How to put Clinically Integrated Networks to Work in an Era of Value Based Reimbursement

Foundation of the American College of Healthcare Executives
for leaders who care

2016 CONGRESS ON HEALTHCARE LEADERSHIP

MARCH 14–17, 2016
HYATT REGENCY CHICAGO

LEADING WELL

Presenters

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Learning Objectives

Lessons Learned from Three Perspectives:

- Identify the key challenges arising under value-based reimbursement models when structuring clinically integrated networks
- Develop the necessary legal and financial strategies for use in negotiations with payors to meet these challenges and successfully develop and implement a clinically integrated network

Agenda

- Present an overview of potential structures of clinically integrated networks (CINs)
- Identify issues arising under value-based contracts with payors, employers, and health systems
- Discuss the challenges in implementing value-based reimbursement methodologies
- Provide tips and resources for combating significant financial issues relating to CINs' maintenance of compliance with applicable law
- Discuss top strategies to successfully implement value-based reimbursement methodologies

Three Perspectives on CINs

- Operational/Strategic
- Regulatory/Compliance
- Value Metrics

Clinically Integrated Networks:

Why are they Important?

What are they?

CINs: Why Important?

New FMV Opinion Needs for a Professional Services Participation in CINs (and Accountable Care Organizations) Future Initiatives and Developments

- Analysis will vary by specific situation and actual agreement for both employed and affiliated physician – but professional service participation requirements should include:
  - Identifying the number of clinical physician FTEs required to support the CIN and health systems in specific clinical services
  - Identifying regulatory exceptions for alternative compensation and service arrangements
  - Documenting the proposed and actual performance metrics
  - Determining emerging compensation levels to appropriate "newly emerging" regional and national benchmarks
  - Developing performance-based payment criteria and payout rates that include both "*service delivery and incentives*" (i.e., like a third party payor and employer)

CINs: Why Important?

- Value-Based Reimbursement (VBR):
  - U.S. Department of Human and Health Services' (HHS) initiative to transfer large share of Medicare to VBR
    - Goal to tie 30% of Medicare payments to value by the end of 2016, and 50% by the end of 2018 through alternative payment models, "*such as Accountable Care Organizations (ACOs) or bundled payment arrangements*"
    - Goal to tie 85% of Medicare payments to value by 2016, and 90% by 2018 through programs, such as the *Hospital Value Based Purchasing* and the *Hospital Readmissions Reduction* Programs

"Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value" U.S. Department of Health and Human Services, January 26, 2015 (Accessed 3/12/15).

CINs: Why Important?

- Medicare VBR Programs
  - Next Generation ACOs
  - Bundled Payments for Care Improvement (BPCI) Initiative
  - Physician Value Based Payment Modifier (PVBM)
  - Hospital Value-Based Purchasing Program
  - Hospital Readmissions Reduction Program
  - Hospital Acquired Conditions (HAC) Reduction Program
  - Comprehensive Care for Joint Replacement (CJR) Program

CINs: Why Important?

- Population Health
  - "*[T]he health outcomes of a group of individuals, including the distribution of such outcomes within the group*"
  - Lowers healthcare costs
  - Increases efficiency

"What Is Population Health?" By David Kindig and Greg Stoddart, American Journal of Public Health, Vol. 93, No. 3. (March 2003), p. 381.

CIN Definition(s)

- American Medical Association (AMA) describes clinical integration as the means to facilitate the coordination of care across conditions, providers, settings and time in order to achieve care that is safe, timely, effective, efficient, equitable and patient-focused.
- American Hospital Association (AHA) describes clinical integration as the means to facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused. Given the fragmentation within the healthcare system, coordination of care between providers has both economic and quality benefits.

"Insight Paper: Considerations for Clinical Integration" By Jason Goldwater, VP of Programs and Research eHealth Initiative, and Larry Yuhasz, Director, New Market Initiatives at Truven Health Analytics (Accessed 12/28/2015); "Clinical Integration" American Health Association, http://www.aha.org/advocacy-issues/clininteg/index.shtml (Accessed 12/28/2015).

CIN Definition(s)

- Federal Trade Commission (FTC) states that clinical integration as is used to describe certain types of collaboration among otherwise independent health care providers to improve quality and contain costs. The 1996 joint FTC/Department of Justice Statements of Antitrust Enforcement Policy in Health Care expressly recognize the potential benefits of this type of integration, and that more-extensive antitrust analysis of the competitive effects of such arrangements may be warranted where collective negotiation and contracting with payers is reasonably necessary to achieve clinical efficiencies.
- In 1996, the Department of Justice and the FTC defined CI as an active and ongoing program to evaluate and modify practice patterns by the CI network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Generally, the FTC considers a program to be clinically integrated if it performs the following:
  - 1. Establishes mechanisms to monitor and control utilization of healthcare services that are designed to control costs and ensure quality of care.
  - 2. Selectively chooses CI network physicians who are likely to further these efficiency objectives.
  - 3. Utilizes investment of significant capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 1996), *available at* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm, https://www.ftc.gov/news-events/press-releases/2008/03/federal-trade-commission-host-workshop-health-care-clinical, https://www.ftc.gov/news-events/events-calendar/2008/05/clinical-integration-health-care-check (Accessed 12/28/2015).

CIN Spectrum

Less Integrated — More Integrated

Bundled payment for single episode of care	Bundled payment for chronic care management	Clinically Integrated PHO	Medical staff includes both employed and independent physicians	Medical Staff includes only (or almost only) fully-employed physicians
• Fairview Health (Minneapolis) • Geisinger Proven Care Program for Coronary Artery Bypass Graft Surgery (Danville, PA)	• Fairview Health (Minneapolis) • Sutter Health (California) • Park Nicollet Health (Minneapolis)	• Advocate Health Care (Chicago) • Tri-State Health (Maryland)	• Presbyterian Health (Albuquerque) • Virginia Mason Hospital (Seattle) • Geisinger Hospital (Danville, PA) • Intermoutain Health Care (Utah)	• Cleveland Clinic (Ohio) • Billings Clinic (Montana) • Kaiser Permanente (multi-state)

"Clinical Integration the Key to Real Reform" American Hospital Association, Trendwatch (February 2010), p. 7.

Clinically Integrated Networks:

Regulatory Considerations

Regulatory Considerations

Law	What Is Prohibited?	The Concern Behind the Law	Unintended Consequences	How to Address?
Antitrust (Sherman Act §1)	Joint negotiations by providers unless ancillary to financial or clinical integration; agreements that give health care provider market power	Providers will enter into agreements that either are nothing more than price-fixing, or which give them market power so they can raise prices above competitive levels	Deters providers from entering into procompetitive, innovative arrangements because they are uncertain about antitrust consequences	Guidance from antitrust enforcers to clarify when arrangements will raise serious issues. DOJ indicated it will begin a review of guidance in Feb. 2010.
Ethics in Patient Referral Act ("Stark Law")	Referrals of Medicare patients by physicians for certain designated health services to entities with which the physician has a financial relationship (ownership or compensation)	Physicians will have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient's best interest	Arrangements to improve patient care are banned when payments tied to achievements in quality and efficiency vary based on services ordered instead of resting only on hours worked	Congress should remove compensation arrangements from the definition of "financial relationships" subject to the law. They would continue to be regulated by other laws.
Anti-kickback Law	Payments to induce Medicare or Medicaid patient referrals or ordering covered goods or services	Physicians will have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient's best interest	Creates uncertainty concerning arrangements where physicians are rewarded for treating patients using evidence-based clinical protocols	Congress should create a safe harbor for clinical integration programs
Civil Monetary Penalty	Payments from a hospital that directly or indirectly induce physician to reduce or limit services to Medicare or Medicaid patients	Physicians will have incentive to reduce the provision of necessary medical services	As interpreted by the Office of Inspector General (OIG), the law prohibits any incentive that may result in a reduction in care (including less expensive products)…even if the result is an improvement in the quality of care	The CMP law should be changed to make clear it applies only to the reduction or withholding of medically necessary services

"Clinical Integration – The Key to Real Reform" American Hospital Association, Trendwatch (February 2010), p. 11.

Regulatory Considerations

Law	What Is Prohibited?	The Concern Behind the Law	Unintended Consequences	How to Address?
IRS Tax-exempt Laws	Use of charitable assets for the private benefit of any individual or entity	Assets that are intended for the public benefit are used to benefit any private individual (e.g., a physician)	Uncertainty about how IRS will view payments to physicians in a clinical integration program is a significant deterrent to the teamwork needed for clinical integration	IRS should issue guidance providing explicit examples of how it would apply the rules to physician payments in clinical integration programs
State Corporate Practice of Medicine	Employment of physicians by corporations	Physician's professional judgment would be inappropriately constrained by corporate entity	May require cumbersome organizational structures that add unnecessary cost and decrease flexibility to achieve clinical integration	State laws should allow employment in clinical integration programs
State Insurance Regulation	Entities taking on role of insurers without adequate capitalization and regulatory supervision	Ensure adequate capital to meet obligations to insured, including payment to providers, and establish consumer protections	Bundled payment or similar approaches with one payment shared among providers may inappropriately be treated as subject to solvency requirements for insurers	State insurance regulation should clearly distinguish between the risk carried by insurers and the non-insurance risk of a shared or partial risk payment arrangement
Medical Liability	Health care that falls below the standard of care and causes patient harm	Provide compensation to injured patients and deter unsafe practices	Liability concerns result in defensive medicine and can impede adoption of evidence-based clinical protocols	Establish administrative compensation system and protection for physicians and providers following clinical guidelines

"Clinical Integration – The Key to Real Reform" American Hospital Association, Trendwatch (February 2010), p. 11.

Regulatory Considerations

- Antitrust laws
  - e.g., collective bargaining
  - "*Safety Zones*" published by FTC
- Corporate Practice of Medicine
  - Corporation employment of physicians (some argue that "*State laws should allow employment in clinical integration programs*")

"Statements of Antitrust Enforcement Policy in Health Care" By the U.S. Department of Justice and the Federal Trade Commission, April 1996 (Accessed 12/28/15).
"Clinical Integration – The Key to Real Reform" American Hospital Association, Trendwatch (February 2010), p. 11.

Regulatory Considerations

- Anti-Kickback Statute
  - Physician participation agreements should strive to comply with the personal services and management contracts safe harbor, which has seven standards that must be met
  - Need to make sure that physician participation agreement terms are properly set in advance, don't exceed *fair market value* (FMV) and are *commercially reasonable*
  - Exception allows for hospitals to assist providers in developing *electronic health records* (EHRs)
    - But "*does not allow hospitals to share hardware or completely subsidize connectivity and software*"

"Exceptions" 42 C.F.R. § 1001.952(d) (October 4, 2007).
"Legal Challenges and Concerns With Clinical Integration" By Edward Matto and Claire Turcotte, Brucjer & Eckler LLP, https://www.healthlawyers.org/Events/Programs/Materials/Documents/IHC13/legalresources/BricklerEckler_materials.pdf (Accessed 12/28/15).
"Clinical Integration – The Key to Real Reform" American Hospital Association, Trendwatch (February 2010), p. 3.

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"Clinical Integration – The Key to Real Reform" American Hospital Association, Trendwatch (February 2010), p. 3.

Regulatory Considerations

- ACO Waivers
  - CMS published a final rule in 2015 that "*finalizes waivers of the application of the [Stark Law], the Federal anti-kickback statute, and the civil monetary penalties (CMP) law provision relating to beneficiary inducements to specified arrangements involving [ACOs] under the [Medicare Shared Savings Program]…*"
    - Due to legislative changes occurring after the initial publication of the ACO waivers, the final rule "*…does not finalize waivers of the application of the CMP law provision relating to 'gainsharing' arrangements.*"

"Medicare Program; Final Waivers in Connection With the Shared Savings Program" Federal Register Vol. 80, No. 209 (October 29, 2015), p. 66726.

Regulatory Considerations

- ACO Waivers
  - Specifically, the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) amended the gainsharing CMP such that only incentives for the reduction of medically necessary services are prohibited (previously, the statute read that an incentive to reduce any services was prohibited, implying that hospitals could not reward physicians for eliminating wasteful or unnecessary services).
  - As such, CMS decided that a waiver of the amended gainsharing CMP was unnecessary

"Medicare Program; Final Waivers in Connection With the Shared Savings Program" Federal Register Vol. 80, No. 209 (October 29, 2015), p. 66729.
"Civil Monetary Penalties" 42 U.S.C. § 1320a-7a(b)(1) (2013).

Clinically Integrated Networks:

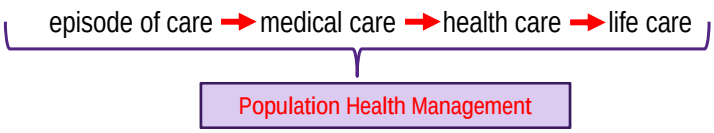
Opportunities and Challenges

Opportunities and Challenges: An Executive's Perspective

1. Setting up the Right Provider Network
2. Setting up the Right Short-Term and Long-Term Networks and CIN Infrastructure
3. Establishing the Appropriate Patient Safety and Quality Incentive Metrics and Measurements for Value-Based Services and Reimbursement
4. Define and Delineate the Funds Flow Into and Out of the CIN
5. Delineation and Differentiation of the Management of the Service Attribution, Network Services, Direct Medical Service and Incentive Value-Based Payment Criteria from the CIN to Network Participants
6. Market Maturity, Risk Tolerance Migration and Achievements of the CIN over time

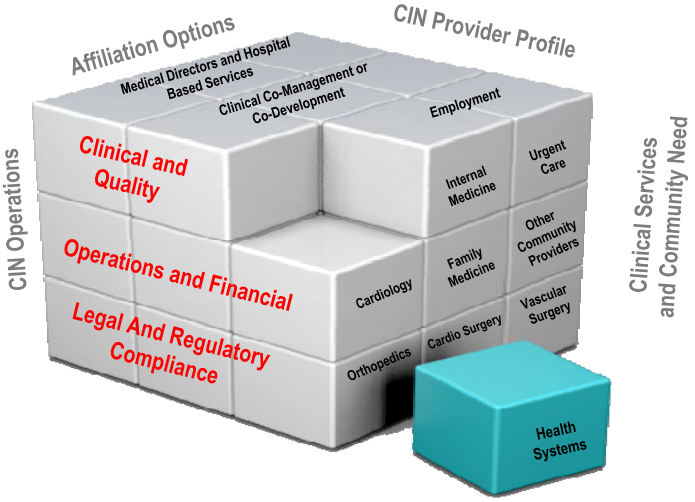
Community and Service Profile

- What has your current investment been in Quality Systems, CINs, ACOs, etc.
- Assess Market Maturity – Culture, Provider Profile, Existing Organizations, etc.
- Who are the Players: Population, Employers, Payors, Providers and Patients
- Avoid Redundancy and Replication of Efforts
  - Existing Legal Organizations and Cross Functions within Organizations
  - Invested Capital
  - Infrastructure
- Status of Quality, Care Delivery and Reimbursement
- How you can Reform or Transition the Current Market to Population Health:

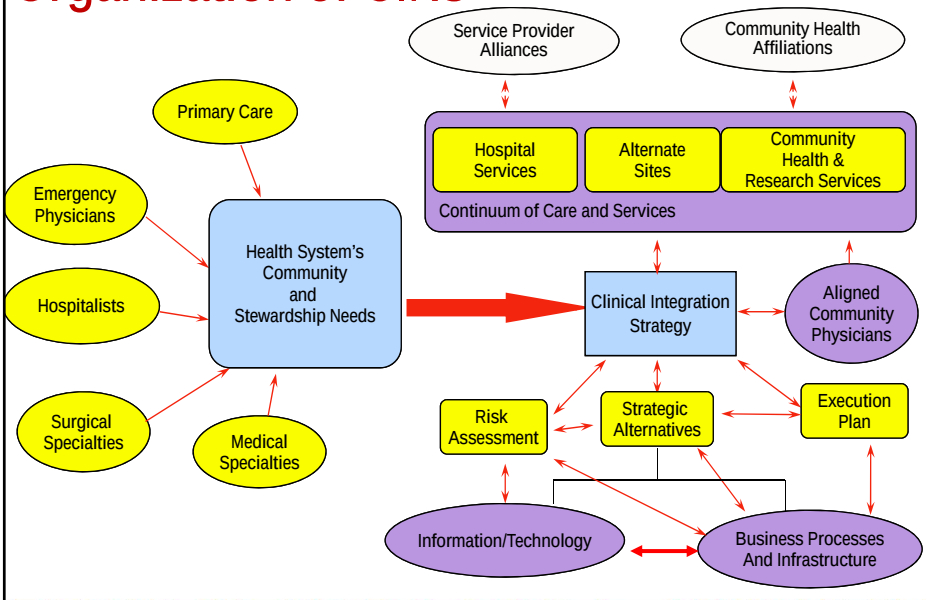


Population Health Management

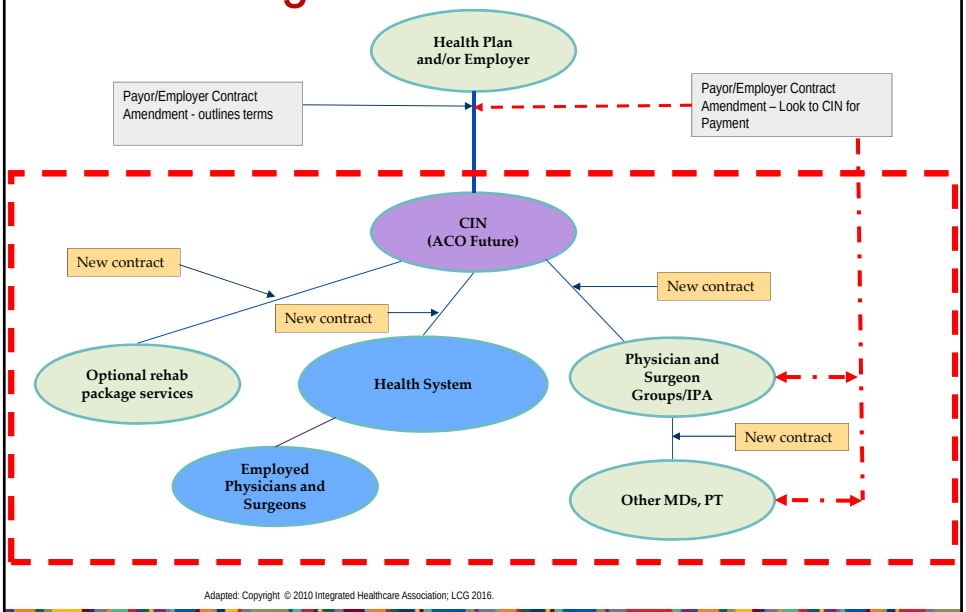
3-D Perspective of Clinical Alignment and Integration



Organization of CINs



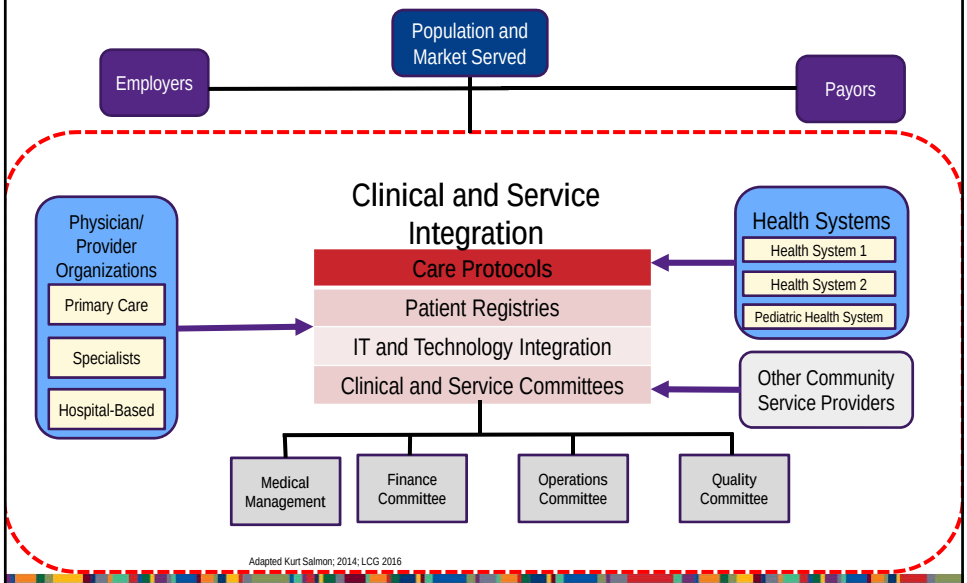
Contracting Model – CIN



Clinically Integrated Networks:

Clinical, Operational and Financial Considerations

Organization of CINs



Adapted Kurt Salmon; 2014; LCG 2016

Organization of CINs

Organizational Structure	Example 1	Example 2	Example 3	Example 4
Joint Venture	IDN affiliating with another hospital/CIN	PCMH combining with a multispecialty group practice	CIN merging with a medical home/ multispecialty group practice	
Physician-Owned	Independent Physician Association (IPA)	Multispecialty Physician Group	Physician Hospital Organization (PHO)	Group Practice Subsidiary Model
Hospital-Owned	ACO	Integrated Delivery Network (IDN)	Professional Services Agreement (PSA)	Independent Contractor Status (i.e., 1099)

"New Trends in Hospital/Physician Integration" By Daniel Stech and Curt Chase, Husch Blackwell Sanders, http://www.huschblackwell.com/~/media/files/businessinsights/businessinsights/2010/03/weathering%20the%20storm%20critical%20legal%20%20operational__/files/powerpoint%20presentation/fileattachment/healthcare_2010_denver_presentation.pdf (Accessed 1/6/2016). "Healthcare Valuation: The Financial Valuation of Enterprises, Assets, and Services," By Robert James Cimasi, MHA, ASA, MCBA, FRICS, CVA, CM&AA, Hoboken, NJ: John Wiley & Sons, 2014, p. 622. "Developing an Effective Clinically Integrated Network: Part One," Justin Chamblee, Aimee Greeter, and Max Reiboldt, Coker Group, April 2013, p. 27-28, 6, 7, 11.

Organization of CINs: Payor-Owned/Managed

- A commercial payor directly contracts with physicians to create a physician CIN, which then negotiates with a hospital for inpatient services
- The payor would likely provide the financial support for infrastructure

CIN Documentation Checklist

- Governance Documents
- Provider Participation Agreements
- Policies & Procedures

Provider Participation Agreements

- "*[The Participation Agreement] governs the physician members' relationship with the CIN. It serves as the link between the providers and the CIN.*"
- Agreement's form will be dependent on the structure of the arrangement
- Agreement may be an addendum to an existing employment agreement

"The Nuts & Bolts of Establishing a Clinically Integrated Network" By Michael F. Schaff and Gregory D. Anderson, AHLA, February 2, 2015, https://www.healthlawyers.org/Events/Programs/Materials/Documents/PHS15/g_anderson_schaff.pdf (Accessed 1/6/2015).

Provider Participation Agreements

- Decision Points
  - Quality/performance metrics
    - May require providers to collect/share data through the IT infrastructure, which may also be coordinated through the Participation Agreement (helps show financial integration)
  - Could charge an entry fee to physicians (may be helpful in the eyes of the FTC)
  - May make Agreement an Exclusive Provider Agreement

"The Nuts & Bolts of Establishing a Clinically Integrated Network" By Michael F. Schaff and Gregory D. Anderson, AHLA, February 2, 2015, https://www.healthlawyers.org/Events/Programs/Materials/Documents/PHS15/g_anderson_schaff.pdf (Accessed 1/6/2015).

Provider Participation Agreements

- Decision Points
  - Degree of authority
    - Usually the CIN will be authorized to enter into payor agreements for the physicians
    - If physicians are not exclusive providers for CIN, a process will have to be implemented for dealing with those payors with whom the provider already works

Capital Funding of a CIN

- Funding of investment capital to create CIN
  - May require physicians to pay fee to join CIN
  - Initial investments:
    - Information technology
    - Professional and legal support
    - Staffing
  - CIN investment capital may be between $500,000 and $3 million
  - Will likely not experience ROI for 2-3 years
- Funding which flows through contracts
- Fair market value, commercial reasonableness

"Asked & Answered: 3 Questions About Funding Clinical Integration," By Daniel J. Marino, Health Directions, http://cdn2.hubspot.net/hub/161605/file-502089257-pdf/Original_HD_Publishing/3_Questions_About_Funding_Clinical_Integration.pdf (Accessed 3/23/15).

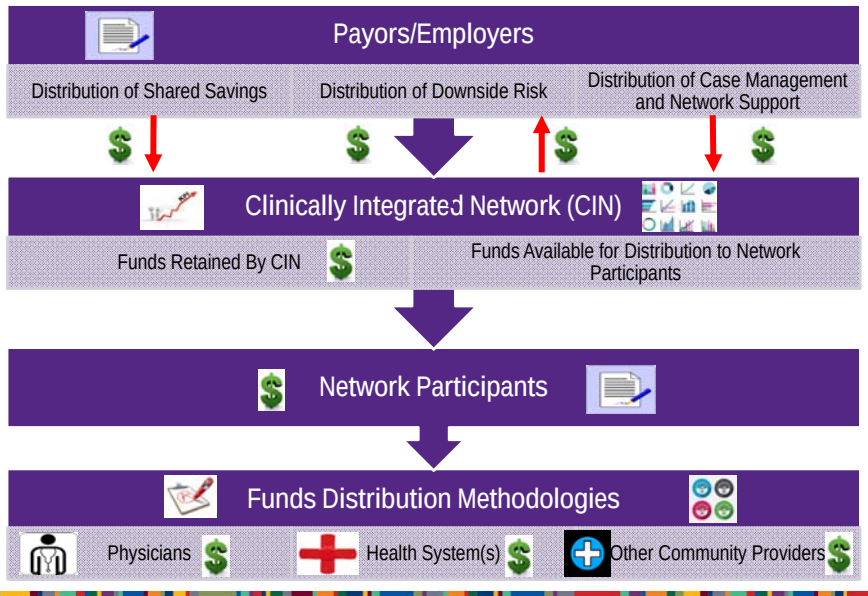
Funds Flow Consideration

- CIN Formation – Invested Capital to Create
  - Majority of $eed Monies and $ourcing from Hospitals and Health Systems (and from payors)
  - Reformation of Existing Organizations or Community Entities (e.g., IPAs, PHOs, etc.)
- CIN Revenue Sources

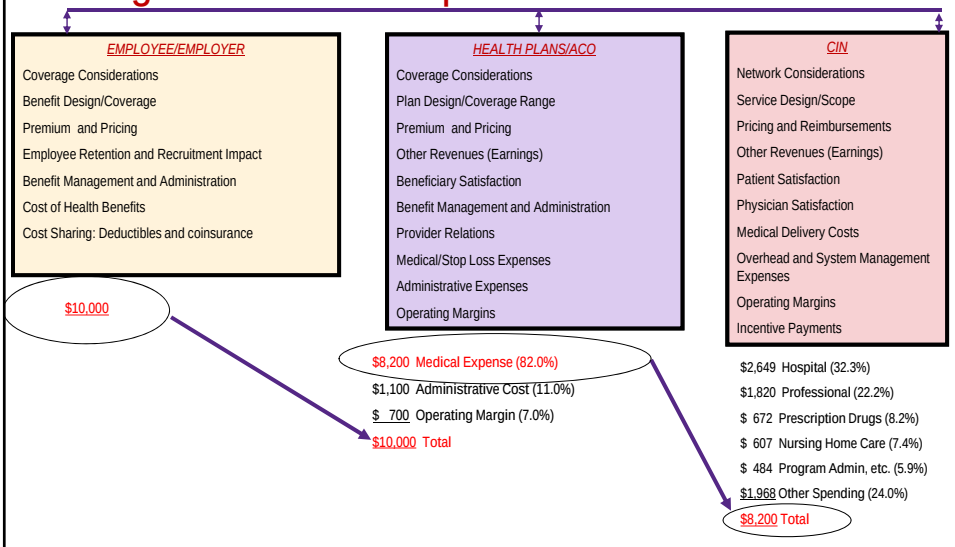
  Sources of Funds:
  - Equity Contributions
  - Membership Fees
  - Distinct Medical and Health Care Services: Payor Contracts and Employer Self-Funded Contracts
  - Administrative and Care Coordination: Network Management, Nurse and Other Care Navigators and Clinical Protocols
  - Incentives: Shared Savings, Reporting Incentives and Performance Incentives

  Use of Funds:
  - Building the Network and Related Infrastructure
  - Ongoing Operating Costs
  - Service and Incentive Reserves
- Service Attribution, Network Services, Medical Service and Incentive Payment Considerations from the CIN to Network Participants

Funds Flow Consideration



Linkage and Relationship of Health Care Stakeholders

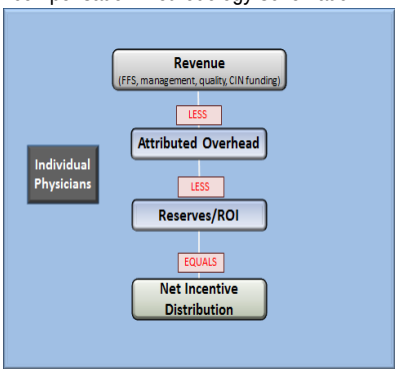


Positioning for CIN and Episode-of-Care Payments

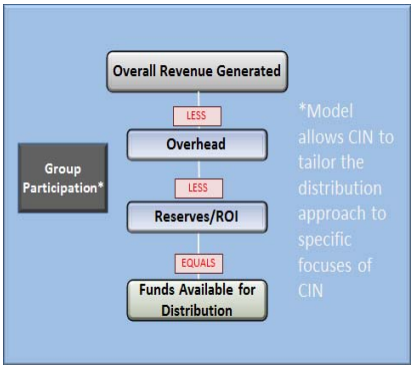
1. Creating a Case Rate for Each Provider in Each Phase of an Episode of Care
   - e.g., paying each physician/provider a single fee for a patient's hospital stay
2. Including a Warranty in Each Provider's Case Rate
   - e.g., including the cost of any related hospital readmissions in the hospital's DRG payment
3. Bundling Case Rates for All Providers in a Particular Phase of an Episode of Care
   - e.g., paying a single fee to both the hospital and physicians managing the hospital stay
4. Bundled Rates with Warranties
   - e.g., paying a single fee to the hospital and physicians, covering the initial admission and readmissions
5. Combining the Case Rates for all Phases of an Episode
   - e.g., paying a single fee for both inpatient and post-acute care

Compensation Methodologies

Individual physician incentive compensation methodology schematic



Group participation incentive compensation methodology schematic

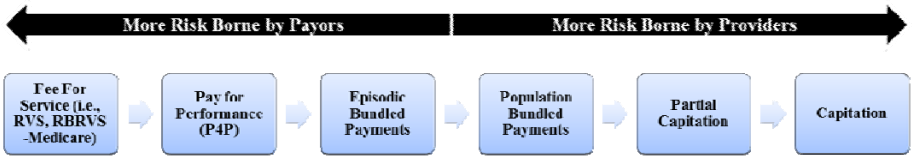


"Developing an Effective Clinically Integrated Network: Part Two," Max Reiboldt, et al., Coker Group, July 2013, p. 15, 16.

CIN and Participant Risk Tolerance

Risk and Market Considerations	Payment Options & Benefit and Network Designs
Upside Risk Only	• P4P • Non-FFS, Non-Visit Payments • Shared Savings
Upside and Downside Risk	• Bundled Payment • Condition-Specific Capitation • Partial Capitation • Full Capitation with Quality/Global Payment • Shared Risk Model (with Shared Savings)
Downside Risk Only	• Non-Payment
Consumer Shift to High Value Care	• Price and Quality Transparency • Reference/Value Pricing • Centers of Excellence • Evidence-Based Plan Design & V-BID • Consumer Directed Health Plans • Tiered and Narrow Network Plans • High Cost Case Management
Regulatory Options	• Rate Setting • Health Plan Oversight • Mandatory Public Reporting/Data Submission

Reimbursement Methodologies



CIN Participant Revenue

- Points of Consideration
  - Was the revenue arrangement set forth in writing and agreed to in advance by the CIN and the CIN participants?
  - What are the economic inputs that the providers are providing to the CIN?
  - What are the *tasks, duties, responsibilities, and accountabilities* (TDRAs) of each CIN provider?
  - Do the CIN providers have physical timesheets upon which these TDRAs are reflected?
  - Productivity basis for revenue sharing

Clinically Integrated Networks:

Why Participate?

Potential Services Offered by CIN to Members

- "*Operate disease registries/data analytics.*
- *Implement evidence-based medicine practices/population health improvement strategies.*
  - *Identify and develop practice protocols (e.g., align with payor-required measures).*
  - *Support protocol implementation & adherence (e.g., education, technology solutions)*
  - *Monitor protocol compliance (reporting on quality measures).*
  - *Implement corrective action for protocol noncompliance.*
- *Establish chronic disease management/patient navigator programs.*
- *Develop transitional care management program (based on new Medicare Physician Fee Schedule payment for post-discharge transitional care management).*
- *Implement medication therapy management programs*."

"Clinically Integrated Networks: Who, What, When, Where, Why, and How?" PYA, PYALeadership Briefing (April 2013), p. 7.

Potential Services Offered by CIN to Members

- "*Provide Physician Quality Reporting System support for physician members (e.g., education, abstracting, and technology solutions).*
- *Provide CMS Maintenance of Certification program support for physician members (e.g., CME opportunities, practice assessment, attestations).*
- *Develop patient education and engagement strategies and tools (e.g., shared decision-making).*
- *Explore clinical co-management arrangements and/or gain-sharing opportunities (hospital service line quality and efficiency improvement programs with financial rewards to physicians if program meets specified targets).*"

"Clinically Integrated Networks: Who, What, When, Where, Why, and How?" PYA, PYALeadership Briefing (April 2013), p. 7.

Clinically Integrated Networks:

Examples

Example: Norman PHO

- *Norman Physician Hospital Association* (Norman PHO)
  - 280 Physicians
  - 38 medical specialties
  - 388-bed Norman Regional Health System
  - *Federal Trade Commission* (FTC) approved the proposal on February 13, 2013 (first advisory opinion on a proposed CIN since the enactment of the *Patient Protection and Affordable Care Act* (ACA))
    - FTC explicitly reserved the right to revoke approval if future implementation of the program, "*results in substantial anticompetitive effects, if . . . used for improper purposes, if facts change significantly, or if it otherwise would be in the public interest to do so*."

"Re: Norman PHO Advisory Opinion" By Markus H. Meier, Letter to Michael E. Joseph and McAfee & Taft, February 13, 2013 (Accessed 12/28/15), p. 3, 20, 21.
"Beyond ACOs: FTC Provides Another Path to Coordinated Care" By Joe Carlson, Modern Healthcare, March 9, 2013, http://www.modernhealthcare.com/article/20130309/ MAGAZINE/303099969/&template=# (Accessed 12/28/15).

Example: Norman PHO

- Included among the clinical integration plan elements proposed by the Norman PHO are:
  - New organizational structure to support clinically coordinated care
  - Obligatory practitioner agreements for participating providers
  - Regular physician quality and performance audits
  - Physician-developed, evidence-based clinical practice guidelines
  - Implementation of an electronic platform supported by a medical informatics officer

"Beyond ACOs: FTC Provides Another Path to Coordinated Care" By Joe Carlson, Modern Healthcare, March 9, 2013, http://www.modernhealthcare.com/article/20130309/ MAGAZINE/303099969/&template=# (Accessed 3/11/2013).

Example: Norman PHO

- FTC decision provides helpful guidance and encouragement to other provider networks that may choose to forgo an ACO model in lieu of alternate integration models in an effort to adhere to changing clinical and quality outcomes in the era of healthcare reform
- These proposed integration elements may potentially provide value to:
  - Patients, through reduced medical errors, earlier disease detection, more timely communication and scheduling, elimination of unnecessary and duplicative paperwork and tests
  - Payers, through centralized administrative work, elimination of duplication of services, avoidance of preventable hospitalization, and lower costs of care
  - Providers, through more timely receipt of protected health information (PHI) and scheduling of services, more streamlined referrals, and reduced paperwork

Example: Norman PHO

- Potential pitfalls in the Norman PHO integration plan:
  - Maintaining a nonexclusive structure
  - Avoiding vertical arrangements that may prevent collaboration between the Norman PHO and non-network providers
  - Potential "*spillover effects*" of participating physicians improperly leveraging market power associated with network participation to drive non-network contract reimbursement rates

"Beyond ACOs: FTC Provides Another Path to Coordinated Care" By Joe Carlson, Modern Healthcare, March 9, 2013, http://www.modernhealthcare.com/article/20130309/MAGAZINE/303099969/&template=# (Accessed 3/11/2013).

Example

- TriState Health Partners, Inc.
  - Over 200 physicians
  - One health system
  - Proposal approved by FTC on April 13, 2009

"Re: TriState Health Partners, Inc. Advisory Opinion" By Markus H. Meier, Letter to Christi Braun, Ober, Kaler, Grimes & Shriver, April 13, 2009 (Accessed 1/4/2016), p. 2, 37.

Example

- Suburban Health Organization, Inc. (SHO)
  - Partial integration of 8 SHO hospitals and their 192 employed primary care physicians
  - Proposal disapproved by FTC on March 28, 2006
    - Opined that the "*collective negotiation of contracts with payors*" would stifle competition among "*otherwise competing participants*"
    - The proposed contracts with the hospitals eliminated the "individual hospitals' freedom to compete with SHO and each other" wasn't necessary to achieve the sought after efficiencies

"Re: FTC Staff Advisory Opinion Concerning Suburban Health Organization, Inc." By David R. Pender, Letter to Clifton Johnson and William Thompson, March 28, 2006 (Accessed 1/4/2016), p. 13.

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