Approved Models to Align Incentives between Hospitals and their Physicians
Agenda

I. Alignment Model Overview

II. Co-Management

III. Clinically Integrated Networks
   - CIN Definition & Overview
   - Network Development
   - Legal Roadmap

IV. DHG Process
ALIGNMENT MODEL OVERVIEW
Driving Forces for Alignment

Hospital Objectives
- Gain Market Advantage for Growth Strategy
- Stabilize Market / Secure Access
- Transform Care Delivery
- Strengthen Financial Position

Physician Objectives
- Stabilize Income from Declining Reimbursement
- Secure Patient Capture / Referral Network
- Improve Work-Life Balance
- Private Practice Exit Strategy
Alignment Model Spectrum

- **TACTICAL**
  - Pay for Call
  - Directorship
  - Co-Marketing

- **STRATEGIC**
  - Joint Venture
  - Independent Practice Association

- **TRANSFORMATIONAL**
  - Accountable Care Organization
  - Clinically Integrated Network
  - PCMH
  - Foundation

- **Degree of Alignment**
  - Low
  - High

- **Resources Required**
  - Low
  - High
CO-MANAGEMENT
Clinical Co-Management is any arrangement involving a fair market value bonus payment to physician based upon achieving certain non-productivity metrics such as clinical, efficiency or patient service metrics. Such a bonus would be in addition to other physician compensation.

**BENEFIT TO STAKEHOLDERS**

**Physicians**
- Shared ownership and governance
- Direct and active role in management
- Bonus payment for achievement of target metrics

**Hospitals**
- Engagement and strategic alignment of physicians across the targeted service line

**WHAT IT’S NOT**
- Model to facilitate the “closing” of a physician acquisition or employment relationship
WHAT IS A CLINICALLY INTEGRATED NETWORK AND HOW DOES IT WORK?
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.

**Clinically Integrated Network**

- **Payors and Employers**
  - Contracts
  - $\rightarrow$ CI Entity
- **Private Practice Physicians**
  - Distribution of Funds
  - $\leftarrow$ CI Entity
- **Health System and Employed Physicians**
  - Participation Agreement
  - $\leftarrow$ CI Entity
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- **Health System and Employed Physicians**

**BENEFITS TO STAKEHOLDERS**

**Physicians**
- Preserving *private practice* model through alignment
- Enhanced *reimbursement* through contracting for demonstrated network quality
- Improved communication, coordination, transparency, accountability

**Markets and Hospitals**
- Align independent, employed, and specialist physicians in one organization
- Enhanced *reimbursement* under FTC guidelines for demonstrated quality
**Definition of Clinically Integrated Network**

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- Enhanced reimbursement under FTC guidelines

**WHAT IT’S NOT**
- Physician employment
- Hospital-led initiative
- Mechanism to gain negotiating leverage with payors
Components of a Clinically Integrated Network

- Structure & Governance
- Infrastructure & Funding
- Contracting
- Distribution of Funds
- Information Technology
- Physician Leadership
- Participation Criteria
- Performance Objectives
- Clinically Integrated Network

Clinically Integrated Network
NETWORK DEVELOPMENT
Role of Hospital or Health System

• Hospitals usually sponsor, but not always
  – Some physician-only models exist, which seek only to have arm’s length relationships with hospitals and other institutional providers

• Network organization and governance must balance potentially competing physician and hospital interests

• Hospitals bring capital, IT and administrative support

• Hospitals reserve certain powers to align the network’s interests with those of the community
Selecting the Best Model for Clinical Integration

• Not all physicians are the same
  – Employed vs. independent
  – Primary care vs. specialists
  – Exclusive medical staff privileges vs. “splitters”
  – New recruits vs. veterans
  – Large group vs. small group
  – Multispecialty vs. single specialty

• Not all terminology has universal or standardized meaning

• The process you use is more important than the model you select
Selecting the Best Model for Clinical Integration (cont.)

- Most models have been around for some time, although they may have changed because of regulatory and economic pressures.
- The choice is often based upon the culture of the medical community and the hospital’s history with physician relationships.
- There are no “right” or “wrong” choices for a particular situation, but off-the-shelf structures rarely work well, if at all.
- **Authentic physician engagement is essential.**
Method of Formation of a Clinically Integrated Network

• Replacement of a Messenger Model network
  – Use an existing network for a modern purpose and avoids duplication and wasted efforts

• Network merger
  – Combine existing entities to bring all specialties under one roof

• Form Super PHO
  – Joint venture or merger of distinct PHOs within a defined service area, typically in large, urban areas

• De novo formation
Examples of Legal Structures

- Subsidiary PHO
- Joint Venture PHO
- Super PHO
- IPA
In a **Health System Subsidiary**, the hospital / health system is the sole corporate member of the subsidiary entity. Physicians sign participation agreements to be participate with the entity. The Board of Managers is composed of both the hospital / health system and its medical staff and operate similar activities as a JV PHO.

### Health System Subsidiary PHO

- **Health System**
- **Subsidiary**
- **Participating Physicians**
- **Participating Agreement**
- **Payors / Employers**

### BENEFIT TO STAKEHOLDERS

**Physicians**
- Limited or no financial costs
- Simplified contracting process
- Shared governance with health system
- Other services including credentialing and malpractice coverage

**Hospitals**
- Quickly deployed strategy for network development
- Additional AKS and Stark considerations
- Vehicle for CIN
- Precursor to shared savings program
A Physician Hospital Organization (PHO) is a joint-venture between a hospital and its medical staff, which allows physicians to maintain ownership of their practice with the option to accept managed care contracts through a messenger model process. Ownership interests dictate board structure and investment.

**Joint Venture PHO**

- **Health System**
  - PHO (XX%)

- **Participating Physicians**
  - PHO (XX%)

- **Payors / Employers**

**Benefit to Stakeholders**

**Physicians**
- Simplified contracting process
- Shared governance with health system
- Other services including credentialing and malpractice coverage

**Hospitals**
- Structure and governance for future network development
- Vehicle for CIN
- Precursor to shared savings program
A **Super PHO** is an amalgamation of distinct PHOs in multi-hospital systems, typically in large, multi-county, multi-MSA regions. The structure and issues relating to a Super PHO are similar to other PHOs with an added layer in the ownership structure.

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<tr>
<th>Super PHO</th>
<th>BENEFIT TO STAKEHOLDERS</th>
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<tbody>
<tr>
<td>PHO #1</td>
<td>Physicians</td>
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<tr>
<td>PHO #2</td>
<td>• Shared governance with health system</td>
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<td>Super PHO</td>
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An **Independent Practice Association (IPA)** is a physician organization comprised of private practice physicians that are joined together as an association. The IPA can contract with health systems and payors through a messenger model as one network for services. This creates a large network of providers that can manage the financial accountability over medical decision-making and populations.

**BENEFIT TO STAKEHOLDERS**

**Physicians**
- Decision-making autonomy
- Maintain private practice model
- Enhanced reimbursement (P4P, Shared Savings)

**Hospitals**
- Provider network, if aligned, can manage large portion of market population
- Existing IPA’s may have experience with risk models

**WHAT IT’S NOT**
- Shared Ownership
- Shared Governance
- Structure for shared network development
Infrastructure & Funding

Overview: The CIN is a separate Business Entity with:
- Distinct Identity, Mission, and Vision
- Dedicated Leadership and Staff
- Sustainable Sources of Revenue
- Participating Agreements with Providers

Sources of Revenue

The CIN will need to offset costs of building the network (Infrastructure) and eventually provide returns through various revenue sources depending on the maturity of the network.

- Reporting Incentives and Membership Fees
- Self Funded Health Plan
- Payor Contracts

Maturity of CIN

Low
- Hospital Efficiency Program
- Pay-for-Performance

High
- Employer Contracts
LEGAL ROADMAP
Addressing the Legal Hurdles Raised By Increased Collaboration

• Antitrust considerations
• Fraud and abuse considerations
• Tax exemption considerations
• State insurance law considerations
• Privacy and data security considerations
• Proper use of general counsel
• Proper use of outside counsel
Antitrust Compliance Overview

- Independent, competing providers’ joint negotiation of fees may raise antitrust concerns.
- The FTC has not identified specific criteria to provide a safe harbor for providers clinically integrating and engaging in joint contracting, but has provided some guidance through statements and advisory opinions.
- Two methods of analysis under Section 1 of the Sherman Act:
  - **Per Se Rule**: certain conduct, including agreements by horizontal competitors to fix prices and allocate markets, is deemed so egregious and lacking in redeeming value.
  - **Rule of Reason**: conduct is subject to a fact-intensive analysis -- balancing of the pro-competitive benefits of the arrangement against its anticompetitive results.
Antitrust Compliance Overview (cont.)

• In 1996, the DOJ and FTC issued a revised document entitled *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*

• Careful adherence to the principles set forth in the Guidelines will assist in minimizing antitrust risk — however, the Guidelines do not have the force of law and are not binding on courts or private litigants

• Can avoid per se antitrust condemnation by either (i) assuring that the participants share substantial financial risk or (ii) *demonstrating sufficient clinical integration*
FTC Definition of Clinical Integration

- Clinical integration requires connection, communication, cooperation, measurement and coordinated contracting.
- The FTC defines clinical integration as having:
  - Active and ongoing program to evaluate and modify practice patterns by providers.
  - High degree of interdependence and cooperation among providers to control costs and ensure quality.
- The test of integration is what the network participants actually do to:
  - Create cooperation and interdependence in providing care.
  - Jointly reduce unnecessary costs, improve quality of care, and increase efficiency in the provision of medical care.
  - Joint contracting ancillary to quality and efficiency benefits.
Elements of a Clinically Integrated Network – FTC Enforcement Guidance

• Substantial capital contributions or contributions of time and effort by the participating physicians
• A dedicated system, preferably electronic, by which all physicians in the network exchange relevant patient medical information
• Development of practice guidelines or care protocols sufficient to improve quality and utilization
• Agreement among the participating physicians themselves and with the network to apply the guidelines to network patients
• Development of quality, efficiency, utilization, and cost goals or benchmarks that, if met, will represent improvement by physicians over their current performance
Elements of a Clinically Integrated Network – FTC Enforcement Guidance (cont.)

• Development, implementation, operation and enforcement (where applicable) of:
  – Process to review and assess the physicians’ performance
  – Process to identify individual network physicians who fail to apply the guidelines, comply with clinical integration policies or achieve efficiency benchmarks
  – Corrective action plans for individual physicians who fail to achieve efficiency benchmarks
  – Process for sanctioning habitually non-compliant physicians after implementation of corrective action plans, up to and including expulsion from the network
Additional ACO Guidance

• In October 2011, the DOJ and FTC issued the Final Statement of Antitrust Policy Enforcement regarding ACOs.
• Agencies will not challenge as “per se” illegal ACO joint negotiations with private insurers in commercial markets, but will apply a “rule of reason” analysis in analyzing a potential antitrust violation, under certain conditions.
• Formal ACO safety zone where the agencies will not, absent extraordinary circumstances, challenge an ACO
  – Each physician specialty in the ACO must not exceed thirty percent of the primary service area where the ACO participates.
• Although the statement relates primarily to ACOs participating in the Medicare shared savings program, its guidance may be helpful in mitigating potential governmental or private litigant antitrust risks for other models.
### Other Legal and Regulatory Compliance Considerations and Risks

| IRS 501c(3) Regulations | - Prohibits potential private inurement and/or benefit from tax-exempt funds  
| | - Scrutinizes FMV and self-interest relationships with “insiders” (e.g., physicians, etc.)  
| | - Further implications re: restricted uses of tax-exempt financing (e.g., bond) funds  
| Medicare & Medicaid (M/M) | - Scrutinizes FMV and self-interest relationships for M/M inpatient referrals, etc.  
| | - Significantly increased scrutiny/enforcement re: “whistle-blower”/anti-kickback suits  
| Civil Monetary Penalties Statute | - Intended to curb financial incentives to reduce care to M/M patients  
| | - Limits forms of “gainsharing” between physicians and hospitals  
| | - May affect incentive programs for Medical Directors and other compensated leaders  
| Stark Regulations | - Developed to reduce financial incentives based upon volume or value  
| | - Technically, only affects selected M/M “designated services”  
| | - Limits sharing of ancillary services revenues per “group practice” definition  
| | - Includes new “service area” definitions; hourly compensation FMV, etc.  
| | - Consider need for ACO waivers  
| Other Pertinent Regulations | - Compliance with state insurance regulations re: Risk Share, IPA, MSO compliance  
| | - Compliance with other state (e.g., corporate practice of medicine) laws and regulations  

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*Source: Dixon Hughes Goodman*
Policies and Procedures/Contractual Best Practices to Implement Clinical Integration

• Clinical protocols
  – Comprehensive standards addressing quality, safety, disease management and utilization management
  – Disease and patient registries

• Referral agreement
  – Requires in-network referrals whenever medically reasonable
  – Exceptions if services not provided by network provider or non-network provider otherwise required or permitted by payor contract

• Financial contributions
  – Equity ownership and/or annual membership fee
Policies and Procedures/Contractual Best Practices to Implement Clinical Integration (cont.)

- **Contracting**
  - Not permitted to opt out of individual payor agreements based on fee schedule or otherwise
  - Provide for financial incentives to meet network’s goals through risk and shared savings arrangements

- **Program compliance**
  - Required compliance with all program policies and procedures

- **Physician monitoring and education**
  - Compliance monitored through clinical performance scorecards or other measurable feedback
  - Failure to meet standards subjects physician to a corrective action plan and possible termination
  - Required participation in educational initiatives focused on continuous improvement
DHG PROCESS
Provider Network Strategy Process

Roadmap to Clinical Integration

**Discover**
- SPONSORSHIP & COMMUNICATION
  - Steering Committee Creation
  - Develop Project Plan and Timeline
  - Maintain Communication
- STAKEHOLDER INTERVIEWS
  - Aligned Vision
  - Vision of Success
  - Barriers
  - Physician Leadership
- ORGANIZATIONAL READINESS
  - Organization (DoC, IPA, PC or Employed)
  - Legal Analysis of Organization
  - Information Technology
  - Ability to Analyze Cost / Quality
  - Financial Requirements
- MARKET READINESS
  - Payer Support
  - Employer Support
  - Competitive Research
  - Best Practice Research
- CURRENT STATE PERFORMANCE
  - Market Share Analysis
  - Demographic growth opportunities
  - Referring Physician Assessment

**Develop**
- CI INFRASTRUCTURE
  - Key Decision Criteria
  - Legal Term Sheet
  - Committee Structure
- TECHNOLOGY SELECTION
  - Capability Assessment
  - Adoption Plan
- CI BUSINESS PLAN
  - CI Comparison to Existing Goals
  - 3-year Pro Forma
  - Physician Leadership Capacity
- COMMUNICATION PLAN
  - Internal Staff Education Meeting(s)
  - Medical Staff Education Session(s)
  - Payer / Employer Support Meeting(s)

**Deploy**
- COMMUNICATION IMPLEMENTATION
  - Educational Sessions
  - Practice Manager Engagement
- COMMITTEE FACILITATION
  - Committee Charters
  - Physician Engagement
- QUALITY IMPROVEMENT
  - Clinical Measures & Metrics
  - Physician Performance Report Cards
- ECONOMIC INCENTIVES
  - Engage Payers, Hospital and Employers
  - Participate in Pay-for-Performance
  - Cost Savings Initiatives
- MONITOR & OVERSIGHT
  - Guidance on Legislation
  - Process Improvement
  - Compliance

**KEY DELIVERABLES**
- Readiness Assessment
- Legal Structure Matrix
- Provisional Implementation Matrix
- Implementation Plan

**Legal Agreements**
- Policies and Procedures
- Business Plan

**Implementation Management**
- Committee Charters
- Recruitment and Education
- Compliance – Monitoring and Oversight

DIXON HUGHES GOODMAN
Annual Healthcare SYMPOSIUM
Defining Market Urgency and Readiness

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<tr>
<th>Urgency</th>
<th>Low</th>
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<tr>
<td>Build</td>
<td>Monitor</td>
<td>Act</td>
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<tr>
<td>Readiness</td>
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- Hospital Profile
- Market Characteristics
- Competitor Profile
- Physician Profile
- Payor Profile
- Employer Profile
- Market Readiness

BUILD

MONITOR

PLAN

ACT
Organizational Readiness

GAP Analysis (2 of 2)

CI Component | Gaps | Future State
--- | --- | ---
**EASE OF CHANGE** | - Experiment with models that allow for a transition from FFS to value-based reimbursement. - Increase urgency for change is important to successfully launch this initiative. - Physicians’ urgency has been building since April retreat. - Multiple physician alignment initiatives / JV’s / MSO’s all of which have different physician governance models.

**PHYSICIAN ENGAGEMENT** | - Develop a small group of committed physicians to act as the sponsors of the IPN. - Lack of a defined primary care network, or alignment for Hospital. - Encouraging physician specialists to be active within the network.

**PHO EFFECTIVENESS** | - Create economic scenarios to determine how much physicians and Hospital would need to invest to implement an IPN through the PHO. - Determine how much physicians would be willing to invest to be a part of the IPN. - Explore options for a sustainable funding mechanism to support operating costs.

**LEADERSHIP REQUIREMENTS** | - Identify requirements for full time leadership team and Board Structure. - Select leadership of IPN. - Design appropriate organizational structure. - Compensation model to fund leadership.

**CLINICAL CAPABILITIES** | - Create opportunities to embed evidence-based guidelines into daily clinical practice on the inpatient and outpatient settings. - Design patient reports used at the point of care to communicate condition specific information. - Monitor performance of practice team and care system.

**ECONOMIC INCENTIVES** | - Implement and monitor Population Health Management initiative with the Hospital associate Health Plan. - Review requirements of two pay-for-performance initiative currently being administered in the market (Payor and Payor Managed Medicaid).

**Increase coordination of care, expand the use of technology, and improve performance of adopted clinical protocols**

- Include independent and employed physicians to help the network:
  - Increase ambulatory connectivity to manage and track the population
  - Grow market presence through expansion of aligned physicians to north

- Improve communication amongst physicians and their patients that increases satisfaction and quality outcomes

- Equal accountability and decision making

- Integrate health system and physicians through IT

- Utilize health information technology to provide necessary information to the provider at the point of care

- Develop integrated contracting for innovative payment models (i.e. Premium Base Rates (FFS), Performance Incentives and Shared Savings)
EXTRA
Evolution of Clinically Integrated Network

NETWORK

Value to Network Participants

- Pay for Performance
- Messenger Model Contracting
- Medicare Advantage Contracts
- Associate Health Plan

Scope of Contracting / Competencies

CIN

Value to Network Participants

- Single Signature Negotiated Contracts
- Hospital Efficiency Agreement

Scope of Contracting / Competencies

- Ability to demonstrate selectivity, cooperation, modified behavior and results; can negotiate agreements with payors, employers or hospital

FTC Criteria
### Considerations for Network Development

#### Advantages of Networks
- Scalable to include entire medical staff
- Legal framework for coordinated care within network
- Global framework for quality improvement
- Platform for physician participation in leadership and governance
- Cost to physician ratio lower than employment

#### Challenges of Development
- Timeframe can be 18-36 months for development
- Physician urgency / patience with network development
- Alignment of win-win criteria
- Defining the right payor partnership model
- Sufficient payor and employer willingness to contract
- Significant investment in time and resources
Structure & Governance

Overview: With the exception of an employment-only model, a CI network can only be structured as a PHO or an IPA. The right structure depends on the desired speed to implement, ideal level of control, and willingness to take on risk.
## CIN Value Proposition

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<th>HOSPITALS &amp; HEALTH SYSTEMS</th>
<th>PHYSICIANS</th>
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<tbody>
<tr>
<td>• Improved coordination, efficiency, satisfaction, transparency and information</td>
<td>• Improved coordination of patient care</td>
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<tr>
<td>• Response to market pressures</td>
<td>• Access to patient information and transparency across the continuum</td>
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<tr>
<td>• Provide right care in the right setting</td>
<td>• Implementation of data-driven clinical best practice guidelines</td>
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<td>• Alignment with independent and employed PCPs and specialists</td>
<td>• Increased input and decision making</td>
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<td>• Enhanced reimbursement for demonstrated quality</td>
<td>• More attractive payor contracts</td>
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<td>• Share in performance based incentives</td>
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<tr>
<th>PAYORS &amp; EMPLOYERS</th>
<th>PATIENTS &amp; COMMUNITIES</th>
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<tbody>
<tr>
<td>• Reduced cost and enhanced value</td>
<td>• Improved coordination and efficiency of care</td>
</tr>
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<td>• Better management of high-cost chronic patients</td>
<td>• More information and control of care</td>
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<tr>
<td>• Increased collaboration between patients and providers</td>
<td>• Higher satisfaction</td>
</tr>
<tr>
<td>• Shift of risk to providers</td>
<td>• Improved quality and outcomes</td>
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<td>• Lower cost and higher value</td>
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