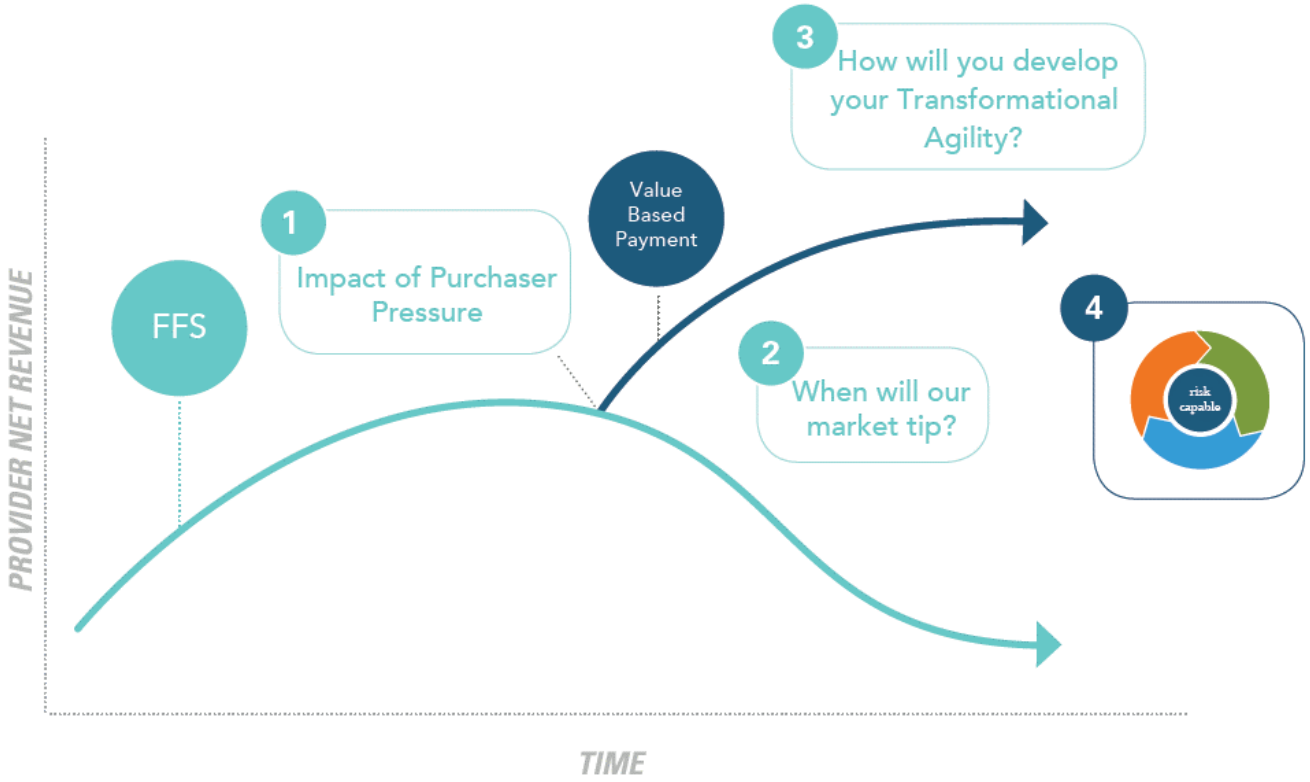
Clinical Integration Network
Key Takeaways

Is Shifting Away From FFS a Threat…YES!!

…what are your options if the market tips and a new entrant captures volume, with a disruptive strategy?



Why Invest in a CIN?

1. Vehicle to drive ***clinical performance improvement*** to decrease cost/patient
2. Shared cost of infrastructure to support ***population health***
3. ***Lower cost/physician*** integration than employment
4. Proactive (if possible) ***contracts that align*** with your market and organizational pace of change

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Q & A

Thank You, Feel Free to Contact Us

DHG Healthcare CIN Development Team

Michael Strilesky
Principal
Michael.Strilesky@dhgllp.com
330.606.0455
Cleveland, OH

Kevin Locke
Principal
Kevin.Locke@dhgllp.com
330.606.4699
Nashville, TN