Welcome to TIM TALKS: Business Acumen "Tips for Forming a Regional Network of Community-Based Organizations" January 31, 2018

Forming Regional Networks

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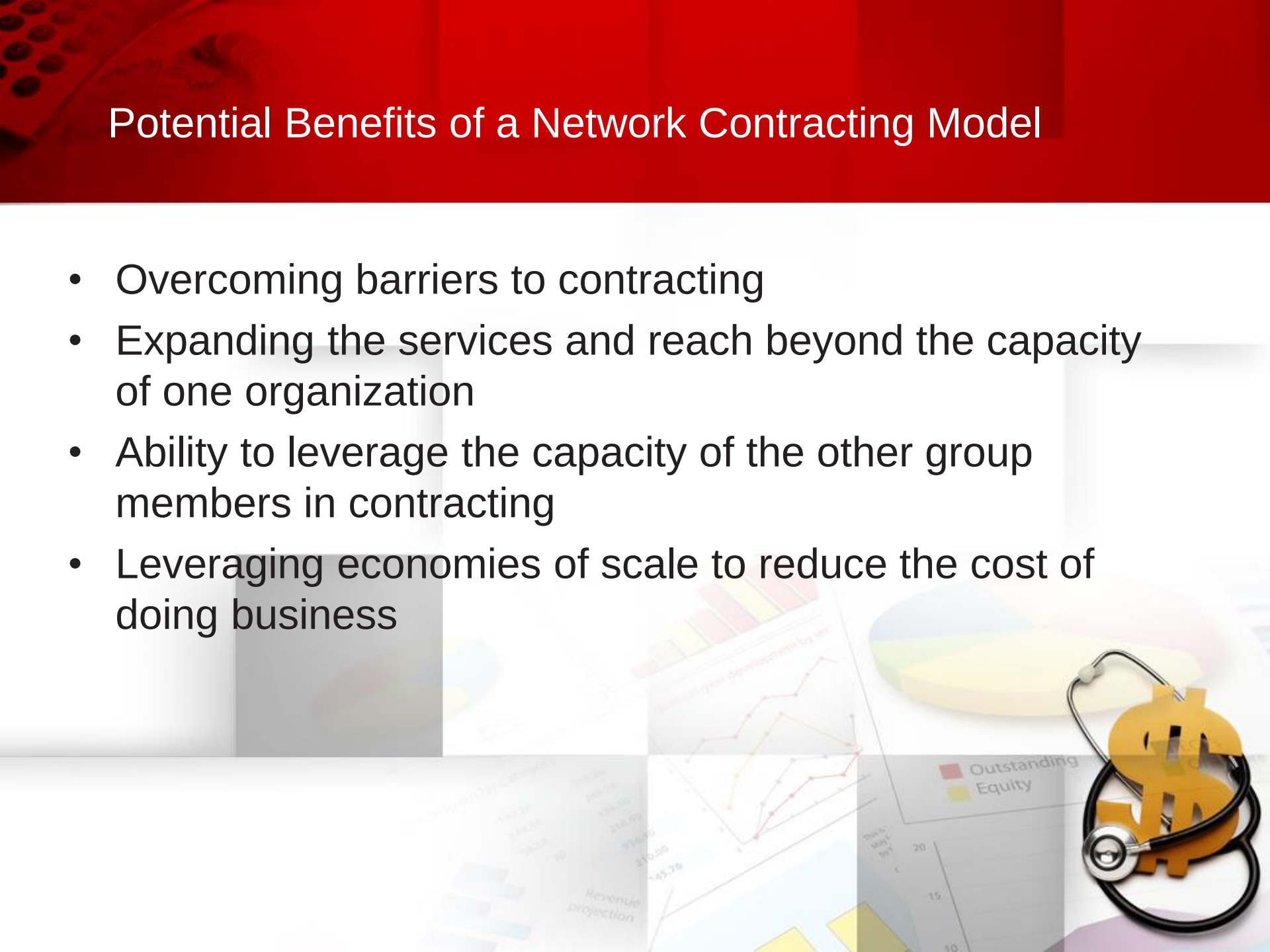
Market Pressure to Form Networks for Contracting

- Networks of Community-Based Organizations (CBOs) are increasingly establishing a legal structure to contract as a group
  - Managed Care Organizations are often adverse to contracting with multiple CBOs to provide similar services across a defined region
  - Healthcare providers and MCOs have to improve clinical outcomes and reduce expenditures for a diverse population of members that often extends beyond the reach of any single CBO

Potential Benefits of a Network Contracting Model

- Overcoming barriers to contracting
- Expanding the services and reach beyond the capacity of one organization
- Ability to leverage the capacity of the other group members in contracting
- Leveraging economies of scale to reduce the cost of doing business



A Network of CBOs Can Address Barriers to Contracting

- Contracting to include Risk-bearing capacity
- National Provider ID number
- Integration with Medical Providers and Referral Systems
- Population Health IT systems
- Population Health Analytics
- Service delivery model based on evidence-based practices
- Standardization of outcome measures
- Quality Assurance and Quality Improvement
- Third Party Administrator services to include billing, collections and claims adjudication services

Is There a Market Opportunity for Networks of CBOs

- Payment Reform models are causing healthcare providers to review their capacity to improve clinical outcomes and reduce expenditures
- A population health approach requires establishing delivery models that extend throughout the target service area
- Many Managed Care Organizations are establishing value-based contract with providers in a similar manner to VBPs under Medicare

Interest in Alternative Payment Models Remains Strong

- Accountable Care Organizations – 2018
  - 561 ACOs, managing 10.5 Million Assigned beneficiaries
  - Up from 480 ACOs in 2017
  - Almost 2 million ACOs beneficiaries are aged duals or disabled
- Bundled Payment for Care Improvement
- *Bundled Payment for Care Improvement Advanced
  - Application window Jan 11, 2018 – March 12, 2018
  - Quality and Cost measures
  - Recent Provider Call – Over 600 questions posted to CMS on this model

Potential Network Contracting Models

- Lead Agency
- Independent Provider Association (IPA)
- Management Services Organization (MSO)

Lead Agency

- One of the agencies in the group agrees to be the contract holder for the group
- The Lead Agency executes a subcontract with the other members of the group
- Subcontract should define roles and responsibilities of each party
- Revenue sharing requirements should be discussed and included in the agreement

Lead Agency – Pros

- Speed to market
- Ability to hold a contract is secured as soon as the lead agency is identified
- Maximum flexibility in determining the members that work under the lead agency.
- Simple contracting with the lead agency

Lead Agency – Cons

- The Lead Agency bears any risk included in the contract
- Lead Agency is responsible for services that are provided by subcontractors
- If the contract is terminated, the impact is bore by the lead agency alone
- Lead Agency bears legal liability and financial liability related to the contract

Independent Provider Association (IPA)

- IPA seeks contracts with member provider organizations
- Single legal entity that contracts with member organizations to provide benefits for members
  - IPA, with a network of member provider organizations, seeks contracts with managed care organizations or healthcare groups
- IPA Generally serves as the entity that holds the contract
  - Members of the IPA do not seek their own contracts in the market

IPA - Pros

- IPA Benefits:
  - Greater bargaining power for the members of the group
  - Eliminate duplication of expenses
  - Ability to maintain individual independence but still gain the option of contracting with the group

IPA - Cons

- IPA must be capitalized or members can sign up with an existing IPA
- Most IPAs are geared towards medical practices
- Limited experience with community-based organizations

Management Services Organization (MSO)

- Historically, MSOs have provided administrative services primarily to clinical practices
- MSOs generally provide services to a group of providers in order to facilitate contracting between MCOs and providers
- MSOs generally do not hold the contract but rather they establish the support for the provider to enable contracting
- A key feature of MSOs is clinical integration with a goal of providing more value to the market

MSO Services

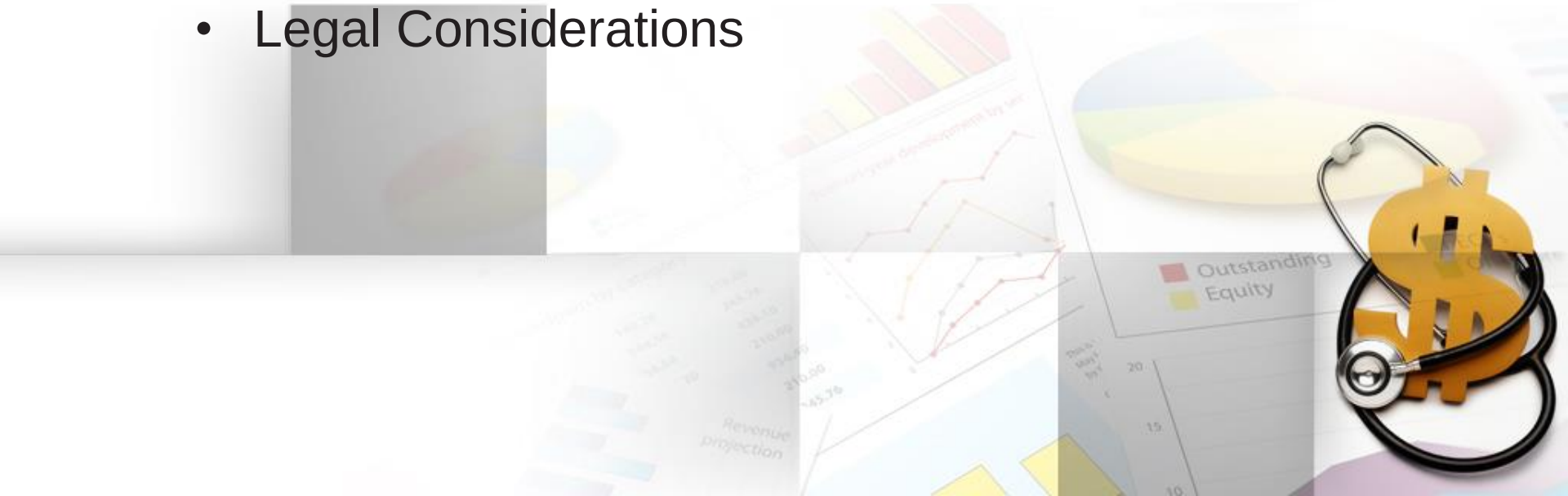
- Electronic medical record access
- Health IT consulting/Systems
- Contract negotiation support
- Equipment
- Group purchasing power
- General management support

MSO Services (cont.)

- Financial
  - Operational capital requirements must be defined and accepted by all stakeholders
  - Establish income requirements to sustain the MSO infrastructure
  - Determine the pricing for services and include this as part of the administrative overhead in the billing structure
  - Define the billing and collections process
  - Closely monitor cash flow

Items to Consider – Regardless of the Network Structure

- Brand Management
- Contracting
- Insurance and Liability
- Financial Management
- Shared Governance
- Legal Considerations



Items to Consider

- Brand Management
  - If you develop a new entity that will be supported by member organizations, you need to make sure that you establish the brand
  - Member organizations must agree to stop marketing their individual entity and promote the brand of the group
  - Ensure that all stakeholders have buy-in and will work collectively to promote the brand of the group entity
  - Ex: The CEO of the AAAs operating in a network continues to promote the individual AAA to local hospitals instead of the group entity. This causes market confusion.

Items to Consider

- Contracting
  - The lead entity must hold the contract
  - Some health plans and hospitals prefer not to limit the number of contracts in a market
  - A single contract option is often preferred over executing a separate agreement with every CBO in a market
  - Ensure that you have a contract strategy that is acceptable to each of the key stakeholders

Items to Consider

- Insurance and Liability
  - The entity that holds the contract also has legal liability related to the contract
  - If multiple member organizations will support the contract holder to provide services, each entity must have liability coverage.
  - Provide a description of the services and copy of the contract with your insurance carrier

Items to Consider

- Financial Management
  - Claims management system
  - Claims management and accounting are separate software applications from a EHR
  - Establish a process to track claims by provider of the service
  - Funding from services should be distributed based upon the terms of the agreement
  - Conduct weekly/monthly reconciliation of claim submission
    - Paid claims
    - Denials
    - Projections

Items to Consider

- Quality Assurance
  - Securing the contract is the easy task. Keeping and expanding the contract is the heavy lift
  - Contracts are won and lost the quality of service
  - Quality includes cost and clinical outcomes
  - The network is only as strong as its weakest member
    - Establish a QA committee
    - Define the performance measures that will be monitored
    - Distribute continual feedback on the performance of each member and the Network

Items to Consider

- Shared Governance
  - Securing commitment from members often requires establishing a shared governance model
  - Networks can provide shared governance that is representative of the CBOs that it supports
  - Networks can have a board of directors that defines the operations of the Network
  - Each CBO can have a seat on the board with an equal vote directing the operations of the Network

Items to Consider – Legal Considerations

- Anti-Kickback Statute
  - The Federal anti-kickback statute26 provides criminal penalties and civil monetary penalties for individuals and entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce business for which payment may be made under a federal healthcare program
- Antitrust
  - Prohibited activities under the antitrust laws of the United States are agreements to fix charges, prices, markups, or the conditions or terms of the sale of any product or service

AMA Recommendations regarding Antitrust laws

- Alignment of entities to provide clinical integration so that the group can provide improved market value that leads to improved health outcomes and reduction in costs is generally an acceptable practice and does not violate antitrust laws.
- Clinical integration has been a practice that is a key indicator for IPAs / MSOs that were ruled as NOT violating antitrust laws.

Next Steps

- Determine if there is a consensus to develop an organizational structure for the network
- Determine the target region that the Network will cover
- Determine the range of services and target population
- Identity the type of organizational structure that is desired: LLC, Non-profit, MSO, IPA, etc.
- Complete a market analysis and gap analysis
- Identify a strategy to eliminate the gaps
- Implement the strategy
- Consult legal counsel

Individual CBO Requirements

- Provide input to the service delivery model
- Commit to the quality assurance metrics
  - Group and Individual CBO performance measures for each defined performance measure
- Ensure adequate training of staff
- Participate in all Network mandated training
- Ensure that service delivery model is adhered to by all participants
- Agree not to compete against the Network for services in the defined target region or to the target population

Population Health and Network Contracting

- Define the members of the Network
- Establish the legal structure of the Network
- Define the Return on Investment and value proposition of the network
  - Clinical Quality Measures / HEDIS Measure Reporting
  - Cost improvement from defined baseline
  - Pay for Performance based on defined outcome measures
  - Support for healthcare providers in Alternative Payment Models
  - Targeting improvement through risk stratification of members
- Define a contract capture strategy and monitor performance