



Health Care Reform in Practice:

*Hospital Physician Collaboration:
Accountable Care Organizations and Beyond*

January 5 – 9, 2011, Vail, Colorado



Boston • Chicago • Houston • Miami • San Francisco • Washington, D.C.



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Today's Discussion

- Health Care Reform – A Deeper Dive
- Design Process
- Design Considerations
 - Network Relationship with Health System
 - Legal Structure
 - Governance Structure
 - Membership and Participation Requirements
- How One System Has Responded

Health Reform Overview

Accountable Care Organizations: A Deeper Dive

Who can be an ACO?

- Not just multi-speciality physician groups or Integrated Delivery Systems
- Any entity willing to be accountable for “cost quality and overall care” of 5,000 Medicare enrollees
- 3 year commitment
- Legal entity / structure: able to receive and share savings
- Clinical and administrative systems (IT) to meet reporting and coordination requirements
- Must meet “patient centered” criteria established in Regs

* Regs not out / effective date January 1, 2012

Health Reform Overview

Accountable Care Organizations: A Deeper Dive (con't)

How does the ACO payment really work?

- Establish expected “cost” of median fee for service for the enrolled group
- Establish target cost lower than expected
- ACO at risk for amounts between expected and target
- ACO may receive % of saving beyond target

Example: \$100 expected cost

 \$95 ACO target

 \$93 ACO actual

 \$2.00 shared w/ACO (ACO then distributes to providers based on contractual arrangements)

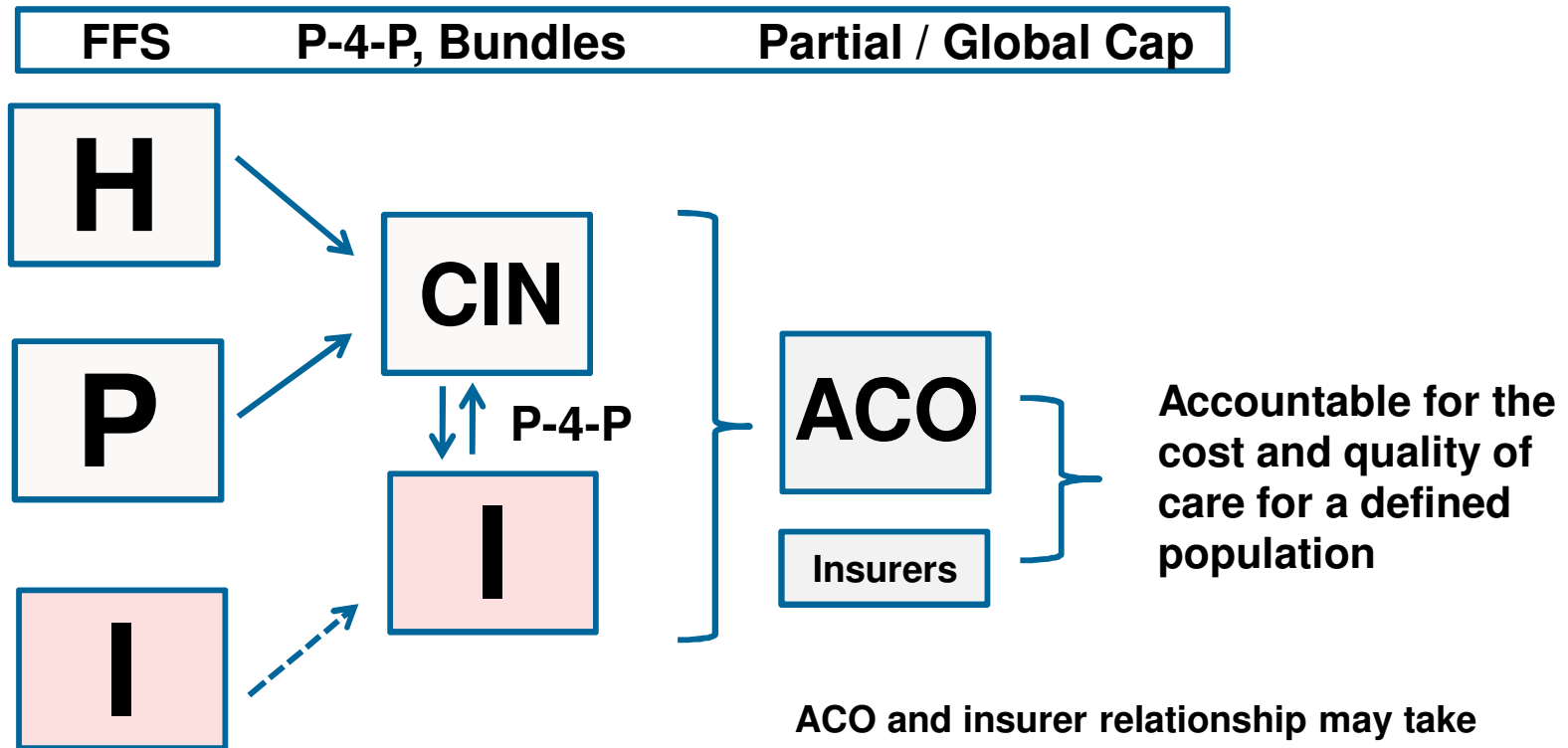
Health Reform Overview

Accountable Care Organizations: A Deeper Dive (con't)

- Accountability is the key: hospitals, physicians, home health, post acute all on same page
- IT will provide “real time” data on quality, cost, efficiency, best practices
- Perform evaluation based on agreed upon data points / measures
- Realign financial incentives - preliminary compensation for meeting range of quality, efficiency and other objective measures
- ACOs are central to bending the cost curve
 - Quality and accountability
 - Over utilization discouraged
 - Not just \$\$ driven capitation

The Path to the ACO - Delivery System Reform

Integrating the three components of the delivery system into a single entity



ACO and insurer relationship may take many forms. No definitive arrangement is mandated.

H = Hospital

P = Physicians

I = Insurers

CI = Clinical Integrated Network

ACO = Accountable Care Organization

Why “Clinical Integration”?

How to get from A to B?

Paralyzed by the Crevasse



FEE FOR SERVICE

- A system we know – all about volume
- Declining margins can “make it up” with volume
- Reinforces work in silos
- Little incentive for real integration

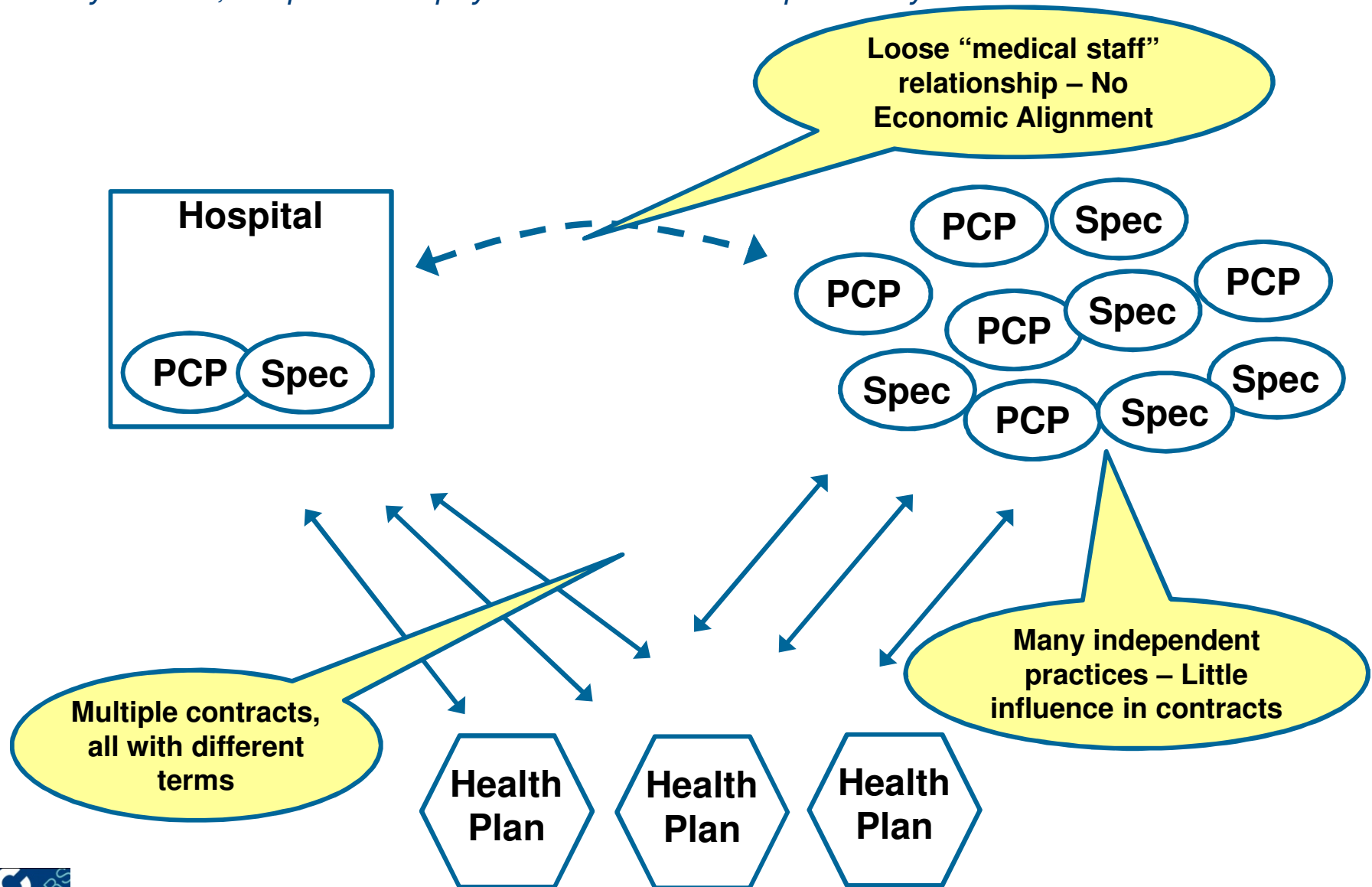
BUNDLED PAYMENT

- Seems so “90s”
- Not burned on this 15 years ago
- Enduring trend?
- Providers share in the benefits of improved quality and lower cost?

Clinical Integration is a way for physicians and health systems to bridge the gap between FFS reimbursement world and tomorrow’s value-based payment world.

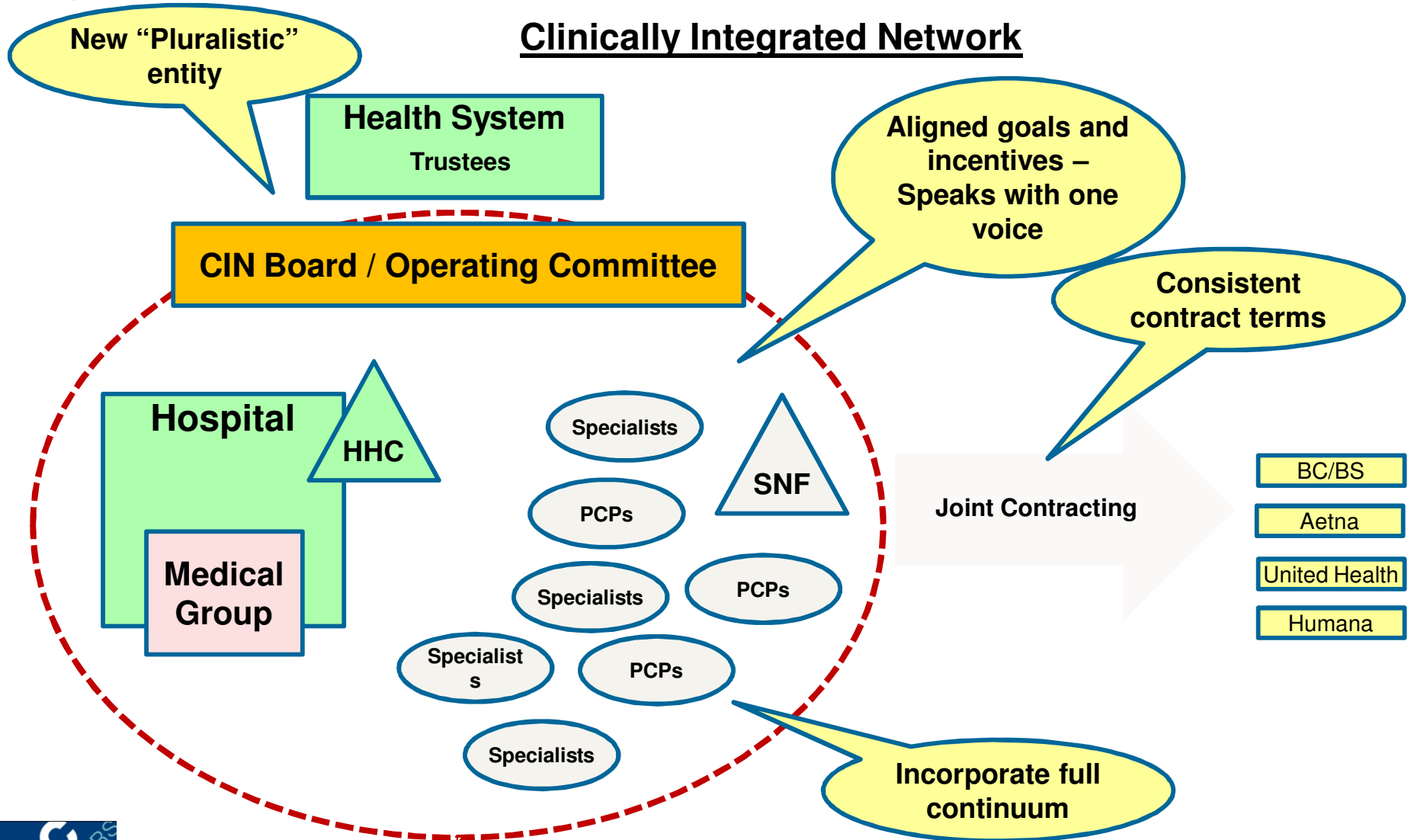
Today's Relationships

In today's world, hospitals and physicians contract independently



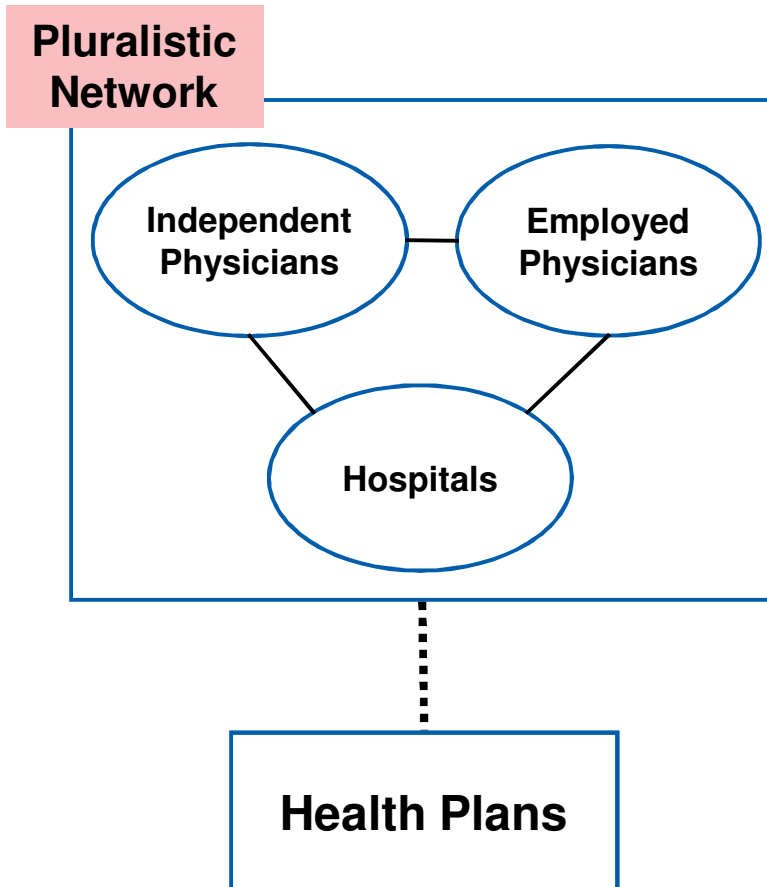
CIN "Vision"

A clinically integrated network can engage all providers and payers in community health improvement and cost containment . . .



Clinically Integrated Network – Fundamentals

Key Elements



- **Clinical management infrastructure**
 - Evidence based clinical protocols to reduce variation in care
 - Clinical IT system to sharing information across entire Network
 - CIN staff coaches practices
- **Joint contracting** for hospital and physicians (employed and private) to enable sharing value for improved performance
- **Rewards and penalties** for joint agreed on attainable goals (Payer-blind – System administrators)
- **New physician governance construct** to support hospital physician decision making, flow of information, quality initiatives

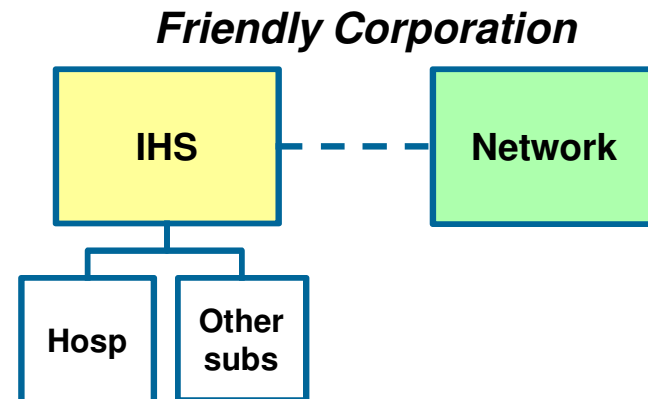
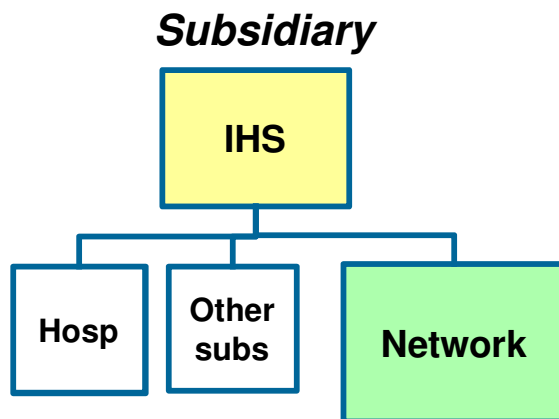
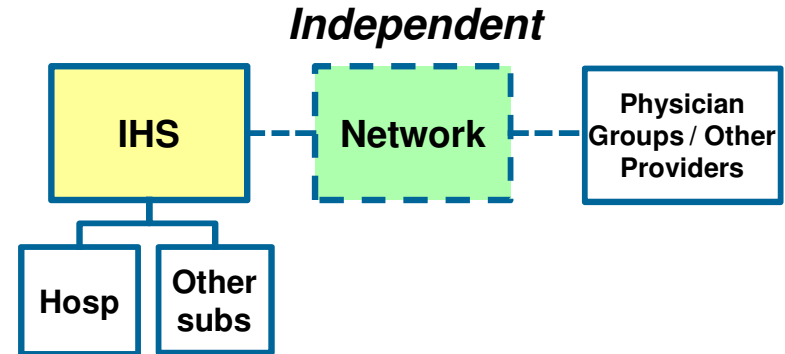
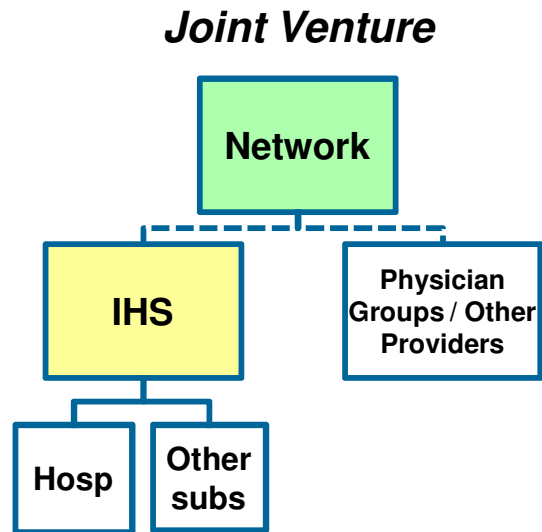
Our design principles will provide the construct that will inform development of the Network design

1. The primary objective of the Network is to improve the quality and efficiency of health care received by consumers living in our service area. The goal is to achieve market leading quality and value.
2. The Network should build on, rather than duplicate, key capabilities in the medical community if possible
3. The Network design must meet FTC / DOJ standards for clinical integration
4. Network governance should maximize physician participation and stimulate physician leadership roles
5. The Network legal structure should reflect participants' ability and willingness to capitalize required infrastructure
6. The Network must operate in such a way that preserves the Health System and Physicians' fiscal viability in a challenging health care reimbursement environment
7. The Network will need a pluralistic clinical information technology strategy that will be centered on JCMR, but that will need to accommodate multiple EMR platforms
 - Performance reporting
 - EMR connectivity

8. The Network should pursue an “all payer” performance management and incentive strategy *[TO BE TESTED]*
 - Common performance metrics across all payers
 - Single consolidated performance incentive structure
 - Contract terms that don’t significantly advantage or disadvantage individual health plans
9. The Network’s incentive structure should be able to accommodate a range of payment models
 - Fee-for-Service, with performance reward
 - Bundled payment options
 - Shared savings (gainsharing)
 - Capitation
10. Network should facilitate compensation of participating independent physicians based on service / productivity rather than ownership
11. Network should support a community benefit and not burden the Network with excessive uncompensated charity care or medical education commitments
12. Network should facilitate collaboration with the System without jeopardizing or encumbering the System’s tax-exempt status
13. Network should be able to endure over time

Network Design – Relationship to the Health System

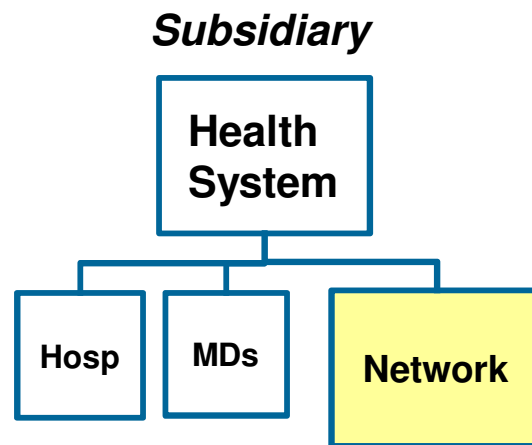
Four principal options...



Network Design: Subsidiary Model

The Subsidiary Model legal structure permits the Health System to exercise fundamental control over the operations of the CIN

- Health System serves as sole corporate member and selects the members of the Network board and has certain “reserved rights” regarding certain significant Network activities impacting its financial reporting obligations
- Ability for Health System to capitalize infrastructure and support Network without arm’s length pricing of services
- Health System plays key role in Network contracting on behalf of both Network and Health System
- Network serves as primary vehicle for clinical integration and performance payments to participants
- Network holds incentive funds and manages incentive compensation program for participants



Network Design: Legal Structure

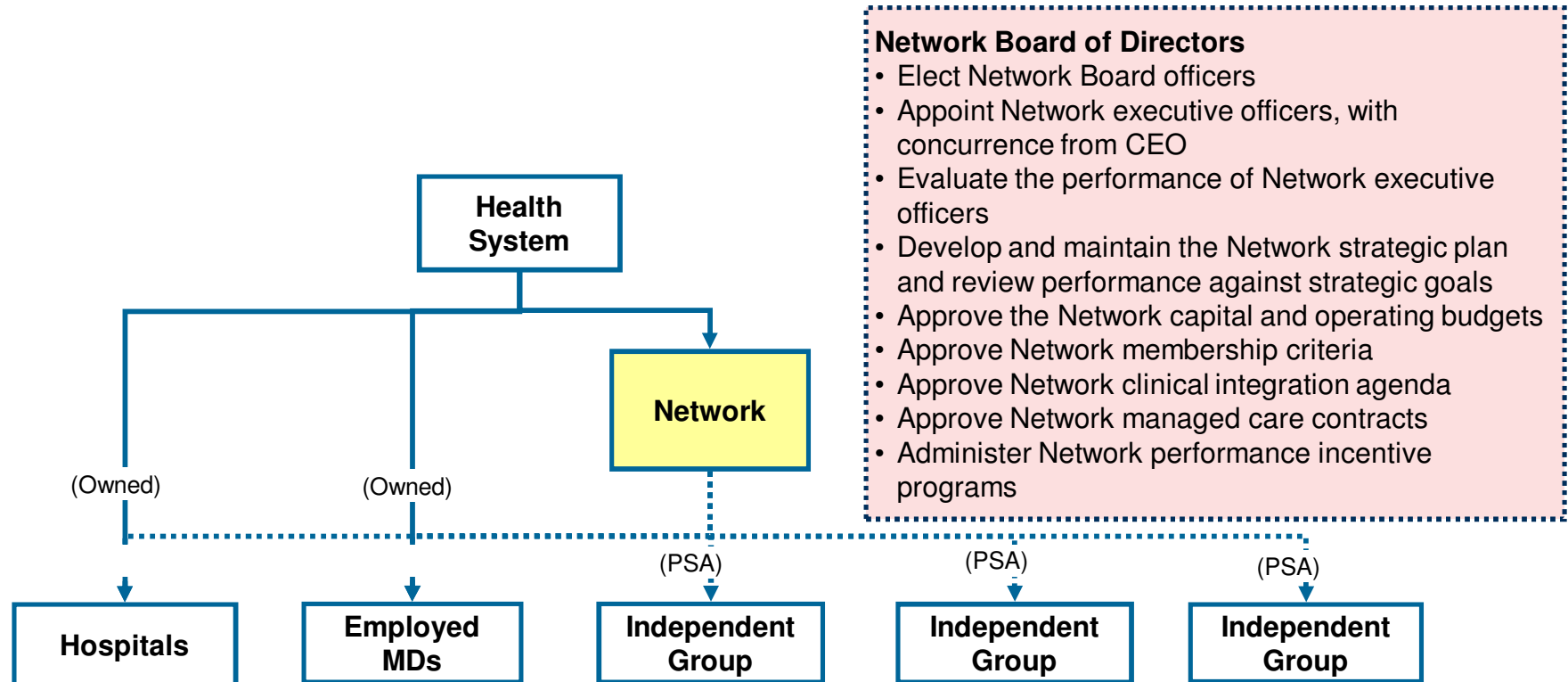
Selection of a corporate form for the Network should be based on criteria that advance its vision and strategic goals

The Corporate Structure should:

- Enable contracting by the Network and joint contracting between Health System and the Network
- Facilitate physician-driven governance / management
- Facilitate the investment of capital into the Network by Health System, in order to shield physicians from capital commitments
- Facilitate the linkage of Network operations with existing Health System programs, resources and capabilities, as well as those of related community entities
- Facilitate compensation of participating private practice physicians based on service / productivity rather than ownership
- Support a community benefit without burdening the Network with excessive uncompensated charity care or medical education commitments
- Facilitate collaboration with Health System without jeopardizing or encumbering the System's tax-exempt status
- Be able to endure over time

Network Design – Responsibilities & Reserved Powers

Governance structure under any model should balance independent, physician directed governance and management with appropriate reserved powers.



Network Board of Directors

- Elect Network Board officers
- Appoint Network executive officers, with concurrence from CEO
- Evaluate the performance of Network executive officers
- Develop and maintain the Network strategic plan and review performance against strategic goals
- Approve the Network capital and operating budgets
- Approve Network membership criteria
- Approve Network clinical integration agenda
- Approve Network managed care contracts
- Administer Network performance incentive programs

Reserved Powers

- Appoints Network Directors from candidates presented by Nominating Committee
- Approve changes to articles, bylaws or tax exempt status
- Approve merger or sale of all, or substantially all, of the Network assets
- Approve capital and operating budgets
- Approve any indebtedness of Network
- Approve appointment or removal of Network CEO

Network Design: Governance ... Key Questions

Key considerations / questions include:

- **Selection.** Should initial Board composition be “locked in” by elections for designated “seats” (“representative Board”), or should initial Board select its own replacements (“at-large Board”)?
- **Nominations Process.** How should Board members be chosen (e.g., nominating committee?)
 - Initial Board
 - Replacement Board members
- **Officers.** What leadership positions should the Board have (Chair, Secretary, Treasurer, etc.)?
 - How should leadership positions be filled?
- **Committees.** What Board Committees should be created?
 - Initially
 - As the Board matures
 - How should these Committees be designed?
 - Overlap with Board?
 - Committee Chairs?

Network Design: Governance

Designing the Network governance will require making decisions about the following:

- **Governing Board**
 - Composition
 - *Ex officio* positions
 - Terms
- **Operating Committee** (if appropriate)
 - Composition
 - *Ex officio* positions
 - Terms
- **Method of Selection**
- **Board Positions** (Chair, etc.)
- **Board Committees.** Possibilities include:
 - Nominating committee
 - Clinical Performance Management committee
 - Credentialing committee
 - Contracting / Finance committee
 - Service Line councils
- **Board Processes** (e.g., budget reviews, strategic planning)

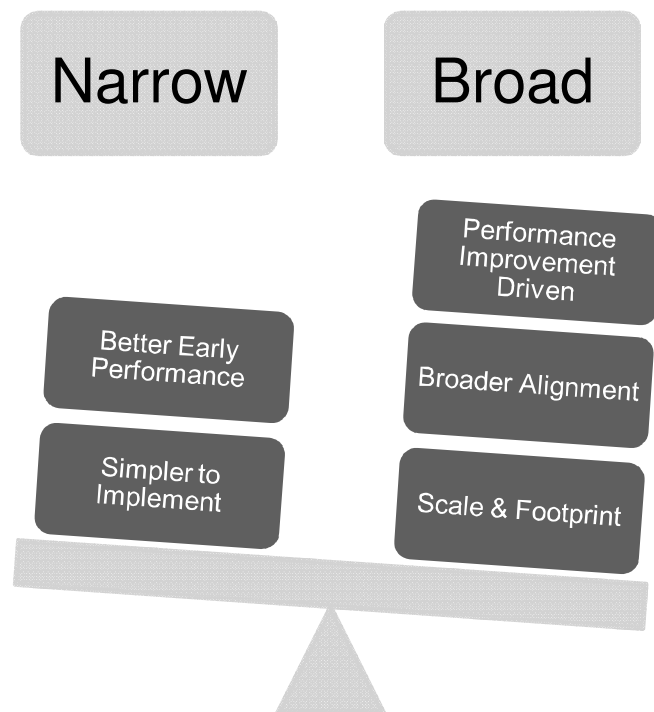
Network Design: Governance ... Objectives

The Network's governance structure should be designed to meet multiple objectives

- Ensure accountability of the Network to its members
- Balance representation of Health System vs. independent physicians; primary care vs. specialists; geographic distribution
- Provide Health System with appropriate reserve rights necessary to operate the Network
- Optimize role of physicians in both governance and management decision making, with physicians comprising a majority of board members
- Contemplate an appropriate transition from founding group to institutional representation and participation

Network Design – Membership ... Principles

Building a narrow vs. broad network is a fundamental design decision... Most networks opt to start broad and tighten participation criteria over time



- Eligibility Options
 - Minimal Requirements – All members of hospital medical staffs
 - Moderate Requirements – Board Certified or Eligible (may need to grandfather some non-Board Certified physicians who have grand-fathered hospital privileges)
 - Tight Requirement – Membership by invitation

Network Design – Membership Requirements

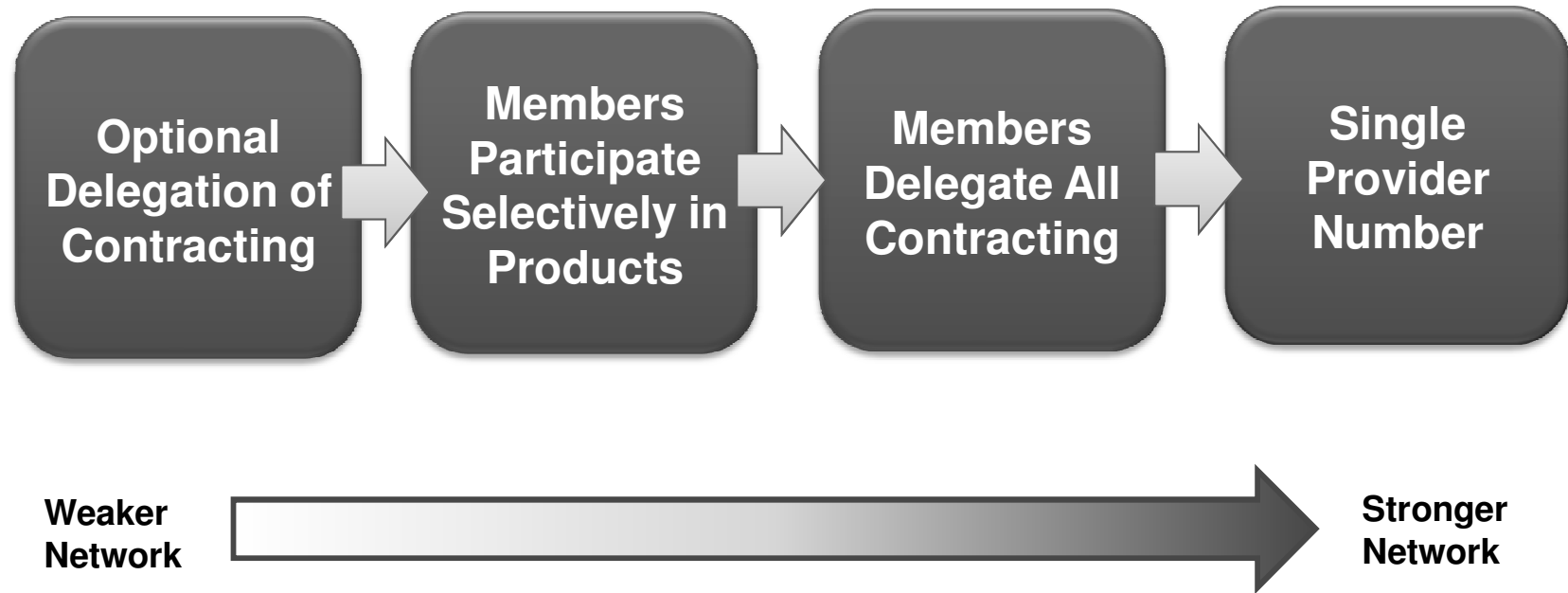
Network members agree to a number of requirements of membership

Requirement	Why
Active participation in clinical integration programs/ initiatives / measures	This is the value that the Network brings to the market... its reason for being
Maintain high speed internet connections at practice sites	Fundamental requirement for exchange of large data files
Share claims data on patients covered by Network contracts	Provide Network with the ability to both track performance and facilitate care management
Board-certified or board-eligible	Basic quality requirement
Commit to standards of access	Facilitates Network access
Commit to reasonable in-Network referral	Ensure that patients covered by Network contracts receive care consistent with Network standards and that Network is able to track clinical data
Participate exclusively where Network contracts	Ensures that Network can offer market consistent value

Generally, requirements for participation become more extensive and rigorous as the Network gains experience and performance improves

- Number of clinical integration programs / measures
- Data management requirements

Network Design – Membership ... Contracting



How One System has Responded

Overview:

- How will Non-Urban Providers fit into an ACO World?
- Physician Employment Model
- Role of the Independent Medical Staff
- Health IT
- Capitation and Beyond
- Likelihood of Success

How One System has Responded

ACOs and Rural Providers:

- 5,000 patient requirement will be barrier to entry (will patients be selected in advance and notified?)
- Most rural providers unable to provide comprehensive services without tertiary affiliation
- Typically independent medical staff model; fully integrated group practices are rare
- Lack of capital to support ACO start up cost
- Regulatory inflexibility concerns (e.g. can physicians be a part of more than one ACO?)

How One System has Responded

Physician Employment Model

- Growth in physician employment – result of recruitment strategy, not integration strategy
- Physician compensation model – historically tied to economic performance factors
- Physicians often function as independent practices, not as multi-speciality group practice
- Need to revise economic model to encourage quality, efficiency, coordination and accountability

How One System has Responded

Role of the Independent Medical Staff

- Joint Commission MS.01.01.01 at odds with ACO objectives
- AMA principles for ACOs - require physician control of governance and patient care decisions
- Use of medical staff bylaws, rules and regulations to accomplish accountable care objectives
- Will professional services agreements be necessary?

What Health Reform Means to Hospitals

Health Information Technology

- Most of the Quality Initiatives, Payment Reforms, Pilot Programs and other innovations in the comprehensive bills will require extensive IT systems
- Clinical integration will require hospitals to share same IT platform or have interface capabilities (e.g. shared Electronic Health Record, physicians utilizing same practice management and revenue cycle management systems)
- Information and Data Management will determine the real winners and losers in the aftermath of health reform
- Use of physician selected, physician developed software system to provide real time decision support

How One System has Responded

Capitation and Beyond

- Governmental and Private Payers will continue shift to Pay for Performance (P4P) models
- Looming deficit reduction effort likely to continue downward pressure on reimbursement
- Will ultimate power to drive cost reductions be held by government, insurance companies or providers?
- Ultimately only providers who are willing to follow evidence based practice guidelines will be able to survive

How One System has Responded

Why will the ACOs of today succeed when the IDSs of the 1990s Failed?

- Focus on quality and accountability (not simply cost reduction)
- Significant economic integration (e.g. physician employment) already exists independent of ACO
- OIG, FTC and DOJ have expressed support for the public policy favoring accountable delivery models
- Use of IT to measure quality performance and economic performance

Conclusion

With the passage of comprehensive Healthcare Reform Legislation, the landscape of the healthcare delivery and payment systems will be transformed over the next decade.