Presentation Overview

1) Brave New World of Healthcare: The Alignment/Integration Imperative
   - Breakdown of the Old Paradigm
   - Impact of the PPACA
   - Transition to the New Healthcare Economy
   - The Push for Integration

2) Clinical Integration Options: Review of Alternative Models

3) Next Steps: Finding the Right Model
Providers Must Navigate the Perfect Storm

Too many patients

Too little funding

Too few professionals

Too much cost

U.S.S. Healthcare System
Healthcare Spending Approaching 18% of GDP

National Health Expenditures: 1960-2010

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP)
Healthcare Inflation Rate Far Exceeds Growth in CPI

Percent Annual Increase in National Health Expenditures (NHE) per Capita vs. Increase in Consumer Price Index (CPI), 1991-2010

Annual Increase in NHE per Capita
- 8.0% in 2010
- 7.1% in 1993
- 6.2% in 1995
- 4.4% in 1999
- 4.5% in 1997
- 5.4% in 1991

Annual Increase in CPI
- 8.0% in 2010
- 7.1% in 1993
- 6.2% in 1995
- 4.4% in 1999
- 4.5% in 1997
- 5.4% in 1991
Cost of Health Insurance Becoming Unaffordable

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2012
Employer Funded Insurance Coverage Declining

Percentage of All Firms Offering Health Benefits, 1999-2012

- Estimate is statistically different from estimate for the previous year shown (p<.05).

Government Payers Now Reimburse Below Cost of Care

Average Reimbursement as Percent of Cost of Care

- Private Payers
- Medicare
- Medicaid

[Graph showing the average reimbursement as a percent of cost of care for different payers from 1998 to 2008]
Structural Impact of PPACA on Care Delivery

- Increasing measurement of quality, efficiency and value
- Reimbursement linked to quality improvement, efficient service delivery and cost reduction thru improvement
- Increasing integration of delivery systems and coordination of care across settings
- Greater use of health information technology
- Public reporting and sharing of data
- Accelerated learning among providers
Dramatic Expansion of Insured Patients Anticipated

Projected addition of 32 million insured patients through Medicaid expansion and development of health exchanges


Among 284 million people under age 65
Physicians Increasingly at a Crossroads

Eroding Practice Financials
- Declining professional fees
- Decreased ancillary reimbursement
- Rise in practice costs
- Recruitment challenges

Challenge of Pending Healthcare Reforms
- Adapting to new clinical models
- Intensified emphasis on “value” and “quality”
- Increasing reliance on EMRs
- Increased payment risk

Local Market Forces
- Formation of narrow provider panels (e.g., Banner/Aetna)
Sea Change in Practice Ownership and Control

Percentage of US Physician Practices Owned by Physicians and Hospitals

"More than half of practicing U.S. physicians are now employed by hospitals or integrated deliver systems, a trend fueled by the intended creation of accountable care organizations and the prospect of more risk-based payment approaches."

- New England Journal of Medicine (NEJM), May 2011

Source: MGMA data
Current vs. Future State of Healthcare

**Current State**
- Expensive and Inefficient
- Cost and Quality Opaque
- Fee For Service / Utilization Driven
- Inpatient Centric
- Fragmented Providers

**Future State**
- Achieve Greater Value
- Transparent and Consumer Focused
- Value Based, Outcomes Driven
- Distributed / Outpatient
- Consolidated and Integrated
**Integration Drivers for Physicians and Hospitals**

**Hospitals**
- Protect and/or grow market share in face of declining reimbursement
- Protect and/or share in downstream revenue
- Preserve existing physician practices in system
- Secure a more stable provider platform
- Create stronger negotiating position with payers
- Physician recruitment and retention
- Improve coordination of care and patient experience
- Focus on efficient delivery of quality care
- Increase physician engagement/Team approach to healthcare delivery

**Physicians**
- Declining practice reimbursement
- Increasing operating costs
- Desire to stabilize or improve compensation
- Challenges of physician recruitment (competition outbidding practices)
- Minimal interest in practice “buy-in”
- Cost of EMR and other IT technology infrastructure
- Desire to focus on quality of care
- Challenge of planning for future payment models
- Increasing complexity of practice management
- Work/life balance

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**Clinical Alignment**

**Mutual Rewards**
Alignment/Integration Options for Physicians and Hospitals

Aligning Physicians and Hospitals
October 11, 2012

SSB Solutions

PROPRIETARY AND CONFIDENTIAL
# Pre-Requisites for Successful Alignment

## Vision/Philosophy
- Create a real and substantive hospital/physician partnership
- Partnership orientation is win/win
- Mission, vision and values are well defined, well known and aligned for all parties
- Focus is patient first, integrated organization second and individual third
- Key drivers are access, service, quality and patient satisfaction

## Rules of Engagement
- Dialogue not a debate
- Meaningful dialogue requires everyone to have a stake in the process
- Must be transparent
- “No surprises” philosophy of communication among all parties

## Leadership
- Requires hospital leadership that trusts physician leadership and physician leadership that trusts hospital leadership
- Goal is integrated enterprise management
- Qualified physician leader paired with a qualified administrative leader moving in a unified direction
## Important Legal Considerations

Broadly speaking, healthcare providers assessing alignment options must consider specific areas of legal and regulatory concern.

### Market Power Concentration

- Mergers which materially reduce competition may be subject to challenge
  - Aggrieved parties usually complain, e.g., the health plans
  - No clear benchmark, but if new entity exceeds 40% of the market, that complaint might find a receptive audience
- Assessment based on market definition
  - Product of geography and competitive alternatives

### Medicare Fraud and Abuse Issues

- Anti-Kickback Statute and implications
- Stark rule and implications
- Resulting requirements
  - Cannot pay for referrals
  - Must have a fair market value (FMV) contractual arrangement (ownership has its own rules) that is:
    - Fair market value
    - Does not compensate for volume or value of referrals
    - At least one-year term

### Licensing/Regulatory Issues

- Corporate practice of medicine doctrine
- Fee splitting

### Additional Issues

- Tax implications (hospital Inurement)
  - Using of non-profit dollars to support private individuals
- State-specific restrictions
Market drivers and reimbursement shifts pushing physician/hospital alignment to clinically integrated models
## Summary of Alignment/Integration Options

<table>
<thead>
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### Sub-Section: Clinical Institute/COE

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Specialty Institute/COE Structure

Joint Leadership Council
Physician Chair

Specialty Institute
Center of Excellence

Credentialing

MEMBERS

MD Group

MD Group

MD Group

Set and monitor clinical strategy and priorities for service line
- Program development
- Clinical pathways
- Quality oversight
- Program outreach
## Specialty Institute/COE Summary

### DESCRIPTION
- Typically organized as a credentialed membership organization for physicians collaborating on growth and operational excellence of designated service line

### COE PARTICIPANTS
- Physician participants are generally:
  - Board-certified in required specialties (or seeking certification)
  - Member in good standing on the active medical staff
  - Primary clinical activities (for physician and group) are oriented
  - Aligned with CoE vision and policies
  - Fully engaged and participating in CoE clinical programs

### GOVERNANCE
- COE Leadership Council comprised of physicians and administrators with selected subcommittees (e.g., clinical affairs, business development)

### SCOPE OF SERVICES
- Elevate quality of care
- Marketing and outreach to physicians and patients
- Develop and promote care pathways based on evidence-based protocols and outcomes

### DEVELOPMENT COSTS AND OPERATING RISK
- Borne by hospital

### COMPENSATION
- Selected COE’s may compensate physicians at fair market hourly rate for their participation in planning and leadership meetings
# Sub-Section: Co-Management Services

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Co-Management Organizational Model

Hospital

SHAREHOLDERS

X%  Y%

Management Services Agreement

LLC Board

Co-Management LLC

Operating Agreement

CO-MANAGED SERVICE LINE

Management Services

Operations  Finance  Quality
Typical Flow of Fees and Incentive Payments

Incentive fees paid based on achieving specified and measureable metrics for:
- Clinical quality
- Budget-related goals
- Operational goals
- Program development

Shareholder distributions made as available and sanctioned by LLC Board of Managers
# Co-Management Summary

## DESCRIPTION
- LLC shareholder roles, responsibilities and equity interests described in a negotiated Operating Agreement
- LLC contracts with hospital to provide defined services focused on improving the operational and clinical performance of the designated service line

## LLC PARTICIPANTS
- Physician/group participants typically required to satisfy certain criteria to qualify for an ownership interest in Co-Management LLC. Normally inclusive of all qualified physicians on the medical staff.

## GOVERNANCE
- Board of Managers appointed by the shareholders manages clinical and business affairs of subject to the terms of the Operating Agreement.

## SCOPE OF SERVICES
- Co-Management LLC is typically responsible for:
  - Quality management and defined clinical protocols
  - Service line strategic planning and associated budgets
  - New program development
  - Medical director services
  - Oversight of staffing, equipment, and supply/purchasing plans
  - Marketing strategies

## DEVELOPMENT COSTS AND OPERATING RISK
- Development costs are split pro-rata between the LLC shareholders.

## COMPENSATION
- Management Services Agreement typically divides LLC compensation between:
  - Base fees to cover LLC administrative costs
  - Incentive fees based on reaching or surpassing defined clinical and operational performance metrics
### Sub-Section: Specialty CIO

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Spotlight on Terminology: CIO vs. ACO

Clinically Integrated Organizations (CIO)

Accountable Care Organization (ACO)

CIO’s are state-based, legal entities typically comprised of physicians, hospital and other providers structured to hold value-based payer contracts.

Must be structured and organized to meet FTC criteria for “meaningful clinical integration”

ACO technically refers to a state based entity that qualifies for participation in the Medicare Shared Savings Program defined in the PPACA. However, term has been used more generically to broadly encompass same concept as CIO.
FTC Criteria for Meaningful Integration

Hospitals and Employed Physicians

Entity structure defined by agreements

Independent Physicians

FTC Organizational Criteria

1) Services encompass full continuum of care
2) Includes key physicians able to drive clinical quality and efficiency
3) Develops and uses pathways and protocols to meet quality and efficiency standards
4) Committed to development of IT infrastructure (clinical and financial) to support improved care delivery

FTC Approval Enables Entity to Contract for Value-Based Services

Payers

Base Reimbursement
Shared Savings
Performance Incentives
CIO/ACO Organizational Structure

Payers

Value-based contracts

LLC Board of Managers

Accountable Care LLC

Network Management Services

Solution Vendor A

Solution Vendor B

Solution Vendor C

Physician Group(s)

Hospital

X% Y%

Value-based contracts

Payers

X% Y%

Solution Vendor A

Solution Vendor B

Solution Vendor C

Physician Group(s)

Hospital

Network Management Services
## CIO/ACO Summary

### DESCRIPTION
- Shareholders form LLC to manage the health, quality of medical services and resource utilization of a designated population
- LLC enters into value-based contracts with payers that provide financial incentives for achieving designated clinical and financial performance targets (e.g., shared savings, bundled payments, pay-for-performance)
- Supported by IT connectivity, data collection and analytics, the organization develops and monitors physician performance, care protocols and resource use to optimize quality and efficiency
- Shareholder roles, responsibilities and equity interests described in an Operating Agreement negotiated between by the parties

### CIO PARTICIPANTS
- Physicians and other key providers with opportunity to have substantial impact on care delivery and management for the designated population

### GOVERNANCE
- Board of Managers appointed by shareholders will manage the business, subject to the terms of the Operating Agreement

### SCOPE OF SERVICES
- Can either be comprehensive medical or specialty specific, but in either case, they must span care continuum (inpatient and outpatient)
CIO/ACO Summary

DEVELOPMENT COSTS AND OPERATING RISK

- Physician participants and hospital will be required to fund a pro-rata portion of the initial LLC’s capitalization requirements
- On-going operating overhead for Accountable Care’s LLC are taken into consideration in pricing the service under the MSA

COMPENSATION

- Periodic, pro-rata distribution to shareholders of shared savings and performance bonuses earned from payers
  - May be driven by compensation algorithm that also weights individual physician performance monitored by CIO
## Sub-Section: Hospital Employment

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### Employment (plus variations)

Employment, by a hospital-sponsored medical group
Options for Physician Employment

**OPTION A: DIRECT EMPLOYMENT BY HOSPITAL**

- Physician Group
- Sale of Practice Assets
- Hospital
- Physicians and Employees
- Employment agreements

**OPTION B: EMPLOYMENT BY SUBSIDIARY OF HOSPITAL**

- Physician Group
- Sale of Practice Assets
- Hospital
- LLC Subsidiary*
  - (Hospital sole member)
- Physicians and Employees
- Employment agreements
- LLC Board of Managers
**Direct Employment Summary**

<table>
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<tr>
<th>DESCRIPTION</th>
<th>• Physician(s) employed by hospital/health system following practice acquisition, either as direct employees or as part of a hospital-sponsored medical group (HSMG)</th>
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<td>GOVERNANCE</td>
<td>• HSMG typically governed by physician-led board of directors, accountable to the parent organization’s board</td>
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<td>COMPENSATION</td>
<td>• Physician employment contracts can include an income guarantee for a specific period of time, base salary, and productivity and performance incentive pay</td>
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| OTHER BENEFITS | • Creates stable and predictable platform for practice of medicine  
• Greatest flexibility to design a clinical and business model that rewards effort devoted to clinical program management, quality improvement, administrative leadership, etc.  
• Provides an environment to leverage administrative infrastructure, information technology (e.g., EMR), and next-generation patient-care models  
• Opportunity for meaningful participation in group governance  
• Provides leadership and resources to position for future payment reform and new reimbursement models |