Clinical Integration

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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

1. Impact of Purchaser Pressure
2. When will our market tip?
3. How will you develop your Transformational Agility?

TIME

FFS

Value Based Payment

Arise, Capable
“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.”


“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

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenses</th>
<th>Reimbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$0.80</td>
<td>$1.00</td>
</tr>
<tr>
<td>2010</td>
<td>$0.85</td>
<td>$1.00</td>
</tr>
<tr>
<td>2011</td>
<td>$0.90</td>
<td>$1.03</td>
</tr>
<tr>
<td>2012</td>
<td>$0.95</td>
<td>$1.08</td>
</tr>
<tr>
<td>2013</td>
<td>$1.00</td>
<td>$1.15</td>
</tr>
</tbody>
</table>

NOTABLE STATE-LEVEL REFORM

<table>
<thead>
<tr>
<th>State</th>
<th>Reform Model</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN</td>
<td>Episodic Bundles, (PCMH coming soon)</td>
<td>Commercial &amp; Medicaid</td>
</tr>
<tr>
<td>AR</td>
<td>Mandatory PCMH</td>
<td>Medicaid</td>
</tr>
<tr>
<td>AL</td>
<td>RCOs</td>
<td>Medicaid</td>
</tr>
<tr>
<td>OR</td>
<td>CCOs</td>
<td>Medicaid</td>
</tr>
<tr>
<td>IL</td>
<td>Alliance for Health Innovation Plan</td>
<td>All Payers</td>
</tr>
</tbody>
</table>

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)

- 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 Partnership(s)

- 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

FEE-FOR-SERVICE → PAY-FOR-PERFORMANCE → VALUE-BASED PURCHASING → BUNDLED PAYMENTS → SHARED SAVINGS → GLOBAL PAYMENTS

EMPLOYERS HEALTH PLANS GOVERNMENT PAYERS

RISK SHIFT

PHYSICIANS HOSPITALS 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

900+ Locations

400+ Locations

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
The movement towards value has already started for physicians and hospitals.

- Patient-centered care
- Evidence-based care
- Effective use of health IT
- Patient satisfaction
- Care coordination
- Bundled payments
- Total cost of care

Abbreviations:
- PCMH
- P4P
- MU
- HCAHPS / CG-CAHPS
- PMPM
- BPCI/CCJR
- MSSP
Provider Response: Risk Capability

- Enterprise intelligence
- Revenue transformation
- Clinical enterprise maturity
- Risk capable

- Populations, Utilization, Costs, Budgets, Monitoring
- “Over-managed,” Portfolio, Multiple Models, Funds Distribution
- Structure, Governance, Alignment, Value
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

**MANAGE DEFINED POPULATIONS**

**CIN OUTCOMES**

**DELIVER VALUE**
- Improve Performance
- Pursue Contracts that Reward Value
“The future is already here – it’s just not evenly distributed”

William Gibson
Clinically Integrated Networks (CINs)
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

<table>
<thead>
<tr>
<th>HOSPITALS &amp; HEALTH SYSTEMS</th>
<th>PHYSICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care coordination “inside” network</td>
<td>• Defining what “Quality” is</td>
</tr>
<tr>
<td>• Alignment with independent and employed PCPs and specialists</td>
<td>• Increased input and decision making</td>
</tr>
<tr>
<td>• Demonstrate quality to earn enhanced reimbursement, sustain rates</td>
<td>• Share in performance based incentives</td>
</tr>
<tr>
<td></td>
<td>• Maintain independent practice</td>
</tr>
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<table>
<thead>
<tr>
<th>PAYORS &amp; EMPLOYERS</th>
<th>PATIENTS &amp; COMMUNITIES</th>
</tr>
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<tbody>
<tr>
<td>• Reduced cost and enhanced value</td>
<td>• Improved coordination and efficiency of care</td>
</tr>
<tr>
<td>• Better management of high-cost chronic patients</td>
<td>• More information and control of care</td>
</tr>
<tr>
<td>• Shift of risk to providers</td>
<td>• Higher satisfaction</td>
</tr>
<tr>
<td></td>
<td>• Lower cost and higher value</td>
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</tbody>
</table>
CIN: Key Components

**Contracting**
Multiple contract options secure rewards for better quality and demonstrated value.

**Structure & Governance**
Limited Liability Corporation, Non Profit Corporation, Health Care Authority

**Infrastructure & Funding**
Single CIN, multiple CINs, or super regional CINs with sustainable revenue and provider agreements.

**Distribution of Funds**
Flow of funds distributes rewards based on measurable performance.

**Participation Criteria**
Provider agreements outlining expectations/requirements for participation in the CIN.

**Information Technology**
Architecture to monitor and track utilization, control costs, ensure quality and demonstrate value.

**Physician Leadership**
Physicians empowered to have an influence on future direction of the network.

**Performance Objectives**
Metrics and targets that impact the clinical practice of all providers to improve care and demonstrate value.
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
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.
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*
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

Legend:
- Director / VP
- Staff

Board of Managers

Executive Director

Medical Director

Quality
- Nurse
- Data Analyst
- Care Manager
- Associate Medical Dir.

Credentialing
- Physician Network Support

Operations
- Accountant / Controller
- IT Specialist
- Physician Office Support

Managed Care
- Data Analyst
- Network Specialist

Provider Relations
- Provider Relations
- Physician Liaison
- Marketing Specialist

Staff Needs / Additions:
- Year 1
- Year 2-3
- Year 4-5

Administrative Assistant

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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
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.

Sources of Revenue

- Membership Fees
- Self Funded Health Plan
- Payer Contracts (no Risk)
- Payer Contracts (Risk)

LOW

Pay-for-Performance

Hospital Efficiency Program

Private Label Health Plan

Direct to Employer Contracts

HIGH

MATURETY OF CIN
Participation Criteria for Physicians

- 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
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

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

Source: Sg2 Analysis
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

Risk & Analytics Solutions
- Identifying population
- Risk stratification
- Performance Metrics
- Incentives Alignment

Connected Health Solutions
- Technology
- Engagement
- Program design
- E2E collaboration

Clinical Transformation Solutions
- Care pathways
- Operations roadmap
- Engagement
- Evaluation & sustainability

Business Analytics
Information Technology
Change Management
Good Governance
Developing the Population Health Model

Cost of care per constituent

Opportunistic, segment-based care
Acute & chronic care management

Coordinated care based on holistic view of patient needs
Collaborative care management

Risk model-/Payer interest-driven care communities
System-wide value-based care

Community health
Community-wide prevention, wellness and value-based care

Reactive, partisan, segment-based

Proactive, coordinated, community-based

Population Management

Population Health

PHILIPS

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

- **HOSPITAL / SYSTEM**
  - Cost Savings
  - Efficiency Gains

- **NETWORK**
  - Equal distribution

- **PAYORS & EMPLOYERS**
  - P4P Contracts
  - Shared Savings
  - Increased Rates

- **LOCAL NETWORK PERFORMANCE** %
  - Hospital
  - Specialty
  - Location

- **GLOBAL NETWORK PERFORMANCE** %

- **INDIVIDUAL ACTIVITY/OUTCOMES** %
  - Performance targets
  - Educational event attendance
  - Submission of Data
  - Adoption of IT platform

Overview: The CIN establishes an organized plan to link performance on defined gradients to eligibility for incentive payments.
# Physician Performance Measurement Options

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

Maturity of Enterprise

Low

Co-Management  Employee Health Plan  HEP  Internal Contracting

Restrictive Network  IP FFS + Shared Savings  Managed Care  ACO / Capitation

FFS HIX  OP FFS + Shared Savings  Episodic Bundled Payment

High

External Contracting

Level of Infrastructure Investment

Additional IT Needed (Patient Registry)

Level of Risk

Upside Only

Risk / Reward
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
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.

**Physician Alignment and Engagement**
- Local committees formed to begin service line and market-focused growth strategies.
- Committees foster shared vision across market.
- Committees evaluate quality and cost opportunities.
- Expectation is that stronger engagement and loyalty leads to sustainability under a FFS model while building the infrastructure to become risk-capable.

**Quality, Efficiency and Standardization**
- Data collection allows definition of quality baselines and targets.
- Physician-approved care protocols and processes drive standardization, cost reduction and quality improvement.
- Typical models that accommodate this phase include co-management, shared savings with hospital employee health plan & HEP contracts.

**Value-Based Contracting**
- Demonstrated improvement in quality and performance creates new value proposition for contract negotiations.
- Value proposition positions hospital and physicians for enhanced reimbursement and narrow network opportunities.
- Incentives from payers and/or employers shared with network participants.
- Expectation is that new revenue through PMPM rates, P4P, VBP and shared savings reimbursement will offset costs of network development.
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

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

<table>
<thead>
<tr>
<th>Target</th>
<th>Lives</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Employee Health Plan</td>
<td>3,500</td>
<td>2016</td>
</tr>
<tr>
<td>Medicare Advantage Plans</td>
<td>8,000</td>
<td>2016</td>
</tr>
<tr>
<td>MEWA with local businesses</td>
<td>6,000</td>
<td>2017</td>
</tr>
<tr>
<td>School System</td>
<td>17,000</td>
<td>2017</td>
</tr>
<tr>
<td>Large Employer</td>
<td>20,000</td>
<td>2018</td>
</tr>
</tbody>
</table>

MEWA = Multiple Employer Welfare Arrangements
## 5 Year Proforma – Sample of Revenue

<table>
<thead>
<tr>
<th>Revenue</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dues</td>
<td>$</td>
<td>-</td>
<td>$80,000</td>
<td>$150,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>Care Management Fees</td>
<td>126,000</td>
<td>215,000</td>
<td>525,000</td>
<td>959,000</td>
<td>852,000</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>-</td>
<td>-</td>
<td>366,000</td>
<td>1,517,000</td>
<td>2,404,000</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>126,000</strong></td>
<td><strong>295,000</strong></td>
<td><strong>1,041,000</strong></td>
<td><strong>2,676,000</strong></td>
<td><strong>3,556,000</strong></td>
</tr>
</tbody>
</table>

### 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 Cl accreditation, legal and FMV support

### Round (000)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<tr>
<td><strong>Revenue</strong></td>
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<tr>
<td><strong>Expenses</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Salaries and Benefits</td>
<td>788,000</td>
<td>812,000</td>
<td>1,068,000</td>
<td>1,422,000</td>
<td>1,465,000</td>
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<tr>
<td>General &amp; Administrative</td>
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<td>206,000</td>
<td>212,000</td>
<td>219,000</td>
<td>225,000</td>
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<tr>
<td>Care Management</td>
<td>126,000</td>
<td>204,000</td>
<td>473,000</td>
<td>815,000</td>
<td>682,000</td>
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<td>Information Technology</td>
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<td>122,000</td>
<td>235,000</td>
<td>464,000</td>
<td>387,000</td>
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<tr>
<td>Outside Services</td>
<td>120,000</td>
<td>124,000</td>
<td>127,000</td>
<td>131,000</td>
<td>135,000</td>
</tr>
<tr>
<td></td>
<td>1,298,000</td>
<td>1,468,000</td>
<td>2,115,000</td>
<td>3,051,000</td>
<td>2,894,000</td>
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</tbody>
</table>
## 5 Year Proforma – Sample

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dues</td>
<td>$</td>
<td>-</td>
<td>$ 80,000</td>
<td>$ 150,000</td>
<td>$ 200,000</td>
</tr>
<tr>
<td>Care Management Fees</td>
<td>126,000</td>
<td>215,000</td>
<td>525,000</td>
<td>959,000</td>
<td>852,000</td>
</tr>
<tr>
<td>Shared Savings</td>
<td></td>
<td></td>
<td>366,000</td>
<td>1,517,000</td>
<td>2,404,000</td>
</tr>
<tr>
<td></td>
<td>126,000</td>
<td>295,000</td>
<td>1,041,000</td>
<td>2,676,000</td>
<td>3,556,000</td>
</tr>
</tbody>
</table>

### Expenses

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Benefits</td>
<td>788,000</td>
<td>812,000</td>
<td>1,068,000</td>
<td>1,422,000</td>
<td>1,465,000</td>
</tr>
<tr>
<td>General &amp; Administrative</td>
<td>200,000</td>
<td>206,000</td>
<td>212,000</td>
<td>219,000</td>
<td>225,000</td>
</tr>
<tr>
<td>Care Management</td>
<td>126,000</td>
<td>204,000</td>
<td>473,000</td>
<td>815,000</td>
<td>682,000</td>
</tr>
<tr>
<td>Information Technology</td>
<td>64,000</td>
<td>122,000</td>
<td>235,000</td>
<td>464,000</td>
<td>387,000</td>
</tr>
<tr>
<td>Outside Services</td>
<td>120,000</td>
<td>124,000</td>
<td>127,000</td>
<td>131,000</td>
<td>135,000</td>
</tr>
<tr>
<td></td>
<td>1,298,000</td>
<td>1,468,000</td>
<td>2,115,000</td>
<td>3,051,000</td>
<td>2,894,000</td>
</tr>
</tbody>
</table>

### Net Income

|                    | $ (1,172,000)| $ (1,173,000)| $ (1,074,000)| $ (375,000)| $ 662,000 |

*Rounded (000)*
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

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**Medicare and Medicaid**

85% of traditional Medicare FFS payments will be tied to quality or value by 2016.

-HHS, 2015

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**Commercial Payers and Employers**

75% of a members’ business will shift to incentives for health outcomes, quality and costs management by January 2020.

- Modern Healthcare, 2015

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

Level of integration required

- FFS Reimbursement Reductions
- Penalty Avoidance and Pay for Performance
- Bundled Payment (BPCI)
- Capitation, Shared Savings (MSSP)

- Fee-For Service
- Pay-for-Performance
- Bundled Payments
- Shared Savings
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Target</th>
<th>Payment</th>
</tr>
</thead>
</table>
| 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.
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.
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

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-Day Readmission Rate</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>HEDIS Measures</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

### Cost Metrics

<table>
<thead>
<tr>
<th>Key Metrics</th>
<th>Baseline</th>
<th>Target 1</th>
<th>Target 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions Trend</td>
<td>#</td>
<td>1% Reduction</td>
<td>3% Reduction</td>
</tr>
<tr>
<td>Total Payout</td>
<td></td>
<td>$50,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>ER Visits</td>
<td>#</td>
<td>1% Reduction</td>
<td>3% Reduction</td>
</tr>
<tr>
<td>Total Payout</td>
<td></td>
<td>$50,000</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

### How You Win:

- Utilize an integrated legal entity as the vehicle for change
- Define the patient population that your organization is managing
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- Align incentives with all providers involved in the care for the defined patient population
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?

Rewards and/or penalties are linked to each program

Scope of services and requirements are already defined

Workflow changes for CMS programs will directly impact on other patient populations.
Legal Considerations
## Legal Issues Affecting Alignment Structures and CINs

<table>
<thead>
<tr>
<th>Issue</th>
<th>Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antitrust – Market Concentration and Integration</strong></td>
<td>Impact on competition by:</td>
</tr>
<tr>
<td></td>
<td>• Too many providers/exclusivity in market</td>
</tr>
<tr>
<td></td>
<td>• Competitor joint action without integration</td>
</tr>
<tr>
<td><strong>Federal Fraud and Abuse – Stark, Antikickback and Civil Monetary Penalties</strong></td>
<td>• Physician financial and referral relationships</td>
</tr>
<tr>
<td></td>
<td>• Hospital incentives/payments to reduce care</td>
</tr>
<tr>
<td></td>
<td>• Beneficiary inducement</td>
</tr>
<tr>
<td><strong>Tax Exempt Organization Concerns</strong></td>
<td>Use of charitable assets</td>
</tr>
<tr>
<td></td>
<td>• Private inurement, private benefit</td>
</tr>
<tr>
<td></td>
<td>• Excess benefit transactions</td>
</tr>
<tr>
<td><strong>HIPAA, Privacy and Confidentiality</strong></td>
<td>• HIPAA privacy and security</td>
</tr>
<tr>
<td></td>
<td>• State confidentiality and restricted records</td>
</tr>
<tr>
<td><strong>State Law Issues</strong></td>
<td>• State/Medicaid fraud and abuse provisions</td>
</tr>
<tr>
<td></td>
<td>• Medical practice and licensure</td>
</tr>
<tr>
<td></td>
<td>• Peer review</td>
</tr>
<tr>
<td></td>
<td>• Business of insurance and any willing provider</td>
</tr>
<tr>
<td></td>
<td>• Form of entity and tax considerations</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>FTC REGULATION</th>
<th>DEFINITION OF CLINICAL INTEGRATION</th>
<th>INDICIA (PROBABILITY) OF CLINICAL INTEGRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Price Fixing:</strong></td>
<td>- An active and ongoing program to evaluate and modify practice patterns by providers</td>
<td>- Use of common information technology to ensure exchange of all relevant patient data</td>
</tr>
<tr>
<td>unreasonable control of market pricing</td>
<td>- A network of select providers based on predefined performance and accountability criteria</td>
<td>- Development and adoption of clinical protocols</td>
</tr>
<tr>
<td><strong>Market Power:</strong></td>
<td>- A high degree of cooperation and interdependence (coordination, standardization) in providing care</td>
<td>- Care review based on the implementation of protocols</td>
</tr>
<tr>
<td>monopolization of a market and constraint of competition</td>
<td>- A commitment to reduce costs, improve quality and increase efficiency</td>
<td>- Mechanisms to ensure compliance with initiatives</td>
</tr>
</tbody>
</table>
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
Thank You, Feel Free to Contact Us

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