Flagler Hospital Physician Clinical Integration Committee

Recommendations Regarding Formation of a Clinically Integrated Network

Presented to the Flagler Hospital Board of Directors
April 18, 2013

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EXECUTIVE SUMMARY

America's health care system is transforming from a traditional care delivery model in which hospitals, physicians, and other providers are compensated based on the volume of services provided, to one in which providers will be measured collectively and reimbursed by payers based on performance outcomes and value.

Recognizing this, Flagler Hospital's strategic plan calls for development of a formalized alignment plan that will closely align the hospital with independent community physicians to ensure we are all prepared to meet the challenges and opportunities that come with this transformation. The principles of quality, value, and service are to remain at the forefront of all such efforts.

Clinically integrated providers are accountable to each other and to the community they serve to deliver high quality care in an efficient manner. They accomplish this by (1) collectively establishing and enforcing standards of care, (2) coordinating patient care (especially for high risk, high cost patients), and (3) jointly negotiating and managing payer contracts.

A clinically integrated network ("CIN") is the lean infrastructure needed to support clinical integration among a community's independent providers. The CIN develops a governance structure through which these providers come together to decide on protocol development and implementation, performance measurement and enforcement, and formulas for rewarding performance.

Given the high level of physician interest and engagement through the planning process, there is no question community physicians are willing and eager to participate as partners with the hospital in forming and maintaining the CIN. The physicians have reached consensus regarding a governance structure to provide the foundation for building trust among the parties. The Physician Clinical Integration Committee ("CIC") has defined key operations for the CIN, the staffing and technology necessary to support those operations, and developed a preliminary budget.

The climate in our State is already changing. Florida providers are aggressively pursuing new care models, including integrated delivery systems and accountable care organizations. This competition demands a well-planned response in our community. The CIC submits these recommendations for the formation of a CIN in our market area on an accelerated schedule to meet near-term challenges and to take full advantage of emerging opportunities.

I. BACKGROUND: FLAGLER HOSPITAL PHYSICIAN CLINICAL INTEGRATION COMMITTEE

The Clinical Integration Committee ("CIC") has evolved from a learning group to a Flagler Hospital Board-appointed committee tasked with a specific charter. Initially, the committee included fourteen physicians, but has expanded to nearly forty participants. A list of the CIC members, including their work group assignments, is included as ***Exhibit A***.

A. CIC CHARTER

The CIC Charter, approved by the Board in July 2012, states the CIC's purpose:

> The Clinical Integration Committee at Flagler Hospital is a board appointed, physician led committee aimed at improving patient outcomes through more formally integrating the coordination of care across the provider continuum through the exploration of new models of care and reimbursement.

The scope of the CIC's work is defined as follows:

> The Board has established the following high level guidelines in order to guide the efforts of the CIC toward exploring and defining the types of partnerships and/or new business arrangements that the Board will be more likely to ultimately approve:
>
> The CIC should focus its efforts on near term (i.e., 24-36 month horizon) arrangements that require collaboration with clinicians and may result in targeted alliances. These alliances may ultimately include Clinically Integrated Networks and other publicly branded and contracted structures designed to promote greater coordination of care between Flagler and its physicians. Any formal alliance structure would require Board approval. The CIC is not empowered to enter into any legally contracted arrangements on Flagler's behalf without approval from the Board.

Most of the recommendations contained in this report were initially developed through the five CIC work groups, each of which included a chairperson, several physician members, and one or more consultant facilitators: (1) Governance; (2) Quality and Operations; (3) Network Development and Communications; (4) Technology; and (5) Finance and Administration. The overall process has been conducted under the guidance of the CIC Executive Committee. The charters for each of these work groups are included as ***Exhibit B***.

B. CIC ACTIVITY

Through 2012, the CIC focused on market research and physician education on new value-based reimbursement models and principles of clinical integration. These efforts culminated with a full medical staff education session in December.

In 2013, the CIC has followed an aggressive timeline to finalize its recommendations on forming and operating a clinically integrated network. Upon Board approval, the CIC will support the transition to an operational CIN governing board and committee structure.

A detailed timeline listing all CIC meetings and related activities is included as ***Exhibit C***. Highlights include the following:

Early to mid-January:	CIC work groups hold organizational meetings
February 8-9:	CIC holds two-day Strategy Summit (including work group meetings)
Mid to late February:	Work groups discuss and finalize initial recommendations
Early to mid-March:	CIC Executive Committee reviews initial recommendations; work groups address comments
March 28:	Full CIC approves CIN recommendations to the Board
April 11:	CIC Executive Committee approvals final report

II. BACKGROUND: PURSING A CLINICALLY INTEGRATED NETWORK

For years, volume has been the driving force in health care: provide more services, receive more payment. Payers now are beginning to discriminate between providers based on quality and cost. Consider the following examples:

- Large employers are steering employees to selected facilities for certain elective surgeries by waiving out-of-pocket expenses and even paying travel expenses. This trend will accelerate as surgery benefit management companies look for more opportunities to serve their clients.
- Employers are providing direct primary care services for their employees including, for example, St. John's County School District.
- Insurers developing plans to offer on the health insurance exchanges are developing narrow networks to keep premiums low and more attractive to consumers.
- Well-publicized provider performance ratings, such as HealthGrades, LeapFrog, and CareChex, have a growing impact on payer and consumer decisions.

If our hospital and medical staff are not prepared to compete on quality and cost, we can expect declining volumes, loss of specialists, and less access to care in our community. Forming a clinically integrated network (CIN) is the best way to ensure we retain our competitive edge and our patients.

Through a CIN, independent providers can negotiate jointly with payers. The antitrust enforcement agencies view provider collaboration through a CIN very differently than collusion among independent providers. To the extent joint contracting is both necessary and subordinate to a CIN's broader effort to improve quality and efficiency, the federal agencies view these arrangements as beneficial to consumers and pro-competitive. Thus, providers' full commitment to achieving critical integration is critical.

Providers in other Florida communities are forming clinically integrated networks to contract with payers and employers. These include Bay Care Physician Partners in Tampa Bay and Holy Cross Physician Partners in Ft. Lauderdale.

Payers and employers in the St. Augustine area have approached Flagler Hospital and other community providers regarding network contracts with pay-for-performance incentives and possibly participation in a shared savings program.

The challenge of establishing a network in a community with mostly independent practicing physicians with limited ties to the hospital should not be underestimated. The consensus building required for effective collaboration and physician alignment takes time, financial resources, and strategic commitment from hospital and physician leaders. The principles of trust, transparency, and collaboration are critical for the initiative to gain the physician participation levels required to be successful.

III. BACKGROUND: CIN-PAYER CONTRACTING

A. NEW TYPES OF CONTRACTUAL ARRANGEMENTS

The contracts the CIN would negotiate with payers would not initially replace the fee-for-service arrangements individual providers now have. Instead, initial CIN-payer contracts would be network access, pay-for-performance, or shared savings arrangements.

Under a network access agreement (also known as a preferred provider agreement), a payer, recognizing the demonstrated quality and efficiency of the CIN's providers, pays the CIN a fee to access its network of providers. Members continue to bill the payer on a fee-for-service basis; those rates also may be part of the contractual arrangement. A network access contract may include performance standards the CIN must achieve to receive such network access payment.

Under a pay-for-performance contract (often referred to as a P4P contract), an individual provider continues to submit claims and receive fee-for-service reimbursement. If the provider achieves a certain goal specified in the contract, the provider receives an additional incentive payment. A P4P contract may provide for a penalty if a provider fails to meet a specified target.

Many commercial payers are looking to include P4P provisions in their contracts with individual providers. Generally speaking, a CIN can negotiate more favorable P4P terms. Also, a CIN supports an infrastructure that enables its members to achieve P4P measures.

For example, some payers are making bonus payments to primary care physicians whose practices have been accredited as patient-centered medical homes. A CIN may support its primary care physicians by negotiating for such payments and providing the support necessary for a practice to achieve such accreditation.

Under a shared savings program, a network of providers is eligible to receive a portion of a payer's savings generated by improved quality and efficiency. This is accomplished through a multi-step process:

(1) The payer assigns a specific patient population to the CIN, usually based on the patients' primary care provider.

(2) Providers in the CIN continue to receive fee-for-service reimbursement for all services, including services for patients in the assigned population.

(3) The payer calculates a benchmark rate based on the payer's historical cost of providing care for that population.

(4) At the end of the year, the payer calculates its actual cost of providing care for the patient population. (This includes the costs of care furnished by providers not included in the CIN. Patients in the assigned population are not restricted from seeking services from providers not participating in the CIN.)

(5) If the actual costs of care are less than the benchmark and if specified quality measures are met, the CIN will receive a percentage of the savings based on a predetermined formula (*e.g.*, the parties split the savings 50/50). If the CIN does not achieve the quality measures, the payer will not share any savings with the CIN.

(6) A CIN may opt for a "two-sided" shared savings programs. Under this model, the CIN and the payer agree to share losses, *i.e.*, the CIN agrees to repay a portion of the difference if actual expenditures *exceed* the benchmark. In exchange for the CIN accepting this risk, the payer agrees to pay a larger percentage of any savings to the CIN.

(7) The CIN is responsible for deciding how the shared savings (or losses) are to be distributed among its members. Typically, a portion of any shared savings payment is retained by the CIN to pay its expenses.

B. MARKET OPPORTUNITIES

Significant changes to the hospital's current patient and payer mix would have a negative financial impact on the hospital and members of its medical staff. It is critical the parties take action to retain the patient base and positive operating margins for Florida Blue, UnitedHealthcare, and Medicare. The table below provides Flagler Hospital unique patient counts for the 12 month period in FY 2013. A total of 36,160 or 57.5% of the unique patients had primary insurance through United, BCBS Florida Blue, or Medicare.

Evaluating Network Size (A starting point)

Unique Hospital Patients (MRN#)
Query of both inpatient and outpatient services
Period of Time: FY 2013 (12 months)

	Unique Patients	
Primary Insurance	Count	%
Humana	891	1.42%
Aetna	1,817	2.89%
UnitedHealthcare	4,058	6.45%
BCBS - Florida Blue	11,468	18.23%
Medicare	20,634	32.81%
All others	24,029	38.20%
Total	62,897	100.00%

United, BCBS, Medicare	36,160	57.5%

In 2012, Florida Blue has approached the hospital with a proposed shared savings contract to start in the fourth quarter of calendar year 2013. The proposed agreement is a one-sided model; participating providers would not be at risk if total cost of care exceeded the benchmark.

The Medicare Shared Savings Program ("MSSP"), which commenced in January 2012, now has more than 250 participating accountable care organizations ("ACO"). Simply stated, an ACO is a CIN that satisfies specific requirements in the MSSP regulations. The basic form and function of the CIN as proposed herein are consistent with these requirements.

Applications to participate in the MSSP are accepted once per year. The Notice of Intent to submit an application for a January 2014 start date is due May 31, 2013, with the full application due July 31, 2013. The next opportunity to submit an application would be summer 2014 for a January 2015 start date.

Once accepted, an ACO must sign a three-year contract, with the option of electing a one-sided or two-sided model. It is unlikely the MSSP will offer the one-sided contracts beyond 2017.

Given the size of the community's traditional Medicare population (the MSSP does not include Medicare Advantage patients), the potential for shared savings is significant. This is illustrated in the financial projections developed as part of the planning process and detailed later in this report.

Also, providers participating in the MSSP enjoy waivers from the fraud and abuse laws. So long as certain limited requirements are satisfied, the federal Stark Law, the Anti-Kickback Statute, and prohibitions on gainsharing and beneficiary inducements do not apply to arrangements relating to the ACO's operations.

Given the unique opportunities presented, the CIC recommends the CIN pursue MSSP participation. The specific recommendations set forth in this report are consistent with regulatory requirements for the MSSP. The overall timeline for implementation is based in part on the MSSP application submission deadline of July 31, 2013. A detailed task list for timely completion of the MSSP application is included as ***Exhibit D***.

IV. RECOMMENDATIONS: PHYSICIAN HOSPITAL ORGANIZATION

A. OVERVIEW

Developing the appropriate CIN governance structure was a major focus of the planning process. Given there is no historical foundation on which to build a framework for collaboration between and among the hospital and community physicians, it is critical to devise a governance structure that fosters trust. All parties must feel confident that the structure affords them the opportunity to be heard with respect to matters of common interest, while protecting their individual interests.

Initial discussions among the members of the Governance Work Group focused on the most appropriate means for physicians to participate in the CIN: either directly as part of a physician hospital organization ("PHO") or through a physician-only organization ("PO") that in turn participated in a PHO with the hospital. In late January, the CIC conducted an electronic survey of all medical staff members regarding this and related issues. Those survey results are included as ***Exhibit E***.

With this information in hand, the CIC fully explored the governance question at its two-day Strategy Summit in February. A summary of the discussions at the Summit is included as ***Exhibit F***.

To address a handful of additional questions on which a clear consensus had not emerged at the Summit, the CIC again conducted an electronic survey of all medical staff members in late February. Those survey results are included as ***Exhibit G***.

Following an additional robust discussion, the Governance Work Group finalized the following recommendations, which were approved by the CIC Executive Committee and the full CIC.

B. LEGAL CHARACTERISTICS

It is recommended that Flagler Hospital and community physicians together form a physician hospital organization ("PHO") structure for the purpose of creating a clinically integrated network of providers ("CIN").

The purpose of the CIN would be to provide a venue for the hospital and participating physicians to develop and implement clinical processes to achieve business efficiencies and improve population health. The CIN would serve as a collaborative contracting entity between the hospital and participating physicians, and would negotiate and manage third-party payer contracts on behalf of the providers.

The following is the recommended CIN governance structure. A chart illustrating this structure is attached as ***Exhibit H***.

- Florida for-profit Limited Liability Company owned by both the hospital and participating physicians.

- Two classes of Members: Class 1 - hospital; Class 2 - physicians.

- The Class 1 Member (hospital) and the Class 2 Members (physicians) shall have voting rights on the governing board. The governing board shall consist of 13 or fewer representatives comprised of two voting blocks:

  – A hospital block consisting of six or fewer representatives. These governing board representatives will be selected by the hospital board. One of these representatives shall be a community representative who is a Medicare beneficiary as required by the Medicare Shared Savings Program.

  – A physician block consisting of seven representatives, all of whom have active medical staff privileges. No more than one physician representative shall be a hospital-based physician, i.e., a hospitalist, emergency physician, radiologist, pathologist, or anesthesiologist. The seven physician representatives shall be elected at-large by the Class 2 Members based upon the candidates' leadership skills, business acumen, and competency. No two physician representatives on the governing board may be from the same group practice.

    - The seven physician representatives on the initial governing board shall be elected by those members of Flagler Hospital's active medical staff who have signed letters of intent to join the CIN and paid the requisite subscription fee ("Eligible Physicians"). Candidates for these seven positions shall be Eligible Physicians who have indicated a willingness to serve on the initial governing board and a commitment to devote the time and energy necessary to perform the duties required. Prior to the election of the seven physician representatives of the initial governing board, a letter will be sent to all Eligible Physicians soliciting their interest in serving on the initial governing board. A list of all who so indicate an interest will be submitted on a ballot to all Eligible Physicians. Each Eligible Physician shall have seven votes to cast. The seven physicians receiving the most votes shall serve as the physician representatives on the initial governing board, except as follows. First, should two or more physicians from the same practice group be among the seven top recipients of votes, only the one with the most votes shall be selected, and the physician candidate not in that practice group receiving the next highest number of votes shall be selected to serve. Second, should two or more hospital-based physicians be among the seven top recipients of votes, only the one with the most votes shall be selected, and the non-hospital-based physician receiving the next highest number of votes and who is not in the same group practice as another physician representative shall be selected to serve.

- Thereafter, physician representatives of the governing board shall be elected from among Class 2 Members who have signed a Participation Agreement to join the CIN and have been nominated by the Governance Committee acting as a nominating committee in a manner specified in the CIN's operating agreement or bylaws.

- The term of office for the *initial* governing board shall be one year. Thereafter, governing board representatives shall serve staggered three-year terms.

- All matters coming before the governing board shall be decided by the hospital representatives and the physician representatives voting as independent blocks with one vote per block of voting representatives.

  - Each voting block's single vote shall be determined by a majority vote of the quorum within that block; *e.g.*, a quorum of seven equals four. If four or five physician representatives are present, three votes would be required to approve the one vote to be cast by that voting block. If six or the full seven physician representatives are present, four votes would be required to approve the one vote to be cast at the board level.

  - The CIN's operating agreement or bylaws shall specify mediation procedures to be employed in the event a deadlock occurs in a board vote.

- The hospital shall retain veto rights in any matter relating to the preservation of its tax-exempt status and its bond covenants. The physicians shall retain reserved powers in any matter relating to protocol approval and exclusion of a physician representative from the network.

- The chairperson of the governing board shall always be a physician elected from representatives of the governing board.

- The initial governing board shall be responsible for setting the standards for Class 2 Membership for physicians who are not members of Flagler Hospital's active medical staff.

C. COMMITTEE STRUCTURE

For the CIN to accomplish its stated purposes, it will develop a robust committee structure. The following committees will be established. Committee members shall be selected in a manner to be specified in the CIN's operating agreement or bylaws:

Executive Committee: An executive committee of the governing board will be established to fulfill the duties delegated to it by the governing board. It will exercise all powers of the board at such times the board is not in session. The Executive Committee shall consist of the officers of the board.

Quality Improvement/Quality Assurance Committee: This committee will be established by the governing board and will be comprised of both primary care and specialty physicians who are members of the network. The committee's purpose will be to accomplish the following: 1) analyze clinical data and develop clinical protocol to further the implementation of a clinically integrated network; 2) monitor the clinical activity of participating physicians and assure compliance with approved clinical protocol; 3) provide physician credentialing and peer review input to the board; and 4) identify and develop clinical co-management relationships and disease management protocol designed to achieve efficiencies and improve population health.

Audit/Finance Committee: This committee will be established by the governing board for the primary purpose of assisting the governing board in overseeing the following: 1) the integrity of the CIN's financial statements; 2) the independent auditor's qualifications, independence, and engagement; 3) the performance of the CIN's independent auditor; 4) the CIN's internal audit and compliance with legal and regulatory requirements regarding the financial affairs of the CIN; and 5) the CIN's system of internal controls regarding finance, accounting, and financial ethics, as established by the CIN's board from time to time.

Governance Committee: This committee will be established by the governing board for the primary purpose of assisting the board in perpetuating the effectiveness of the CIN through the following: 1) periodic review of the CIN's operating agreement and developing revisions for board consideration; 2) periodic review of board operational policies and procedures and developing recommended revisions for board action; 3) evaluating board performance; 4) identifying and sharing with the board the qualities and characteristics required for effective governance; and 5) serving as the nominating committee for the board.

Corporate Compliance Committee: This committee will be established for the primary purpose of assisting the board in the implementation and management of the CIN's corporate compliance program and management of the CIN's system for internal governance controls, legal compliance, and ethics, as established by the board time to time.

Marketing and Education Committee: This committee will be established to accomplish the following: 1) develop and implement a marketing plan for the CIN; 2) develop and promote an educational campaign to encourage patient compliance with care protocol; and 3) develop and implement a continuing education program for network physicians to facilitate compliance with clinical protocol and payer contract requirements.

Network Contract Management Committee: This committee will be established to develop and manage network contracts with third-party payers. The committee will be comprised primarily of individuals with expertise in contract negotiations and contract management. The committee will rely on the work of the Quality Improvement/Quality Assurance Committee to assure that clinical efficacy is built into payer contracts to enhance the competitive attractiveness of the network. The committee shall recommend for board consideration formulas for shared savings distribution for each contract engaged.

IT Committee: This committee will be established to develop and deploy an information technology and business infrastructure to promote the clinical and business efficiencies of the CIN. The hospital and participating providers will need to be linked through electronic information systems to ensure the deployment of clinical protocols, monitor compliance with those protocols, and provide the capacity to accumulate and analyze clinical data for the continued improvement of clinical processes.

It is anticipated physician members of the initial governing board and committee chairs will be required to devote significant time to the CIN's establishment and initial operations. To ensure qualified individuals are not discouraged from participation, the CIN should pay an appropriate level of compensation to these physician leaders.

D. TIMING

It is the CIC's recommendation to move forward expeditiously to have the CIN operational by the beginning of the fourth quarter of 2013. This will afford the CIN the maximum opportunity for payer contracting.

The CIC will solicit expressions of intent to participate in a CIN from members of the hospital's active medical staff. It is understood that the expressions of intent are nonbinding and are contingent upon the physician's final approval of a formal Participation Agreement to be developed by the governing board upon the formalization of the legal governance structure of the CIN and determination of the requirements for participation by its governing board.

Those physicians who execute the letter of intent ("LOI") will have the advantage of being able to participate in the selection of the initial governing board of the CIN, provide final input into the formal organization of the CIN, and influence the business direction of the CIN. It is anticipated that those who sign LOIs and join the network early will have investment advantages over those who join later. Formal investment in the CIN will not be required until the physicians have had a chance to review the detailed Participation Agreement and have confirmed that the CIN's business purposes and operational structure are satisfactory to them.

By signing the letter of intent, an active medical staff member will affirm the following:

- He/she currently is a member in good standing of the active medical staff of Flagler Hospital.

- He/she intends to participate in the CIN contingent upon review and approval of its legal structure, investment obligation, and the provisions of a Participation Agreement governing the rights, duties, and responsibilities of CIN members.

- He/she will actively participate in the selection of the CIN's initial governing board and the establishment of its formal governance structure consistent with the recommendations of the CIC.

- He/she will pay a non-refundable $250.00 subscription fee, which may later be applied to offset amounts owing to the CIN (*e.g*, annual membership fees).

- He/she will participate in CIN planning activities when called upon and will allow his/her office staff to participate in CIN planning activities when called upon.

- He/she will comply with reasonable confidentiality requirements established by the CIN planning committees.

- He/she will share information regarding his/her private practice, as reasonably necessary to establish a clinically integrated network, subject to confidentiality restrictions on the use of that data.

- He/she will commit to improving quality of care and clinical outcomes, improve coordination and continuity of care, control the cost of care, and eliminate unnecessary clinical care variation by participating in the creation and adoption of clinical protocol and pathways, applying evidence-based medical interventions, and supporting comprehensive clinical care with an integrated information technology platform.

Any member of the active medical staff interested in serving as a physician representative on the initial governing board may place his or her name into consideration by submitting a completed self-nomination form. To ensure transparency and thus foster trust, the physician will be required to disclose possible conflicts of interest in completing the self-nomination form.

In anticipation of the Board's approval of the CIC's recommendations, and in response to physician inquiries and a demanding timeline, the CIC Executive Committee circulated to all active medical staff members the following proposed schedule for election of the physician representatives on the initial governing board:

April 19	Letter of intent ("LOI") will be distributed to all active medical staff members.
May 8	Physicians interested in serving on the initial governing board will submit signed LOI, subscription fee, and self-nomination form by 4:30 pm.
May 10	Absentee ballot is made available on physician portal.
May 22	Completed absentee ballot will be accepted from any active medical staff member physician who submits signed LOI and subscription fee until 4:30 pm.
May 23	Physicians may vote between 7:00 am and 4:00 pm and 6:00 pm to 7:30 pm. Any active medical staff member who submits signed LOI and subscription fee (and who has not submitted an absentee ballot) will be eligible to vote.

A copy of the letter of intent (including the cover letter) and the self-nomination form is included as ***Exhibit I***.

It is anticipated the board will hold its organizational meeting on or about May 28. Presumably, the hospital would appoint its board members prior to that date.

At this meeting (or soon thereafter), the board will approve the CIN's operating agreement, as well as the physician Participation Agreement (discussed in the following section). Also, the board will appoint the chairpersons and initial members of key CIN committees.

It will be the task of the initial governing board to formalize the CIN's legal structure, establish business processes, develop its committee structure, and commence business operations. A mission critical task will be the establishment of a committed cadre of participating physicians to provide services through the CIN.

V. RECOMMENDATIONS: PHYSICIAN CIN PARTICIPATION

A. ELIGIBILITY AND REQUIREMENTS

The CIC leaves to the initial governing board to determine the criteria for participation by physicians who are not members of the hospital's medical staff, depending on opportunities presented to the organization.

To participate, a practitioner would be required to execute and adhere to a written Participation Agreement with the CIN. Also, each participant would make an annual payment of $1000.00 to cover a portion of the CIN's operating expenses.

One of the first tasks for the initial governing board will be approving the terms of the Participation Agreement. The CIC has compiled several examples that may inform the drafting process.

Key contract terms include the following:

- **Quality**
- **Technology**
- **Exclusivity**
- **Data sharing**
- **Distribution of CIN receivables**
- **Compliance**
- **Network fees**
- **Termination**

Most importantly, the Participation Agreement will obligate those providers participating in the CIN ("CIN Participants") to actively participate in the CIN's quality improvement and quality assurance programs and care coordination programs. The CIN Participants will agree to utilize technology made available through the CIN, including submission of required data. The CIN Participants also will agree to the CIN's established remedial processes for any participant who fails to adhere to CIN standards, including possible termination of participation.

B. PHYSICIAN EDUCATION AND RECRUITMENT

The CIC has adopted aggressive goals for the initial round of physician recruitment, including 100 percent participation by the community's primary care physicians (family medicine, internal medicine, pediatrics, and OB/GYN) and 50 percent of specialists serving the community. Priority will be given to recruitment of primary care physicians, as most shared savings contracts attribute patients based on their primary care providers.

Through the planning process, the hospital physician portal has been regularly updated with information regarding the CIN, including a detailed list of frequently asked questions. This list has been updated as physicians have expressed concerns, such as the impact of CIN participation on a physician's current billing arrangements. There has been a strong emphasis on transparency to build trust with those physicians not engaged in the CIC process.

Several physicians who participated in the Network Development and Communications Work Group have committed to reaching out to medical staff members through a series of small dinner meetings. These physicians also intend to look for opportunities for one-on-one discussions in the physician lounge lunch/break room.

The Work Group developed the following list of key themes for communications with physicians:

> This is a journey towards clinical integration and will be founded upon the key principles of quality, collaboration, trust, transparency, and efficiency.
>
> The core functions of a clinically integrated network are to promote evidence-based medicine, facilitate care coordination, and negotiate and manage new forms of payer contracts.
>
> There is a window of opportunity for introductory contracts that have no downside risk, including the Florida Blue No Risk Contract and the Medicare Shared Savings Program.
>
> As the network gains experience, risk-based reimbursement models may be considered.
>
> How a newly formed clinically integrated network will impact existing physician practices, including the mechanics of shared savings programs and their impact on current billing arrangements.
>
> How the new network will be governed and operated, how data will be shared and quality metrics measured, and how shared savings will be distributed.

These themes will be highlighted as part of the following communications strategy:

- May 15 – Finalize marketing and branding strategy
- May 31 – Submit notice of intent to submit application for participation in Medicare Shared Savings Program
- June 1 – Develop brochure and network recruitment materials; finalize Participation Agreement
- June - July – Conduct town hall and provider recruitment dinner meetings
- June – July – Engage in e-mail, physician portal, and Medical Staff mailbox campaigns
- June – July – Sponsor Clinical Integration Week – host an exhibit space highlighting the CIN
- July 15 – Initial network established with signed Participation Agreements obtained
- July 31 – Submit application for participation in Medicare Shared Savings Program
- August 30 – Network provided to payer for attribution modeling (Florida Blue)
- Ongoing – Network development and communications

VI. RECOMMENDATIONS: CIN FUNCTIONS

A. OVERVIEW

For the hospital, CIN participation will require a commitment (1) to pursue center of excellence designations and other certifications to meet payer demands, (2) to improve the hospital's scores on key performance ratings. Also, other participants will expect the hospital to commit significant resources to support care coordination activities.

A physician's responsibilities will include, but not be limited to, (1) meeting or exceeding clinical performance standards established by the CIN's governing board; (2) fully utilizing in his or her practice evidence-based medicine protocols approved by the CIN's governing board; and (3) participating in care coordination programs established and supported by the CIN.

The value of the CIN, and thus its ability to negotiate favorable terms in payer contracts, is based on its participants' demonstrated commitment to deliver high-quality care in an efficient manner to promote the health of the population served. Thus, it is critical the CIN establish and enforce demanding standards of care and support robust care coordination activities among its participants.

The Quality and Operations Work Group was charged with evaluating options and making recommendations regarding network standards of care and processes for care coordination. The Q&O Work Group also as responsible for identifying and prioritizing other functions to be performed by the CIN to support its participants and defining administrative support personnel and other resources necessary for the CIN to perform these functions.

Following discussions during the Strategy Summit and subsequent meetings, the Q&O Work Group made the following recommendations, which were reviewed and approved by the CIC Executive Committee and the full CIC.

B. STANDARDS OF CARE – HOSPITAL

Recommendations: With the hospital's full support, the CIN immediately should undertake a comprehensive review of payer requirements with regard to accreditations, certifications, and other quality-based criteria for hospital inpatient and outpatient services. Once these payer expectations have been fully vetted, a comprehensive strategy involving all CIN participants should be developed to maintain compliance with these standards.

Similarly, the CIN should compile the hospital's ratings on Delta Carechex Scores, (www.carechex.com/), HealthGrades, (www.healthgrades.com/), Leapfrog Group, (www.leapfroggroup.org/cp) Consumer Reports, (www.consumerreports.org/health/doctors-hospitals/hospital-ratings.htm), Joint Commission, (www.jointcommission.org/accreditation/top_performers.aspx), CMS Hospital Compare, (www.medicare.gov/hospitalcompare/), and other recognized ratings. Once opportunities for improvements are identified, a comprehensive strategy involving all CIN participants should be developed to improve the hospital's scores on critical ratings.

C. STANDARDS OF CARE – PHYSICIANS

1. Evidence-Based Medicine Clinical Protocols

Background: Through the adoption and implementation of evidence-based clinical protocols for identified chronic conditions, the CIN can standardize and improve care across network providers. Well-researched and well-designed protocols that support individual provider's clinical decision-making result in improved outcomes and enhanced efficiency. Additionally, the CIN can support its participants in complying with payers' rules regarding medical necessity.

Recommendations: The CIN governing board should charge the Quality Improvement/Quality Assurance Committee with establishing procedures for protocol development and implementation, subject to the governing board's approval. This would include identification of sources for model protocols, *e.g.*, specialty society publications, ABIM Foundation's *Choosing Wisely*® campaign, www.guidelines.gov. The committee should complete this task as soon as possible, as physicians will want to understand this process as they consider participation in the CIN.

Once the procedures are approved by the CIN governing board, the Quality Improvement/Quality Assurance Committee should commence protocol development on the following chronic conditions, as they present the greatest opportunity for quality improvement and cost savings through standardization: **(1) asthma; (2) diabetes; and (3) preventive care (by age group).**

Again, the work on protocol development should commence as soon as possible, as it would be beneficial to have protocols (at least in draft form) available to share with physicians considering CIN participation. Also, early adoption and successful implementation of key protocols (with attendant performance improvement) will demonstrate the CIN's value in quality improvement.

The other priority task with respect to evidence-based medicine clinical protocols is the identification and implementation of tactics to support CIN participants' compliance with payers' medical necessity requirements and utilization guidelines. This may include, for example, tools a provider may use to evaluate the application of such a requirement or guideline in a specific case.

2. Quality of Care Measures

Background: Providers' scores on well-recognized quality of care measures provide an objective basis for demonstrating the CIN's value to payers and patients. These measures also serve as network regulators, as providers who score poorly may be subject to remedial measures and possible exclusion from the network. It is critical, therefore, for the CIN to identify appropriate measures on which it will report and evaluate providers' performance.

Recommendations: The Q&O Work Group reviewed and considered several recognized sets of quality of care measures, including PQRS measures, EHR meaningful use measures, and Medicare Shared Savings Program measures. Based on this, the Work Group recommended the CIN initially employ the measures utilized by the National Committee for Quality Assurance ("NCQA") to accredit private health plans.

The NCQA measures of clinical quality are a subset of the Healthcare Effectiveness Data and Information Set ("HEDIS") measures. These measures are used by more than 90 percent of health plans to measure provider network performance on important dimensions of care. A copy of the current NCQA measures is included as ***Exhibit J***.

Scores on these measures are calculated based on claims data. For example, the percentage of women over a specified age covered by the health plan who receive screening mammography would be calculated by analyzing plan enrollment information (to determine the denominator) and the number of claims paid for this service (to determine the numerator).

Through NCQA's website, a consumer can obtain a report detailing a specific health plan's performance on the identified measures. Beginning in 2014, a consumer who utilizes a state health insurance exchange to purchase health insurance will have immediate access to this information for comparison purposes. Presumably, consumers will be attracted to those health plans whose provider networks achieve the highest scores on these measures. As a result, health plans now are focusing on their contracted providers' performance on these measures.

Utilizing the NCQA measures, which are consistent with the other measure sets identified above, will place the CIN in the best position to negotiate favorable shared savings arrangements with private payers, while positioning the CIN for participation in other new payment models. For example, a copy of Florida Blue's most recent NCQA report is included as ***Exhibit K***. That report identifies several areas for improvement by the health plan. This gives the CIN the opportunity to work with that plan to identify specific interventions to "move the needle" on the plan's overall scores.

Because the NCQA measures are claims-based reporting, it would be relatively simple to establish a process for tracking CIN participants' scores, as opposed to imposing new reporting requirements. This ease of transition favors the use of these measures, also.

Specifically, the NCQA measures should be employed as the CIN's initial set of quality measures. The Quality Improvement/Quality Assurance Committee should be charged with defining minimum performance standards for CIN participation and the IT Committee should be charged with identifying a technology solution for tracking participants' performance with respect to these measures. The Marketing and Education Committee should be charged with developing educational programs and materials for physicians regarding these performance measures and standards. These tasks should be completed as soon as possible, so that physicians considering participation in the CIN will understand these performance expectations.

As the CIN contracts with payers that employ different measures to evaluate provider performance and distribute payments (*e.g.*, the Medicare Shared Savings Program), the CIN governing board should have the authority to expand and/or refine the CIN's set of quality measures. The Participation Agreement should require a participant to fully cooperate with the CIN's quality improvement/quality assurance activities, including achieving specified performance standards on then-current CIN quality measures.

3. "Good Citizenship" Measures

Background: Unlike quality of care measures that address direct patient care, good citizenship measures relate to individual provider activities that enhance the CIN's overall operations. These include, for example, active participation in CIN committees, accurate coding to ensure appropriate risk adjustments, and completion of continuing education activities.

Recommendation: Because participation in a CIN requires a new level of cooperation for physicians, the use of objective good citizenship measures to incent certain behaviors is important. Examples of such measures include the following:

- Completion of specialty-specific CMEs
- Use of patient registry to confirm preventive care
- Engagement with medication management staff
- Use of Level II codes to document risk factors
- Participation in CIN meeting

Satisfaction of specified good citizenship measures should be a precondition for a physician to receive any shared savings distribution through the CIN (as opposed to a condition of participation in the CIN). Thus, it is critical to employ objective, well-defined measures for which there is clear consensus regarding their relevance to CIN performance.

The CIN governing board should charge the Network Contract Management Committee with setting the specifications for satisfaction of these measures, as well as the inclusion of additional measures, as soon as possible, with approval by the governing board soon thereafter. Again, it is important to communicate these expectations to physicians considering CIN participation.

4. Efficiency Measures

Background: The Centers for Medicare and Medicaid Services ("CMS"), along with other payers, now are analyzing vast amounts of claims data to calculate total costs of care for (1) a particular episode of care (e.g., a surgical procedure) and (2) the care of an individual with a particular medical condition over a period of time (e.g., care for a diabetic patient over a one-year period). Currently, CMS uses this data to establish benchmarks for the Medicare Shared Savings Program and bundled payment initiatives.

Also, CMS is refining efficiency measures to compare the costs for similarly-situated patients who receive care from different providers. CMS intends to calculate each physician's score on these measures as part of the Physician Feedback Reports, which each physician will receive on an annual basis beginning in the fall of 2014.

Beginning in 2017 (2015 for physicians in group practices with more than 100 physicians), CMS will use a physician's scores on these yet-to-be fully developed efficiency measures, along with scores on specified quality measures, to calculate the physician's value-based purchasing modifier. The physician's payment under the Medicare Physician Fee Schedule will be adjusted up or down based on his or her modifier. Private payers intend to use data for similar purposes, including network design.

Recommendation: The CIN should closely monitor the development and use of efficiency measures and provide regular updates and educational opportunities for CIN participants, especially as it relates to Physician Feedback Reports and the physician value-based purchasing modifier. In evaluating technology solutions, the CIN should consider a system's ability to track and report on patient total cost of care.

Initially, the CIN should not impose efficiency measures as a condition of provider participation. The CIN governing board should charge the Marketing and Education Committee with providing education to CIN participants regarding the importance of tracking and reducing patient total cost of care in new payment models.

Given the critical role primary care physicians play in controlling patient total cost of care through effective care management and care coordination, consideration of reductions in patient total cost of care as a measure for distribution of shared savings among primary care providers.

D CARE COORDINATION

The second critical function to be performed by a CIN is care coordination. Generally speaking, there are two types of care coordination programs: (1) a program to provide follow-up care for patients following discharge from an institutional setting; and (2) a patient navigator program that identifies and provides care management for chronically ill patients. Both types of programs are supported by systemic patient engagement efforts.

1. Transitional Care Management

Background: One of the greatest opportunities for increasing savings and efficiency – and for improving outcomes - is to provide patients discharged from an institutional setting with certain follow-up care. Health systems that have implemented even the most rudimentary transitional care management ("TCM") programs have realized impressive results.

However, two significant barriers have prevented widespread adoption of TCM programs. First, such a program requires collaboration between a hospital and its medical staff to coordinate post-discharge services. Second, there has been no financial incentive for providers to furnish or arrange for any sort of post-discharge services. Because they have not generated revenue to offset their costs, TCM programs have not been a high priority.

The formation of the CIN now provides a vehicle for collaboration. Also, beginning January 1, 2013, however, Medicare now pays for TCM services on the Medicare Physician Fee Schedule. CMS has identified specific requirements for billing these services.

Recommendation: The development of a TCM program should be an immediate priority for the CIN. The CIN governing board should charge the Quality Improvement/Quality Assurance Committee with developing a work plan to achieve full implementation of a TCM program by no later than October 1, 2013. Thus, the committee should submit its proposed work plan to the governing board for its consideration by no later than September 1, 2013.

There are two options for such a program. First, the hospital could contract through the CIN to provide physicians or mid-level providers to furnish the required professional services and supervision (*e.g.*, the face-to-face visit), with the hospital providing the other services (*e.g.*, medication reconciliation, patient education, follow-up calls). The physician or mid-level provider would reassign his or her right to bill for the service to the hospital.

Alternatively, the CIN could contract with the hospital for the support staff and technology needed to operate a TCM program. Under such an arrangement, CIN physicians would bill directly for the TCM service and pay the CIN fair market value for the support staff and other services. Such an arrangement would permit a smaller practice otherwise lacking necessary resources to provide TCM services.

2. NCQA Recognition as Patient-Centered Medical Home

There is significant physician interest in pursuing NCQA certification as a patient-centered medical home. The CIN should initially focus on supporting primary care physicians in achieving NCQA recognition for their practices as patient-centered medical homes. Achievement of such recognition will benefit all CIN participants, as more payers expect and eventually require primary care practices to operate as medical homes.

The governing board should charge the appropriate committee with developing a detailed blueprint for the CIN's medical home building project. That plan should be presented to the CIN governing board for review and approval by no later than September 1, 2013, with implementation commencing no later than October 1, 2013.

3. Patient Navigator Program

Background: A patient navigator is a member of the healthcare team who helps patients with chronic conditions "navigate" the healthcare system and get timely care. Navigators work with patients to identify their barriers to healthcare and connect them to the resources they may need such as financial assistance, counseling, language translation, or transportation. Navigators also support patient compliance through regular monitoring and availability to address patient and family member concerns and questions.

Recommendation: The governing board should charge the Quality Improvement/Quality Assurance Committee with developing a work plan for initial implementation of a CIN-sponsored patient navigator program (including identification of chronic conditions on which to focus, staffing needs, and process recommendations) by no later than January 1, 2014. The program should begin coordinating care for patients during the first quarter of 2014.

4. Patient Engagement

Background: Activities that promote patient engagement may include, but are not limited to, use of decision-support tools and shared decision-making methods that help patients assess the merits of various treatment options in the context of their specific values. Patient engagement also includes methods for fostering basic knowledge about maintaining good health, avoiding preventable medical conditions, and managing existing conditions.

Technological solutions that support patient engagement include a patient portal (patient and family member access to electronic records) and remote home monitoring and telehealth services.

Financial incentives also play a role in promoting patient engagement. This may include lower co-payments and deductibles for patients who engage in certain activities (such as seeking care from network providers or receive specified preventive services) to giving small rewards to patients who complete a specified task or reach a certain milestone.

Recommendation: The governing board should charge the Marketing and Education Committee with developing a work plan for a patient engagement strategy by the end of the first quarter of 2014.

E. OTHER FUNCTIONS

Beyond the core functions of promoting evidence-based medicine practices, supporting care coordination, and negotiating and managing payer contracts, the CIN has the opportunity to provide essential services for the hospital and the CIN's physician participants.

1. Hospital Efficiencies

The CIN presents an unprecedented opportunity for the hospital to engage physicians in identifying and implementing process improvements and cost-saving measures. Rather than pursuing separate clinical co-management agreements with individual physicians to address specific clinical departments, the hospital can contract with the CIN for these services. Using hospital and payer data, the CIN can identify high-priority targets for improvement and develop and implement related work plans.

Pursuit of such "gainsharing" arrangements should be an early priority for the CIN for several reasons: (1) cost savings resulting from improved efficiencies are relatively easy to calculate and illustrate, and thus provide "quick wins" on which to build momentum (2) cost savings provide an immediate return on investment for the hospital; and (3) the arrangements promote cooperation and collaboration between the hospital and physicians, thus providing a foundation for trust.

The CIN governing board should charge the Quality Improvement/Quality Assurance Committee with developing a detailed and prioritized efficiencies work plan. That plan should be presented to the CIN governing board for review and approval by no later than November 1, 2013, with the first specific project commencing no later than January 1, 2014.

2. Management Services

Also, the CIN should evaluate opportunities to provide contracted management services for physician practices in the community. In particular, the CIN should survey local physicians to identify interest in specific services and willingness to purchase them. However, the CIN should not consider launching these services until its core operations are well established.

The governing board should charge the Marketing and Education Committee with developing, circulating, and analyzing the results of the physician survey regarding management services. The committee should submit its report on the survey results to the governing board by January 1, 2014.

3. "Mid-range" Strategic Planning

Recognizing the potential for the CIN to become reactive based on the wants and needs of particular constituent groups, the CIN governing board should develop a focused, long-term strategic plan by the end of its first year of operations. At a minimum, the plan should address the three items listed above, as well as participation in the Medicare Shared Savings Program, pursuit of bundled payment opportunities, the development of Centers of Excellence, and the creation of a hospital employee health plan.

VII. RECOMMENDATIONS: CIN OPERATIONS

A. STAFFING

Effective performance of the specified CIN functions will require the following staffing. These individuals may be employed directly by the CIN, but most likely it will be more feasible for the CIN to contract with the hospital or other third party for services.

Executive Director – Full-time position with overall responsibility for CIN operations. Individual should be retained in this position as soon as possible.

Medical Director – Half-time position responsible for provider relations and coordinating protocol development and enforcement. Individual should be identified as soon as possible and retained for this position by January 2014.

Director of Quality Improvement/Quality Assurance – Full-time position serving as Assistant Executive Director with primary responsibility for CIN's QI/QA program. Individual should be retained for this position by July 1, 2013.

Network Manager/Compliance Officer – Half-time position with primary responsibility for (1) payer and employer negotiations, contracting, and on-going relationships; and (2) CIN's patient-centered medical home initiative. Individual should be retained for this position by August 1, 2013.

Nurse Managers/Patient Navigators – Two to four full-time positions with primary responsibility for CIN's care coordination activities, including direct patient contact. Initial staff of two Nurse Managers/Patient Navigators should be retained for these positions by October 1, 2013, with additional two staff retained during the first half of 2014.

Medical Economist & Analytics – Half-time position responsible for CIN's hospital efficiencies program and analyzing data to identify opportunities for quality improvement and cost savings. Individual should be retained for this position during the first half of 2014.

In addition, it is anticipated the CIN also will require the support of qualified outside health care consultants, business advisors, and legal counsel as it establishes its operations.

The estimated cost associated with CIN staffing is included in the financial projections found in Section VIII of this report.

The CIN will require sufficient support staff to oversee the installation and operation of the technology solution discussed in the following section. It is assumed this staff will be housed in the hospital's IT department and loaned to the CIN as necessary and appropriate. The cost of this staff is included in the budget estimates for the technology solution.

B. TECHNOLOGY SOLUTIONS

A robust technology solution is essential to the operations of a network of independent providers. This solution will, among other things, identify patients in need of care management, support clinical decision-making at the point of care, facilitate performance measurement and management, and enable the exchange of clinical information for care coordination purposes.

Working closely with the hospital's Chief Information Officer, the Technology Work Group has developed a Request for Proposal ("RFP") to provide a technology solution to support the CIN's operations. A copy of the RFP is included as ***Exhibit L***.

The Technology Work Group determined the tight timeline for CIN implementation necessitated the RFP be released prior to the Flagler Hospital Board's approval of the CIC's recommendations. The Work Group determined there was no risk to the CIC or the hospital associated with this strategy, as there is no legal obligation to accept any proposal received in response to the RFP.

The Work Group established the following timeline to implementation of a CIN technology solution.

TASK	DUE DATE
RFP Released	March 11
Proposals Due From Vendors	April 5
Flagler Narrows Vendor List	May 3
Vendor On-site Demonstration of Products by Narrowed List of Vendors	May 3 to June 14
Vendor Selection by CIN Governing Board	June 21
Contract Negotiations Complete and Contract Signed	July 19
Solution Implementation	July 19 – September 1

The estimated cost associated with the technology solution is included in the financial projections found in Section VIII of this report.

VIII. RECOMMENDATIONS: FINANCIAL PROJECTIONS

A. PRELIMINARY MATTERS

Forward-looking financial projections are inherently susceptible to uncertainty and changes in circumstances. The CIN's actual results may vary materially from the projections expressed or implied in this early stage modeling. Such variation may result from levels of provider participation; government regulation; payer strategies; changes in payment methodologies; strategic, political, and social conditions; and other future events not known or projected at this time.

These projections are illustrative only, based upon the key assumptions outlined below. They provide the following information to potential participants:

- Information regarding network economics. The forecast and associated assumptions offer potential participants the opportunity to better understand the mechanics of a clinically integrated network, and the economic drivers that determine whether the CIN will be capable of participating in revenue streams sufficient to cover (or exceed) the costs associated with network functions identified previously.

- The opportunity to review the initial CIN financial projections. By participating in the review of the economic forecasts from the outset, potential participants will have an informed perspective on future forecast revisions. ***PLEASE NOTE THAT ALL POTENTIAL PARTICIPANTS WILL RECEIVE PRIOR TO EXECUTION OF THE PARTICIPATION AGREEMENT UPDATED FINANCIAL INFORMATION, INCLUDING MONTHLY PROJECTIONS, CASH FLOW, BALANCE SHEET, AND CAPITALIZATION.***

- The opportunity to provide input and to challenge assumptions in the early phases of the economic forecast development.

By including these projections in its recommendations, the CIC intends to demonstrate its commitment to open dialogue regarding CIN development. The assumptions underlying this projection (described below) will change as additional information is obtained from payers, employers, network participants, and others in the coming weeks and months. Therefore, the best descriptor of this preliminary version of the financial projections is "directional."

B. FINANCIAL MODELING OVERVIEW

This high level financial model construct allows for varying sensitivity analysis related to key assumptions over a five-year period (calendar year ("CY") 2013-2017). Specifically, the approach deployed for the initial modeling focuses on the following:

- The impact of revenue opportunities available to the CIN, ranging from:
    - Access/Membership fees paid by members of the CIN
    - CIN access fees paid by employers/payers
    - Pay for performance opportunities aimed at incentivizing physicians for quality and patient experience improvements
    - Potential for onsite clinics at employer locations for optimal cost effectiveness
    - Shared services to be offered to providers by the network
    - Shared savings contracts from all potential payers.
- A high level illustration of the potential impact related to physician contribution
- The initial cost estimates to establish and operate a successful CIN achieving improved population health in the community
- An early predictor of the minimum revenue stream needed to ensure the CIN is self-sustaining

A number of scenarios were modeled in relation to shared savings performance and provider participation. The projections included here are based on the CIN achieving care management levels halfway between what Milliman identifies as "loosely" and "moderately" managed care levels.[1]

According to Milliman, networks functioning in a loose manner are those whose providers have started building the necessary infrastructure for care management across a population, but are not effectively utilizing the infrastructure to its maximum potential. By contrast, networks functioning at a moderate level have more successfully utilized the network infrastructure, have begun communicating more functionally, and are experiencing positive results in the care of the populations they serve.

The following projections, therefore, are based upon the CIN achieving the level of savings that falls between the Milliman estimates for networks categorized as "loose" and "moderate." This translates into estimated savings in healthcare costs of 3%-4% below benchmark estimates (or below historical healthcare costs experienced by the population being served by the network.) It is important to note that Milliman estimates that successful CINs, particularly those with high levels of community saturation, integration with facilities, and physician collaboration, can achieve up to 18% savings as compared to benchmark estimates.

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[1] Milliman is an international actuarial and consulting firm that provides information regarding healthcare costs, benefit plan design, and usage rates to companies worldwide.

C. PROJECTED FIVE-YEAR INCOME STATEMENT

During 2013, the start-up year, the only source of revenue would be membership fees. Flagler Hospital would fund the shortfall between membership fees and the agreed upon budgeted expenses. This financial support would be in the form of a loan to the CIN that would be repaid to the hospital through future shared savings.

It is critical that a commercial payer arrangement commence in 2013 to ensure the projected 2014 shared savings can be achieved. The following model assumes over 5,000 lives and a target of 3% savings below a 3-year risk adjusted total cost of care benchmark in the mid $500 PMPM range. Optimally, the arrangement would be structured to include an interim settlement at the 6 month point so that an initial payment would be paid in 3rd quarter of CY2014.

The projections also assume the CIN will apply in 3rd quarter 2013 to participate in the Medicare Shared Savings Program beginning January 1, 2014, with no downside risk in the initial 3-year contract term. Additional shared savings arrangements and CIN access fee/performance payment $PMPMs are modeled to begin in 3rd quarter 2014 and continue over the course of the projections.

The table below illustrates the five-year profit and loss statement. The projections result in a cumulative investment of $1.7 million to cover the initial start-up cost with positive income generated in 2015.

The key revenue drivers associated with projections relate to provider participation within the CIN, entrance into new shared savings contracts, and performance related to new shared savings contracts. The key expense drivers in the projections include staffing, technology, and professional fees needed to support the network in achieving the quality, efficiency, and patient satisfaction standards required for shared savings distribution.

TABLE 3:	2013	2014	2015	2016	2017
Revenue					
Annual Membership Fees	$ 258,000	$ 400,000	$ 400,000	$ 400,000	$ 400,000
Access Fee / Care Mgmt Fee - United TPA - $6 PMPM	$ -	$ 144,000	$ 144,000	$ 144,000	$ 144,000
Shared Savings - BCBS Fully Insured	$ -	$ 567,042	$ 567,042	$ 567,042	$ 567,042
Shared Savings - United Fully Insured (including Mcare Adv)	$ -	$ -	$ 105,537	$ 211,074	$ 211,074
Shared Savings - MSSP - 3%/4%/4% savings per year	$ -	$ -	$ 795,694	$ 1,602,012	$ 1,602,012
Total Revenue	**$ 258,000**	**$ 1,111,042**	**$ 2,012,273**	**$ 2,924,128**	**$ 2,924,128**
Expenses					
Salaries, Wages, Benefits	$ 313,125	$ 1,171,625	$ 1,206,774	$ 1,242,977	$ 1,280,266
General Expenses	$ 175,000	$ 180,250	$ 185,658	$ 191,227	$ 196,964
External Professional Fees - includes PCMH support	$ 600,000	$ 150,000	$ 75,000	$ 150,000	$ 75,000
Technology Liscensing Fees ($2,000/physician)	$ 129,000	$ 258,000	$ 265,740	$ 273,712	$ 281,924
Informatics Vendor Fees ($1.00 PMPM)	$ 33,600	$ 67,200	$ 69,216	$ 71,292	$ 73,431
Credentialing Fees	$ 15,000	$ 15,450	$ 15,914	$ 16,391	$ 16,883
Total Expenses	**$ 1,265,725**	**$ 1,842,525**	**$ 1,818,301**	**$ 1,945,600**	**$ 1,924,468**
Total Income Available for Distribution	**$ (1,007,725)**	**$ (731,483)**	**$ 193,972**	**$ 978,528**	**$ 999,660**

A summary of the key Income Statement assumptions driving the model are outlined below.

D. INCOME STATEMENT REVENUE ASSUMPTIONS AND DRIVERS

Annual CIN/PHO Membership Fee:

The forecast assumes the CIN receives an annual recurring membership fee of $1,000 per physician, with an equivalent matching of $1,000 per physician from Flagler Hospital. This annual membership fee ensures the network of an ongoing revenue stream to cover a portion of the CIN's operating expenses.

Physician Participation Levels:

The included projections assume the majority of community PCPs and half of community specialists will join in 2013 with the remaining specialists joining in 2014. PCP participation is critical to revenue potential of the CIN as they are the drivers of patient attribution in shared savings arrangements.

Commercial Network Access Fees and Care Management Fees:

These are fees paid by payers, TPAs, or employers (collectively "payers") who are not participating in a shared savings contract with the network, but instead compensate the network for providing care management services to the payers' population. These are typically expressed as an amount "per member, per month," or "PMPM."

For example, if a payer were to provide Access and Care Management Fees of $5 PMPM, and the CIN was contracting for the care of 1,000 covered lives for that payer, annual Access and Care Management Fees for that payer would amount to $60,000 ($5PMPM x 1,000 covered lives x 12 months.)

Access and Care Management Fees would be negotiated with payers during the contracting process. The model included in this illustration assumes minimal fees to be conservative; however there is a significant opportunity to maximize this source of revenue. As the success of the CIN is demonstrated, a strong value proposition is created and payers may become willing to utilize the services of the CIN to gain efficiencies for their populations not covered through a shared savings contract. These payers will transition members from traditional payer-based programs for utilization management, case management, chronic care management, to the CIN in the form of a $PMPM fee.

Shared Savings:

New shared savings contracts are the primary revenue source driving the CIN's revenue performance of the organization. The projections include assumptions regarding the network's participation in the following shared savings contracts:

- *Florida Blue* - The lives attributed to shared savings contract establish the cost basis and revenue potential associated with the contract. The Florida Blue projected contract lives of 5,600 is based upon analytics Florida Blue provided when analyzing the primary care community in our service area. These lives include both self-insured TPA lives and fully insured lives. Florida Blue is presently amending contracts with self-insured groups in our service area for value based contracting and is very interested in entering in a shared savings contract in Q4-2013.

- *Medicare Shared Savings Program* - The lives attributed to the Medicare Shared Savings Program will be directly correlated to the primary care physician base submitted during the application process and the attribution methodology utilized by CMS in assigning beneficiaries. A minimum of 5,000 beneficiaries are required in order to participate in the program. A recent analysis in unique patient counts for Medicare beneficiaries (FFS & Medicare Advantage) that received services at Flagler hospital resulted in 20,634. Consultative experience with other CMS applications has traditionally yielded lower than expected attributed lives returned from CMS. The model assumes 8,400 lives as the projected attributed lives.

- *United* - With the CIN operational with Florida Blue and Medicare, the model projects participation with United HealthCare will begin Q4-2014 with a base of 1,000-2,000 members.

The CIN may also derive revenue from other activities provided to the medical community. Included in the sources of revenue presented below are "placeholders" for activities that are not yet formed adequately for purposes of estimating economic impact.

- MSO service fees – As the CIN develops the necessary infrastructure to support its activities, there is an economic opportunity to leverage this infrastructure for use by providers in the community. For example, providers might utilize the CIN's credentialing services, billing and collections services, staffing services, management services, coding services, among others.

- On-site clinics – Some employers may choose to offer care to their employees through on-site clinics. Most recently, the St. John's County School System provided this service to its employees. The CIN is positioned to offer such a service effectively and efficiently through its network of providers and infrastructure which supports coordinated and efficient care.

- Pay for Performance Initiatives – The CIN can also contract with payers to provide incentives to providers for the achievement of certain metrics in addition to, or in lieu of, shared savings.

The two tables below illustrate the projected revenue and key revenue drivers as described above.

PROJECTED REVENUE

TABLE 1	2013		2014		2015		2016		2017	
	Rev.	% Rev.	Rev.	% Rev.	Rev.	% Rev.	Rev.	% Rev.	Rev.	% Rev.
Annual Membership Fees	$258,000	100.0%	$400,000	36.0%	$400,000	19.9%	$400,000	13.7%	$400,000	13.7%
Access Fee / Care Mgmt Fee - United TPA - $6PMPM	$0	0.0%	$144,000	13.0%	$144,000	7.2%	$144,000	4.9%	$144,000	4.9%
Shared Savings										
BCBS Fully Insured	$0	0.0%	$567,042	51.0%	$567,042	28.2%	$567,042	19.4%	$567,042	19.4%
United Fully Insured (including Mcare Adv)	$0	0.0%	$0	0.0%	$105,537	5.2%	$211,074	7.2%	$211,074	7.2%
Medicare (MSSP) - 3%/4%/4% savings per year	$0	0.0%	$0	0.0%	$795,694	39.5%	$1,602,012	54.8%	$1,602,012	54.8%
Subtotal Shared Savings	$0	0.0%	$567,042	51.0%	$1,468,273	73.0%	$2,380,128	81.4%	$2,380,128	81.4%
Other CIN Revenue Sources										
MSO Service Fees	TBD		TBD		TBD		TBD		TBD	
Pay for Performance Incentives	TBD		TBD		TBD		TBD		TBD	
Onsite Clinics	TBD		TBD		TBD		TBD		TBD	
Total Revenue	$258,000	100.0%	$1,111,042	100.0%	$2,012,273	100.0%	$2,924,128	100.0%	$2,924,128	100.0%

KEY REVENUE DRIVERS

TABLE 2:	2013	2014	2015	2016	2017
Primary Care Physicians Participating	54	54	54	54	54
Specialists Participating	75	146	146	146	146
Total Physicians	129	200	200	200	200
Lives with CIN Fee Contracts					
United TPA		2,000	2,000	2,000	2,000
Lives Attributed to Shared Saving Contract					
BCBS (Q4-2013 Start)	5,600	5,600	5,600	5,600	5,600
United Fully Insured (Q4-2014 start)		1,000	2,000	2,000	2,000
Medicare MSSP (Q1-2014 start)		8,400	8,400	8,400	8,400
Total Lives Managed by CIN	5,600	17,000	18,000	18,000	18,000
Shared Savings Assumptions (% Saved)					
BCBS - (Q4-2013 Start)	3% Savings	3% Savings	3% Savings	3% Savings	3% Savings
United (Q4-2014 start)		3% Savings	3% Savings	3% Savings	3% Savings
Medicare MSSP (Q1-2014 start)		3% Savings	4% Savings	4% Savings	4% Savings

E. INCOME STATEMENT EXPENSE ASSUMPTIONS

Staffing:

The projections assume the following key staffing assumptions. Hiring will begin in earnest in 3rd quarter of 2013 with staff in place by 2014. It is assumed that staffing resources will be leveraged and shared between the CIN and Flagler Hospital to generate cost and benefits for both organizations. Benefits expense of 25% is included in the amounts presented in the projected Income Statement.

Staffing					
Planned Staff	2013	2014	2015	2016	2017
Executive Director	$ 175,000	$ 180,250	$ 185,658	$ 191,227	$ 196,964
Medical Director - 50%	$ 125,000	$ 128,750	$ 132,613	$ 136,591	$ 140,689
Nurse Managers @$75k each (ratios)	$ 300,000	$ 386,250	$ 397,838	$ 409,773	$ 422,066
Med Econ & Analytics	$ 85,000	$ 87,550	$ 90,177	$ 92,882	$ 95,668
Network Manager / Compliance	$ 75,000	$ 77,250	$ 79,568	$ 81,955	$ 84,413
Asst Executive Director / QI QA	$ 75,000	$ 77,250	$ 79,568	$ 81,955	$ 84,413
Total Staffing [1]	$ 835,000	$ 937,300	$ 965,419	$ 994,382	$ 1,024,213

[1] Year 2013 reflects total annual salary, for recruitment purposes, the Financial Projections will only include a partial year expense in Salary, Wages and Benefits.

Other Expense Assumptions:

- *General Expenses* – These are expenses such as rent, office supplies, and other miscellaneous expenses.

- *External Professional Fees* – These are expenditures for attorneys, accounting, legal and consulting expenses anticipated to be incurred. As indicated below, the amount is inclusive of support offered through the network for the achievement of NCQA Level III recognition by primary care participants as a patient centered medical home ("PCMH.")

- *Technology Licensing and Informatics Fees* - Technology, data analytics, and informatics are critical to the success of a CIN. The ability to secure data exchanges with providers and track quality and efficiency measures at a detail level is a core requirement of a CIN. A RFP has been released to over 25 potential vendor partners that can assist with CIN technology needs. For initial modeling purposes, the projections include a $2,000 annual licensing fee per provider and $1.00 PMPM vendor informatics fee for data exchange and predictive modeling needs.

- *Flagler Start-up Loan Debt Service* – As mentioned in the introduction to the financial projections, the CIN has and will continue to incur start-up costs that have been funded solely by Flagler. In order for Flagler to recover these costs, the CIN will negotiate repayment terms of the loaned start-up capital to Flager at terms and rates consistent with fair market value. The terms of this repayment may include provision for consideration of debt service by means other than monetary repayment. For example, benefits accruing solely to the benefit of the hospital for services or patients not covered through a network contract may be valued and considered debt service repayment. As a result of the significant uncertainty surrounding the terms of such a loan, the projected income statement does not include projected debt service payments from the CIN to Flagler.

The results of these expense assumptions are included in the table below:

Expenses	2013	2014	2015	2016	2017
General Expenses	$ 175,000	$ 180,250	$ 185,658	$ 191,227	$ 196,964
External Professional Fees - includes PCMH support	$ 600,000	$ 300,000	$ 150,000	$ 300,000	$ 150,000
Technology Liscensing Fees ($2,000/physician)	$ 129,000	$ 258,000	$ 265,740	$ 273,712	$ 281,924
Informatics Vendor Fees ($1.00 PMPM)	$ 33,600	$ 67,200	$ 69,216	$ 71,292	$ 73,431
Credentialing Fees	$ 15,000	$ 15,450	$ 15,914	$ 16,391	$ 16,883

F. INCOME STATEMENT ASSUMPTIONS – RESULTS AND POTENTIAL DISTRIBUTIONS

As mentioned in the revenue assumption section, physicians would be required to contribute the equivalent of $1,000 per year in payment, with the some potential opportunity to offset a portion of this cost with participation/intellectual contributions. This annual physician contribution would be matched equally by Flagler Hospital. It is important for physician participants to understand what economic opportunity may be available to them for this membership fee and any other investment they may choose to make in the network. The information above presented the overall projected revenues and expenses for the CIN. However, in order to more effectively communicate at an individual provider level, the following information should be considered.

Providers may receive a financial distribution of a portion of shared savings after expenses (including Flagler hospital start-up loan debt service) if they meet certain criteria established by the CIN, and at the discretion of the CIN's Board of Directors. The Participation Agreement and Operating Agreement (both of which will be available to prospective participants before joining the network) will outline the terms and provisions governing the distribution of payments to participating providers. **The highest level of engagement and collaboration among the participating providers will yield the highest level of steerage and population health improvement, which leads to the highest levels of revenue retention, and the highest probability of economic enhancement for participating providers.**

The following table presents the factors to be considered by an individual provider when considering the potential economic impact of network membership. Note the following:

- Impacts to individual physician practices for the improvement of patient outcomes and quality of care among non-participating payers is included by reference, but not quantified.

- The impact of retaining existing practice patients or realizing additional patient population as a result of network activities is included by reference but not quantified.

- The "value" of CIN services to the practice (in the form of credentialing, contracting, and other services) is estimated based on previous experience.

- The "Potential Physician Payout" is based on the current financial projections and **will change as additional information is obtained in the development of the CIN**

2013 -2017 Aggregate	Moderate	High
Membership Fees for CIN Participation	($5,000)	($5,000)
↑ Quality Practice Revenue	$xx	$xx
NI of Retained Practice Revenue Steerage	$xx	$xx
Value of CIN Services	$25,000 - $50,000	$25,000 - $50,000
Potential Physician Payout	$3,500	$17,000
TOTAL		

THE FINANCIAL PROJECTIONS PRESENTED HEREIN, INCLUDING THE SUPPORTING ASSUMPTIONS, WILL BE MODIFED AND UPDATED AS ADDITIONAL information is available. All potential network participants will receive updated information as part of the participation process.

IX. RECOMMENDATIONS: TIMELINE

Subject	Recommendation	Time Frame
Technology RFP	Implement technology solution to support CIN operations	RFP released - March 8; proposals due back from vendors - April 5; narrow vendor list -May 3; on-site demonstrations - May 3 to June 14; vendor selection - June 21; signed contract - July 19; implementation - through September 1
Election of physician members of initial governing board	Active medical staff members who sign letter of intent and pay $250 application fee eligible to vote for six physician board members	Nominations due May 8; absentee ballots available May 10 and due by May 22; live vote on May 23
First PHO Board meeting; approval of operating agreement; initial committee appointments		May 28, 2013
Board approval of Participation Agreement	Initial governing board to determine whether non-medical staff members eligible to participate	By June 1, 2013
Physicians sign Participation Agreement and make first annual payment of $1000.00		Initial contracting period through July 15, 2013
Participation in Medicare Shared Savings Program	CIN should submit application to participate commencing January 1, 2014	Notice of intent to apply due May 31, 2013. Full application due July 31, 2013.
Evidence-based medicine protocols	Quality Improvement/Quality Assurance Committee to establish procedures for protocol development and implementation for approval by governing board; initial focus on protocols for asthma, diabetes, and preventive care (by age group)	ASAP (reference in Participation Agreement)
Evidence-based medicine protocols	Identify and implement tactics to support participants' compliance with payers' medical necessity requirements	Ongoing

Quality of care measures - hospital	Comprehensive review of payer requirements with regard to accreditations, certifications, and other quality-based criteria for hospital inpatient and outpatient services; develop and implement strategy to address any identified gaps	Ongoing
Quality of care measures - hospital	Compile hospital ratings; develop and implement strategy to improve key ratings	Ongoing
Quality of care measures - physicians	Utilize NCQA measures as standard for physician performance; Quality Improvement/Quality Assurance Committee to recommend minimum performance standards for CIN participation for governing board approval; IT Committee to report to governing board on technology solution to collect and report data	ASAP (reference in Participation Agreement)
"Good citizenship" measures	Quality Improvement/Quality Assurance Committee to identify relevant measures and criteria for governing board approval	ASAP (reference in Participation Agreement)
Efficiency measures	Not included as condition of participation; Marketing and Education Committee to monitor and provide physician education, as necessary; consider total cost of care as measure for PCP shared savings distribution	Ongoing
Transitional care management program	Quality Improvement/Quality Assurance Committee to develop work plan for governing board approval	Work plan due to governing board by October 1, 2013
Patient navigator program	Quality Improvement/Quality Assurance Committee to develop work plan for governing board approval; IT Committee to report to governing board regarding technology solution to identify patients for program participation	Work plan due to governing board by January 1, 2014
Patient engagement	Marketing and Education Committee to develop work plan for governing board approval	Work plan due to governing board by March 31, 2014

Hospital efficiencies	Quality Improvement/Quality Assurance Committee to develop work plan with priorities for hospital gainsharing activities for governing board approval	Work plan due to governing board by November 1, 2013; first project to commence by January 1, 2014
Patient-centered medical home	Marketing and Education Committee to develop work plan for CIN support of PCP PCMH initiatives for governing board approval	Work plan due September 1, 2013; program operational by October 1, 2013
Management services	Marketing and Education Committee to survey physicians regarding interest in various management services and report results to governing board	Survey report due to governing board by January 1, 2014
"Mid-range" strategic planning	CIN governing board to develop long-term plan addressing, at a minimum, MSSP participation, bundled payments, and Centers of Excellence	Plan finalized by end of first year of operations
Administration support staff/other resources	Hire/contract for executive director; identify other immediate staffing/resource needs and contract with hospital for same	ASAP for executive director