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ADVISORS' CORNER

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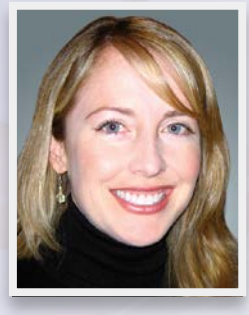
The Day After...



I was listening to the soundtrack of the original London cast of Les Misérables on Bastille Day, working on the usual Governance Institute projects and had no idea about what was going to be happening in a few hours in Nice. Now, writing this editors' letter, it is the only thing on my mind.

As always, this issue of *BoardRoom Press* covers critical strategic issues for the nation's healthcare boards and senior leaders, and we work diligently at The Governance Institute to create resources that really make a difference to those leading the front lines of healthcare. But I would like to dedicate this issue to all of the care providers across the world, the first responders, the people who are joining in the fight, who have to get dirty and bloody and risk their lives to try to keep the death tolls in check. Somehow, in our world today, the lessons of the past must be repeated and repeated again, and we don't yet know when we will be able to breathe normally. I hear the music over and over again: "It is time for us all to decide who we are. Have you asked of yourselves what is the price you might pay? The color of the world is changing day by day. Red—the blood of angry men. Black—the dark of ages past." We honor the brave and selfless men and women who try to make this world whole again, one patient at a time.

Kathryn C. Peisert, *Managing Editor*

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Selecting Value-Based Metrics for Physician Enterprise Success

BY KEVIN WILSON AND JEFFREY WEISZ, M.D., SULLIVAN, COTTER AND ASSOCIATES, INC.

Legislation and reimbursement changes seen in the past year signal the ongoing acceleration from volume-based to value-based healthcare. Despite the additional clarification of government payment models for healthcare providers, the operational and strategic implications for healthcare systems, consumers, and commercial payers is uncertain. As in any major industry transformation, success under the "new rules" will require participants to develop innovative skills and capabilities to navigate uncertain times.

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Key Board Takeaways

Five fundamental questions to consider when selecting value-based metrics are:

1. Where is your organization on its journey to value-based delivery and payment systems?
2. What portion of reimbursement is value-based and what remains based on fee-for-service?
3. What are your organization's goals with regard to population health management? Does the primary care enterprise have the capability of managing population care and risk?
4. What role does physician incentive compensation play in affecting change?
5. Does your organization have the technology to collect, analyze, and report data to physicians in order to drive value-based healthcare?

As leaders of healthcare organizations manage this fluid environment, they need to establish short-term and long-term goals and new measurement systems to define success. Physician performance metrics must also evolve as physician roles change from managing "sickness models" of healthcare to leading systems of care focused around population health. These changing roles will redefine what it means to be a successful physician.

A key challenge for physician leaders will continue to be the engagement of physicians in the data analytics and selection of appropriate and reliable performance metrics. Given the hundreds of potential measures to choose from, this process can be complex. However, with physicians actively involved in the selection process and reporting of metrics in a consistent and meaningful way, there is greater potential for success.

This article provides a framework and system of critical thinking that can guide this challenging process. Selecting meaningful performance metrics for providers begins with the future state in mind—achieving population health by providing access to high-quality, affordable care and an outstanding patient experience.

Much at Stake

Overall, provider performance metrics must align with three key elements of an organization's vision and strategy:

1. Business model: What is the strategic direction of the organization and how is it likely to change over the next three to five years? What changes are sought at the individual, team, and enterprise level?
2. Population health: More than just a focus on preventive care or coordination of chronic conditions, a population health strategy defines an optimal patient care experience, clinical quality outcomes, and resource management methods to improve the health of the communities served.
3. Payer reimbursement: How much revenue is still derived from fee-for-service arrangements? All organizations are experiencing transition in which productivity-based payment is still in play. Implementing performance measures, designed to drive quality outcomes, can have a negative financial effect when a number of commercial payer contracts still have volume-based reimbursement provisions. To combat this potentially invalidating effect, organizations need to employ short-term measures that balance the financial realities of existing contractual arrangements with the transitioning value-based reimbursement environment.

Understanding the evolving reimbursement landscape and its implications on performance measure selection is critical. Last year, the Centers for Medicare & Medicaid Services (CMS) announced its intention to accelerate the transition from volume to value reimbursement and the industry took notice. Specific details have now emerged through the recent CMS announcement of a new physician reimbursement system known as the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA will assign organizations a composite score, based 50 percent on quality, 25 percent on advancing care information, 15 percent on clinical practice improvement, and 10 percent on cost. Over the next decade, Medicare will increase the level of reimbursement risk associated with value-based performance up to an additional 9 percent of total fees by 2025.

Many agencies, such as CMS (through the Physician Quality Reporting System) and the National Committee for Quality Assurance (through its Healthcare Effectiveness Data and Information Set) already measure value-based performance through the use of quality and service metrics. MACRA will allow healthcare entities to select a set of six quality metrics, including at least one outcomes-based and one cross-cutting measure.

In addition, physician performance scores are now becoming available to the public through CMS and other agencies. Thus, an organization's chosen metrics have the potential to impact not only its financial performance, but also its reputational strength, and therefore require appropriate oversight including board-level governance.

Four Pillars of Value-Based Metrics

Specific metrics chosen will depend in part on their ability to align physician performance with the elements of organizational strategy noted above. They should, however, also be selected based on the core principles of population health:

1. Access: To receive timely treatment, patients need appropriate access to

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Cybersecurity Responsibility and Accountability: What Directors and Officers Must Understand About Managing Data

BY CAROLYN V. METNICK, J.D., LL.M., AKERMAN LLP

Healthcare organizations are increasingly falling victim to cybercrimes, particularly data hostage through ransomware attacks. Healthcare providers may be more vulnerable than other industry organizations due to their relatively recent embrace of information technology and the overall low prioritization that cash-strapped providers facing reimbursement changes and regulatory challenges have placed on information technology security. While there has been an urgency for meaningful use adoption and compliance, the same urgency has not been placed on information security beyond complying with HIPAA and HITECH. Moreover, because of the life and death issues hospitals and health systems face, they tend to be more willing to pay a ransom to regain access to medical data necessary to provide care. Consequently, due to the exigency of patient care, providers are more likely to be targeted.

Proliferation of Cyber-Attacks

The FBI recently issued a warning about the proliferation of ransomware attacks, a number that increased in 2015 and is expected to rise again in 2016.[1] Although cyber-attacks in other industries have been well publicized in recent years, hospitals and health systems have only recently become regular targets. In the first five months of 2016 alone, attacks were reportedly launched on hospitals in Kentucky, Kansas, California, and Maryland. Unfortunately, with the number of cyber-attacks on the rise and the level of sophistication necessary to accomplish such attacks, providers must be serious and strategic about cybersecurity oversight, which begins with an organization's board of directors.

Fiduciary Responsibilities

Of course, directors and officers owe fiduciary responsibilities, including the duty of care, to their organizations. The duty of care requires the exercise of reasonable care and attentiveness in the decision-making process. A director must act in good faith and as an ordinarily prudent person would act under similar circumstances. While directors may reasonably rely on information, advice, and reports from counsel, advisors, and management, the duty of care requires directors to stay informed, be attentive, and act in the best interest of the organization. A director's obligation includes a duty to attempt in good faith to ensure that a corporate information and reporting system exists that is designed to bring information to the board and management's attention concerning compliance with the law and business performance.

Shareholder Derivative Litigation Against Directors Arising out of Data Breaches

To add insult to injury for directors and officers who have attempted—but failed—to prevent a cyber-attack, regulators, shareholders, and consumers have actively pursued claims against organizations involved in data breaches. The Federal Trade Commission has initiated investigations and litigation against corporations involved in data breaches. Consumers, who have been the subject of such breaches, have initiated litigation, and shareholders have increasingly filed derivative litigation against such organizations and their officers and directors alleging that the defendants failed to take reasonable action to secure the organization's information technology infrastructure thereby allowing the breach incident to occur. In almost every case, the plaintiffs alleged that the organization, through its officers and directors, failed to implement adequate data security mechanisms, resulting in damage to the organization's reputation and significant legal fees.

In one shareholder derivative action arising out of the data breach of a large retailer, the plaintiffs alleged that the officers and directors failed to take reasonable action in the face of known threats to, and vulnerabilities in, its network and sought redress for breaches of the fiduciary duties of loyalty, obedience, and care. Specifically, the plaintiffs alleged, in part, that the defendants failed to exercise reasonable and prudent supervision of the management, policies, practices, and controls of the financial affairs of the corporation by failing to protect personal and financial information and comply with legal obligations.

The plaintiffs in another derivative action involving a retailer alleged that the officers and directors failed to implement internal controls designed to detect and prevent a data breach. They alleged that defendants failed to remain informed of the organization's conduct in its operations, to make reasonable inquiry in connection therewith, and to take steps to correct any imprudent or unsound practices. In both cases, the plaintiffs also alleged claims arising out of each corporation's response to the breach.

Although much of the litigation is ongoing and it is too early to conclude how it will fare, officers and directors of healthcare organizations can take away several important lessons from the recent shareholder derivative lawsuits.

Cyber-Risk Oversight Is a Board Responsibility

First, directors and officers must embrace cybersecurity oversight as one of their duties. Lacking the necessary technical expertise to add value in cybersecurity

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Key Board Takeaways

Cybersecurity oversight begins with an organization's leaders. A board member's failure to take reasonably prudent steps and exercise care in overseeing the organization's information technology system can have serious consequences and result in personal liability for failure to fulfill a director's duty of care. In satisfying this duty, board members should:

- Understand where the organization's information is stored and how.
- Receive education on the organization's systemic vulnerabilities and risks.
- Reasonably mitigate against any vulnerabilities and risk on a timely basis.
- Stay current on industry cyber-risks.
- Ensure the organization has an incident response plan that is annually reviewed and updated as necessary.
- Receive reports about breaches and risks and make cybersecurity a regular agenda item at board meetings.

1 "Incidents of Ransomware on the Rise: Protect Yourself and Your Organization," FBI, April 29, 2016.

The Board's Accountability for Complex Healthcare Strategies: Exercising "Due Care" in the Face of Unfamiliar Organizational Strategy and Strategy in Action

BY DANIEL K. ZISMER, PH.D., AND KEVIN J. EGAN, J.D., CASTLING PARTNERS

Strategy is the pathway to mission fulfillment; tactics are the action of strategy. The purpose of strategy is the development and application of the full potential of an organization's ability to move it forward towards its vision and mission responsibilities for those served.

Boards, by definition, are accountable for the actions and outcomes of all corporate strategy, with the CEO and other senior leaders serving as instruments of strategy management. Further, boards and senior leadership share the responsibilities of "due care" as strategic goals and objectives are initiated and pursued. Governing boards cannot avoid nor compartmentalize the duty of due care in the development and management of strategy by exclusively utilizing committees of the board (e.g., the strategy committee) or the senior leadership team. The full board owns all related responsibilities and the accountabilities of an organization's strategic planning process, as well as the results and consequences of the execution of a strategy ("strategy in action").

Boards and senior leadership share the responsibilities of "due care" as strategic goals and objectives are initiated and pursued. But the full board owns all related responsibilities and the accountabilities of an organization's strategic planning process, as well as the results and consequences of the execution of a strategy.

Due Care Defined

Fiduciaries of hospitals and health systems that engage in governance are bound by three critical duties:

- The duty of care
- The duty of loyalty
- The duty of obedience

By definition, the duty of care requires all boards (and individual board members) to exercise due care in discharging their duties of governance. "Due care," defined in a practical sense, means that board members individually and collectively bring to bear their experience and judgment in service to the mission of the organization, exercising reasonable and sufficient effort to best ensure that the organization they govern operates prudently as it pursues its mission within all appropriate boundaries of legal and regulatory guidance, sound fiscal and managerial practices, according to the highest standards as amplified within industry practices. This is a high standard often lacking clear "bright-line tests" defining due care, except to the extent that governmental regulation applies. In corporate governance disputes, issues surrounding compliance with these illusive standards of due care are judged based upon alleged violations of these uncertain standards. In other words, a governmental agency or a court will itself define and apply a "standard" to adjudicate the actions of a governing board. The governing definition of due care can come *ex-post facto*; i.e., following the event warranting judicial or regulatory review.

Key Board Takeaways

Board members are ultimately responsible and accountable for the design and execution of strategy. While responsibilities of execution may be delegated to management, state statutes regulating licensed hospitals will see a board as the accountable body regarding plan design, execution, and outcomes. A few things for boards to consider include:

- Directors are charged with the responsibility of "due care" as it relates to the design and execution of strategy. Board members are expected to be qualified and competent to approve and oversee the execution of decisions they make.
- Due care, as it relates to organizational strategy, must address a comprehensive range of potential risk exposures, including the risks that derive from the interaction and interplay of multiple tactics of a strategy (referred to as "integrative risk"). A comprehensive range of integrative risk extends beyond legal, regulatory, and compliance risk to include financial, patient care, reputational and brand risk, work environment, cultural, and the risks of dysfunction of the senior team.
- Required board behaviors, as it relates to due care of strategy, involve ongoing demonstrations of effort in monitoring strategy in action—a concerted and recorded effort of evaluating outcomes of an approved strategy, including the identification and mitigation of observed and potential risks of the strategy.
- Insurances covering directors and officers (D&O insurance policies) should be examined for gaps and coverage limitations relating to an active organizational strategy.

The Complexity of Strategy and Related Integrative Risk

Healthcare system strategies must embrace a complex series of marketplace inevitabilities including:

- A consolidating payer market
- Governmental payer pressures for demonstrable value
- Downward pressures on price, utilization rates, and total costs of care
- A waning interest in independent practice by physicians
- Patients' demands for services, availability, access, and a superior experience
- Intense price competition

- The emergence of niche market (and service) innovators and disruptors
- The need for scope, scale, and related economies to remain relevant and viable

It is apparent that governing boards are required to authorize strategies of increasing complexity and often uncertainties. Resulting tactics put into play present increasing organizational risk and these tactical risks must be considered in at least two dimensions. Initially, the risk of each tactic operating in isolation of all others must be weighed. The second dimension of risk to be carefully reviewed involves the intersection and interaction of all tactics together. This latter dimension, not always fully considered, is referred to as "integrative risk." As the performance of individual tactics are encouraged and often pushed to higher levels of performance, so too is the integrative risk profile of a given organization. The two case examples below better illustrate the need to carefully consider organizational risks.

Case Example #1

Community Health System (CHS) operates a clinically integrated network inclusive of employed physicians and affiliated independent physicians. CHS launches an aggressive "brand value" marketing campaign, emphasizing its ability to coordinate care according to evidence-based best practices.

A new patient joins the system as a result of being positively impressed by the campaign. Not surprisingly, this patient's first visit is with a primary care physician employed by CHS; the visit goes well. A referral is next made to an independent cardiologist affiliated with the network. Another related referral is then made from the second physician to a non-affiliated consultative specialist. Neither of the referral physicians are employed by CHS nor do they operate within CHS's electronic medical record. The primary care physician who first saw the patient is unaware of the referral to the third physician. A key lab result never reaches the primary care physician and the patient's health suffers, accordingly. Additionally, the patient bears a high percentage of cost for services performed by the third physician, as that practice is out-of-network given the patient's insurance coverage.

From the perspective of strategy and tactics approved by governance:

- The first physician is employed by CHS; the organizational tactic was to pursue and "employ more primary care physicians."
- The second physician is an independent affiliate of CHS's clinically integrated network; this tactic was applied to expand the number of affiliated specialists cost-effectively.
- The third physician was not in the strategic plan at all.

Here the tactics were sound, by design, but the tactics in action produced unexpected, and potentially costly and harmful, integrative risk results. So far as the plaintiff's lawyer is concerned, all physicians involved were operating as "agents" of the health system.

"Agents" can bind their "principals" by what they do or fail to do. In the employment context, an employee is unquestionably an agent of his/her principal and a mistake of the agent/employee can impose liability on that principal/employer. For example, if an employed OR nurse makes a mistake, his/her employer/principal is liable under the law for whatever damages flow from the misadventure of the agent/employee.

In this case, the plaintiff's attorney will assert that all of the physicians involved in patient care in this setting are agents of the health system and that it is legally responsible for the actions of these physicians, even if they were not technically employees of the organization. The law may (or may not, depending on what comes out at trial) conclude that the facts proven allow the jury to conclude that *apparent* agency was created by all of the facts involved in the care of the patient/plaintiff.

A finding of apparent agency will impose legal liability upon our hypothetical health system that often does not carefully consider the risk of this occurrence. One caveat—state law varies here and some states will not yet apply the law of apparent agency to all healthcare activities.

Case Example #2

A principal goal of the strategy for CHS is partnerships with independent physicians. One tactic within the strategic plan calls for joint ownership of an ambulatory surgery center (ASC), shared between physicians and the hospital, which will retain a 51 percent ownership. Ten surgeons are included in the venture, including one employed by CHS. The physicians are paid as "managing partners" of the entity, based partially on the financial performance of the venture.

The partnership exceeds volume and financial performance projections well ahead of the expected timeline. Clinical outcomes are good and patients report "excellent experiences." All seems good. But underneath, there are issues brewing:

- Since the hospital is a 51 percent owner, the health system's auditor concludes that the partnership should be viewed as a "consolidated entity" for accounting purposes meaning that, while the terms of the partnership remain in place, the venture will be reflected and reported by the auditors as a "consolidated entity" of the health system.
- The payer mix of the surgery center is weighted to patients covered by commercial insurance, reflecting a more favorable

payer mix than that of the health system's hospital.
- The physician management company earns bonus payments based upon the financial performance of the ASC.
- The hospital provides a number of support services to the ASC that may not be fully accounted for and billed to the partnership, and the ASC benefits from supply contracts held at the local hospital (a tax-exempt entity), for necessary items including medications.
- Two physicians employed by the health system have ownership interests in the ASC.

While there may be no obvious legal, regulatory, or tax violations apparent in the operation of the partnership, based upon the facts presented, none of these facts or circumstances were disclosed to the board and may or may not be known by the full senior leadership team. At this point, the board's responsibility for strategy (beyond approval of the strategic plan) is guided by a fiduciary's responsibility of "due care." As noted above, boards and their officers are fully responsible for the actions of implementation and the consequences of strategy—known or unknown.

How Can Boards Exercise Due Care in the Management of Integrative Risk?

There are no tried and true recipes for the exercise of due care by a board as it relates to strategic initiatives and plans. Likewise, there are no bright-line legal tests of a board exercising due care in the face of ever more complex legal and regulatory action in the healthcare industry. Experience does demonstrate, however, that best efforts have value and do indeed "count" at least in matters of civil litigation and non-criminal governmental enforcement actions.

How can a governing board and senior leadership teams of healthcare organizations effectively execute a goal of "due care" as it relates to the management of a complex market strategy? A best practice approach can be devised.

One effective approach calls for the senior leadership to present its evaluation of a risk and reward profile for one or all tactics encompassed by the proposed strategic plan (see **Exhibit 1**). In the example in Exhibit 1, each member of the senior leadership team (SLT) establishes their position regarding the value and risk profile of a specific tactic of a strategic plan under development: equity partnerships and contractual arrangements with independent physician specialists (and specialty groups).

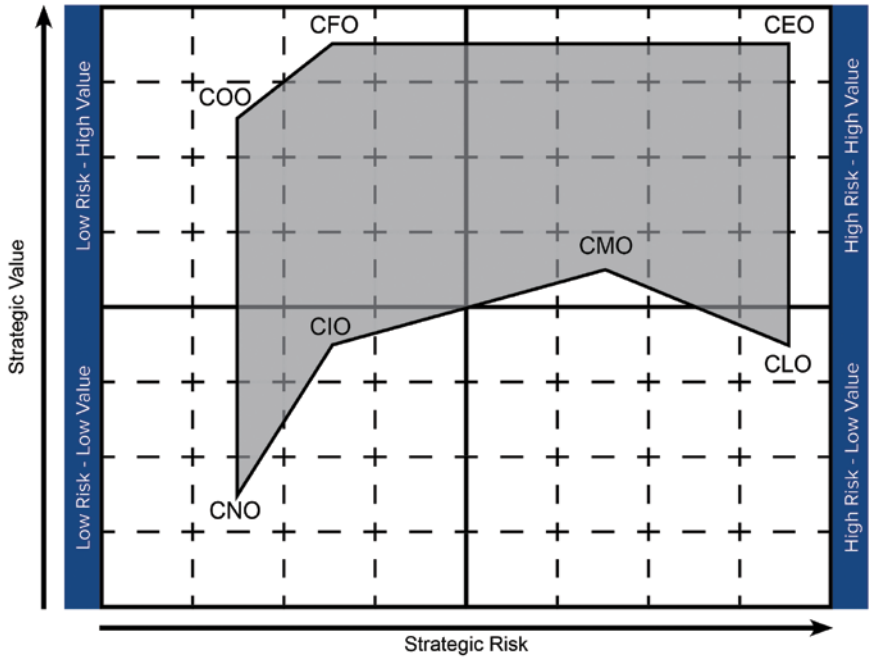
The consensus is that success in the markets served will require new and innovative relationships with independent physicians who practice specialty care in areas of strategic interest to the organization. Consensus among SLT members does not, however, mean that each feels the same about the value-to-risk profile of the tactic. Based upon the concordance profile of the group, it is clear that individual officers' sentiments are "all over the map." Notable are the differences in sentiment between the CEO (who sees the tactic as high value and high risk) and the CFO (who also sees high value, but much less risk). The CNO sees the tactic as low value and low risk. There are no correct answers here. The need is for a frank conversation among members of the SLT. The three important questions are:

1. What causes such apparent "discordance"; why do members of the SLT judge the value/risk profile to be so different?

Exhibit 1: Strat-a-Map

Organization: Community Health System **Date:** December 2015

Tactic: Equity Partnerships and Contractual Arrangements with Independent Physician Specialists (and Specialty Groups).



Response Qualifiers	Tactics to be Judged by SLT
A. Financial: P&L, Cash Flow, Balance Sheet	1. Employed PCPs
B. Brand Value	2. Employed SCPs: Cardiology
C. Market Position Geographic	3. Large Ambulatory Centers 2 x 100,000 sq. ft.
D. Payer Opportunities and Relationships	4. Clinical Service Lines with Geographic Reach
E. Competitor Positioning/ Response	5. Our Own Health Plan
F. Internal Culture	6. Clinically Integrated Network
G. Physician Attractiveness	7. Population Health with Financial Risk
H. Total Allocation of Org. Resources	8. Partnerships with Independent Physicians
I. Internal Competencies ("Know How")	9. Acquisition of Home Health Agency
J. Risks to "My Performance"	10. Tele-Health Development
K. Quality of Patient Care	
L. Key People Response: Those Essential to Success	
M. Other:	

Exhibit 2: Strategy Performance Scorecard

Strategy Plan Section: **Reporting Period:**	Physician Services Tactics Third Quarter, FY 2017	Plan Status	Risk Status
Tactic #1:	Expand employed primary care network	🟢	🔴
Tactic #2:	Expand number of employed specialists; cardiovascular and hospitalists	🟢	🟢
Tactic #3:	Develop regional clinical service line; cardiovascular and cancer	🔴	🟢
Tactic #4:	Develop partnership with orthopedic group	🔴	🔴
Tactic #5:	Engage key independents in clinical network formation	🟢	🟢
Tactic #6	Ensure timely patient access across pcps	🟢	🔴
Tactic #7	Interprofessional team development - Primary Care	🔴	🔴
Tactic #8	Network-in regional CAH's	🟢	🟢

Note:
The strategy scorecard is designed for use with governing boards. This report provides progress status indicators for tactics in action. Two status indicators are recommended; "Plan Status" and "Risk Status". Green and red colors are used to indicate need for management and board interaction; green for "on-plan" or "no risk briefing required" and red meaning "progress negative to plan" or "risk briefing required".

2. With this apparent discordance, can all members of the SLT support execution of the tactic?
3. What will each individual's outward response be if execution doesn't yield the expected outcomes?

CEOs or chief strategy officers may be reluctant to share results of such an exercise with the full board. Results could be used as "strategy work in process" to be shared with a standing or *ad hoc* strategy committee of the board. Work such as this can be summarized for the board as it considers the approval of the plan. A process such as this provides the SLT the opportunity, regarding the risks of execution, for transparency.

Evaluation of a Strategy in Action

With every board meeting, a report of "strategy in action" should be provided by the leadership team (see **Exhibit 2**). For each tactic of the approved strategic plan, a member of the leadership team should clearly:

- Identify the tactic.
- Note the parties responsible for oversight and management of the tactical plan.
- Report the results expected as well as those achieved.
- Illustrate the categories of potential risk identified, as well as the method of risk management applied.

This report should often include commentary by internal legal counsel or outside experts supporting oversight of risk management related to the strategic plan.

The CEO is accountable for providing the board with a detailed assessment of the current state of the management of the strategic plan. This review should include future actions anticipated to best ensure favorable performance of the plan, with a clear focus on balancing expected returns with all inherent organizational risk.

Prudence dictates that physician leaders of the organization also participate actively in such a strategy performance review, as they are often in a position to see consequences of strategy through a "set of eyes" burnished by education, training, and experience, different from senior leaders who are not clinicians. Boards should encourage these physician leaders to speak as accountable partners when evaluating the organization's strategy in action.

There is reason to believe that courts and regulatory bodies at both the state and federal levels intend to hold governing boards and the officers of not-for-profit healthcare organizations to an increasingly high standard of due care emphasizing organizational behaviors that fall within the ambit of strategy and strategies in action.

The Tests of the Process of Due Care by a Governing Board

There is reason to believe that courts and regulatory bodies at both the state and federal levels intend to hold governing boards and the officers of not-for-profit healthcare organizations to an increasingly high standard of due care emphasizing organizational behaviors that fall within the ambit of strategy and strategies in action. While it is challenging to reduce the process of managing related risks to a collection of "operating checklists," policy and process do matter in this setting, as a well-defined process indeed represents a governing board's clear commitment to meet that illusive "reasonable person standard."

Regulatory agencies and the courts will likely be sympathetic to sincere attempts by governing boards and officers to safeguard an organization and those it serves from possible missteps arising out of strategy in action, providing there are not blatant attempts to create benefit by violating the law. In such cases, governing boards may indeed be accorded consideration in their sincere efforts to manage this challenging risk.

The Governance Institute thanks Daniel K. Zismer, Ph.D., and Kevin J. Egan, J.D., Managing Directors and Co-Founders of Castling Partners, for contributing this article. *They can be reached at daniel.zismer@castlingpartners.com and kevin.egan@castlingpartners.com.*

Three Leadership Imperatives for Success with Value-Based Care

BY PATRICK M. ALLEN AND MARK E. GRUBE, KAUFMAN, HALL & ASSOCIATES, LLC

Healthcare's transition to value-based care delivery and payment is appropriate and inevitable. It cannot and should not be resisted, but rather, planned for and implemented by providers nationwide. Unlike the "tipping point" described by Malcolm Gladwell,[1] which happens quickly and is hard to prepare for because predictions are lacking, healthcare organizations have had ample forewarning of the basic trajectory of health system change.

Value-based contracting may be developing slowly in some markets, but in other markets it's moving rapidly as organizations assume responsibility for managing the health and care needs of defined populations. Many hospital systems, physician groups, and other providers are working hard to transition to value-based care delivery. Much of their future success will ride on their leaderships' commitment to meeting three imperatives.

1. Planning and Using a Blueprint for the Journey

Hospital and health system executives and directors should closely track trends and issues associated with the industry's changing model, assess the financial implications to their organizations, and devise and implement effective plans to address the challenges. Deliberate thinking and controlled contingency planning will help organizations secure a solid market position and continued financial stability.

Significant investment of human and capital resources will be required to build value-based care delivery vehicles, such as accountable care organizations and clinically integrated networks. Care delivery design often must be reshaped or developed anew. Revisioning and redesigning the delivery system should be staged based on the entity's unique market, capabilities, desired role, and competitive factors. The foundational planning is grounded in fact-based market, financial, and clinical/quality realities, and the organization's current and expected performance related to these realities.

Leaders must be committed to use of an integrated planning process and plan. The plan positions the organization to provide services in an environment characterized by better informed and more cost-conscious consumers. It identifies the pieces of infrastructure required for a delivery system that firmly positions the organization in the ambulatory sphere, and with a blueprint-like approach, determines how and where those pieces would be assembled.

A blueprint identifies the items to tackle first, but leaders ensure that all of the puzzle pieces are on the table so that the organization applies objective criteria to drive delivery decisions and their implementation. The existing hospital chassis is *not* likely to have the right assets in the right geographies to manage population health under value-based arrangements. The board should be involved in, or provide close oversight of, relevant analyses and planning exercises.

Key Board Takeaways

It is clear that healthcare is transitioning to value-based care delivery and payment. Rather than resisting this change, providers nationwide need to be planning for and implementing new contracting arrangements. To ensure success with value-based care, healthcare leaders should focus on the following imperatives:

- Use of an integrated planning process and plan that positions the organization to provide services in an ambulatory-centric environment.
- Partnering with and/or managing a network of post-acute providers to better position the hospital or health system for success under value-based payment models, particularly bundled and capitated payment.
- Use of arrangements that incentivize employed and independent clinicians in post-acute settings, hospitals, and doctor's offices to ensure that patients receive care in the lowest-cost setting appropriate to the patient's condition.

2. Drive Value through an Aligned Post-Acute Network

Efficiency will be critical for hospitals and health systems that want to be included in value-based delivery networks forming nationwide. Broad strategic thinking about the care patients receive after they leave the hospital's four walls is required to yield such efficiency, resulting in the right care in the right place at lower costs and better quality.

New payment models emerging under a population health/value construct are incentivizing closer relationships between acute hospitals and post-acute care (PAC) providers that offer skilled nursing, home health, inpatient rehabilitation, hospice, and palliative care. The goals are to:

- Reduce costs related to uncoordinated care transitions between acute and PAC.
- Eliminate avoidable readmissions and their associated penalties.
- Increase the efficiency and quality of PAC.

Hospitals and health systems should consider post-acute services within the broader continuum, and integrate PAC within their strategic-financial planning process. Partnering with and/or managing a network of PAC providers can better position hospitals for success under risk- and value-based payment models, particularly bundled and capitated payment.

A range of alignment options exist for hospitals and health systems, including:

- General outreach/marketing/support (for example, IT integration for record sharing)
- Preferred provider agreements (if certain quality, service, cost, and other metrics are achieved)
- Joint ventures through an equity or other type of investment
- Ownership

Organizations can pursue multiple options simultaneously, depending upon the post-acute business. Owning everything typically is not a desired or viable option. Through preferred arrangements, hospitals can tighten the strategic-financial connection with their PAC providers to ensure that care consistently meets quality, utilization, and cost targets.

Whether joint venture, acquisition, or another option is selected, the criteria are the same. The business case for the hospital–PAC provider partnership must be based on quantitative and qualitative analyses of the strategic-financial impact, geographic coverage and access, ability to provide the required care, and management strength.

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1 M. Gladwell, *The Tipping Point: How Little Things Can Make a Big Difference,* New York: Little, Brown & Company, 2000.

Selecting Value-Based Metrics…

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primary and specialty care. Evening and weekend clinic hours with 24/7 availability are required to prevent unnecessary emergency room visits and hospitalizations. Telephone consultations and telemedicine provide efficient avenues of patient care and minimize the necessity of on-site office visits.

2. Quality: Measures should relate to four key areas that span the continuum from prevention to acute care. These include:
   - » Healthy lifestyle and disease prevention initiatives, through screening and immunizations
   - » Coordination and management of chronic disease
   - » Hospital care focused on patient safety and the reduction of acquired hospital infection and readmission rates
   - » Medicare-specific measures that address falls, depression, urinary incontinence, and polypharmacy
3. Service/patient experience: The rise of consumerism transforms the patient into the consumer, and heightens the importance not only of clinical outcomes, but of the all-around patient experience. The physician/patient bond centers around mindful listening and is essential in addressing wellness, shared decision making, culturally sensitive care, and healthcare disparities.
4. Affordability: Operational efficiency and resource management is key to reducing costs and achieving the value required by payers. This includes the appropriate utilization of medications and imaging and laboratory testing as well as standardization of processes and tools. Identifying the bases of litigation cases and correcting their causes will improve processes of care and prevent future adverse outcomes.

Choosing Value

Incenting physicians to deliver value—high-quality, cost-effective, consumer-friendly healthcare—is a brand new objective for many healthcare organizations. The selection of performance metrics should be approached with careful consideration that includes an understanding of how each measure aligns with overall strategic and financial objectives. Remember that the metrics themselves should be adjusted and replaced to reflect changing needs and objectives, but they should adhere to the core principles of population health.

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Cybersecurity Responsibility and Accountability…

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oversight is not an excuse for ignoring cyber-risks. Boards need to understand where organization information is located and how it is maintained. One cannot understand the cyber risks without understanding the landscape. Board members must then be educated at a high level on applicable laws governing the maintenance and protection of data, as well as cyber risks and system vulnerabilities. Second, vulnerabilities and risks require proper attention. If leadership becomes aware of specific vulnerabilities, it must promptly address them.

Additionally, it is essential that board members stay current on risks impacting the industry. They should be aware of the ransomware attacks that were made on other hospitals and evaluate their organization's readiness for such an attack, as well as its incident response plan. The incident response plan should clearly describe the internal and external reporting process as well as record-keeping, documentation, and the incident response team. Given the regularity of these events and the FBI's recent notice, boards need to be prepared to prevent and respond to incidents. Cybersecurity should be a regular item on the board agenda and the board needs to receive updates and reports from the chief technology officer or other employee responsible for managing the information technology system, along with any committee that has been delegated cyber-risk oversight. It is important for the board to be informed of any risks or incidents and be involved in decisions about mitigating and managing those risks. These reports and discussions should be carefully documented in board minutes in a way that does not reveal existing risks but memorializes that the board was apprised of the risks and made a reasonable decision regarding them based on the available information. Recruiting board members who have expertise in the area of information technology can also be helpful. Certainly, organizations can delegate risk oversight to an audit committee, which reports to the board, as long as the audit committee members are appropriately educated and trained to understand the information technology and the issues it poses.

It is not a matter of if a breach occurs; it is a question of when. Criminal attacks have been identified as the primary cause of healthcare data breaches.[2] Providers need to be ready and it is the board and management's responsibility to oversee the preparedness. An officer or director's failure to take reasonably prudent steps and exercise care in overseeing an organization's information technology system may result in personal liability.

The Governance Institute thanks Carolyn V. Metnick, J.D., LL.M., Partner, Akerman LLP, for contributing this article. She can be reached at carolyn.metnick@akerman.com.

2 See "Criminal Attacks Are Now Leading Cause of Data Breach in Healthcare, According to New Ponemon Study," Ponemon Institute, LLC, May 7, 2015.

Three Leadership Imperatives...

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3. Ensure That Clinicians Are Part of the Solution

Under the value-based model, improved economic and clinical alignment between hospitals and clinicians will be essential to:

- Change the way patient care is delivered and reduce clinical variation.
- Enhance patient, family, and provider satisfaction and engagement.
- Improve each element of the value equation.

Developing a solid hospital–clinician alignment plan involves recognizing that one strategy will not be appropriate for all physicians or other clinicians, and that hospitals and health systems should offer multiple options. A pluralistic model or hybrid strategy that includes independent clinicians, clinically integrated physicians, and employed clinicians (as permitted by law) is recommended.

Whether employed or independent, clinicians in post-acute settings, hospitals, and doctor's offices must be aligned through arrangements that incentivize them to ensure that patients receive care in the lowest-cost setting appropriate to the patient's condition. The hospital's goal should be to encourage/reward behavior that helps to reduce unnecessary admissions and readmissions, emergency department visits, and discharge to PAC facilities that provide a higher level of care than a patient requires.

Hospitals may wish to consider the following approaches:

- Employing the lead physician(s) practicing in the preferred skilled nursing facility(ies), or making arrangements to provide coverage by hospital-employed physician(s), particularly for patients at high risk for readmission
- Educating clinicians in physician-support/extender roles, such as nurse practitioners and physician assistants, about preferred PAC options in the community
- Ensuring that case/discharge planning managers who work with the patient and family understand the patient's social infrastructure, know the PAC options in the community, and can refer patients to preferred home care agencies and PAC facilities

Hospital leaders must encourage and incentivize doctors to have much earlier conversations with patients about end-of-life care than they typically do. Increased use of hospice and palliative care will be critical to improving patients' quality of life and reducing care costs.

Closing Comment

Hospital and health system leaders should use an iterative approach to timing and coordinating the transition to value. Frequent strategic and financial planning will be required to fully understand the implications of evolving payment and care delivery models. Regular assessment of the market, the organization's position in its market, and value-based arrangements will better enable leadership teams to build sustainable care delivery strategies.

The Governance Institute thanks Patrick M. Allen, Managing Director, Kaufman, Hall & Associates, LLC, and Mark E. Grube, Managing Director, Kaufman, Hall & Associates, LLC, and Governance Institute Advisor, for contributing this article. They can be reached at mgrube@kaufmanhall.com and pallen@kaufmanhall.com.

MACRA Physician Payment Reform...

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to shift market share or increase physician alignment?

- Are the core capabilities essential for financial success in place or being developed?
- Is our organization ready to proceed with two-sided risk?
- Can we implement operational offsets if revenues decrease due to declining use rates?

As a board, be prepared to address these questions:

- Is the board comfortable with assuming the financial risk of an APM?
- What are potential impacts on bond ratings or our ability to raise capital?
- Is our leadership ready and capable to manage added risk?
- Is offering an advanced APM likely to draw physicians to our hospital/system?
- Can we partner with others to reduce the impact?
- What additional IT/EMR funding might be needed to add physicians and/or to meet Meaningful Use standards?

The following work streams should be considered to prepare for MACRA:

- Develop a roadmap to understand and assess merits and risks of MIPS and APMs for employed and independent physicians, and the organization.
- Assess the MIPS/APM options based on your unique market position, resources, experience with, and appetite for financial risk, IT capabilities, care coordination, and care management capabilities.
- Determine how the disruption caused by MACRA can be used to align with independent physicians by providing appropriate resources for them to meet MACRA requirements.

Final Word

MACRA establishes financial incentives to accelerate the physician transition to population health and value-based reimbursement models. These options increase both financial risks and potential rewards to physicians. MACRA ensures that status quo is not an option. There will be winners, and there will be losers. There are opportunities to increase alignment with physicians, improve quality, and create efficiencies. Do not become so distracted by the details that you lose sight of potential strategic, financial, and patient care benefits associated with this change.

The Governance Institute thanks Guy M. Masters, Principal, Premier, Inc., and Governance Institute Advisor, and Seth Edwards, Director, Population Health Management Collaborative, Premier, Inc., for contributing this article. They can be reached at Guy_Masters@PremierInc.com and Seth_Edwards@PremierInc.com.

MACRA Physician Payment Reform: Board Considerations for Strategy, Financial Risk, and Physician Alignment

BY GUY M. MASTERS, PREMIER, INC.

The Medicare Access and CHIP Reauthorization Act (MACRA) was passed by Congress and signed by President Obama on April 15, 2015, receiving broad bipartisan support. MACRA replaces the outdated Medicare Part B sustainable growth rate (SGR), the fee-for-service (FFS) adjustment method used since 1997 to reimburse physicians for Medicare services. MACRA creates two new payment formula options for physicians and other clinicians: the Merit-Based Incentive Payment System (MIPS) and eligible advanced Alternative Payment Models (APMs).

MACRA will have economic and strategic impacts for physicians, clinicians, hospitals, and health systems and will accelerate the transition to population health-oriented, value-based payment structures. It is essential to assess the potential effects of MIPS and APM options to determine which is best suited for employed, aligned, and independent clinicians associated with your organization. (Note that payments for physician services provided to Medicare Advantage [HMO] patients are not affected by MACRA.)

Key Elements of MIPS

The proposed MACRA rule consolidates three historic FFS payment adjusters into a single program under MIPS. A portion of an eligible clinician's payments are put at risk, beginning at 4 percent in 2019, increasing up to 9 percent by 2022. Individual physicians will be measured and given a score based on performance across four population health-oriented domains:

- Quality: Physician Quality Reporting System (PQRS) measures, Prevention Quality Indicators (acute and chronic), readmissions
- Resource use: value-based payment modifier measures, total per capita cost, episode
- Advancing care information: Meaningful Use/electronic health record (EHR) incentive program measures
- Clinical practice improvement activities including:
  - » Expanded access (same-day appointments)
  - » Population management (participation in a qualified clinical data registry)
  - » Care coordination (remote monitoring or telehealth use)
  - » Beneficiary engagement (shared decision making)
  - » Patient safety and practice assessment (surgical checklists)
  - » APM participation

The weighting of the domains in the payment equation will evolve over time, with an increasing emphasis on resource use.

CMS has augmented the measurement methodology for eligible provider participation in a non-qualifying APM, with a goal to incent participation in these population health models.

Key Elements of APMs

MACRA creates a second reimbursement option to reward providers engaged in qualifying APMs. Final regulations will define which risk-sharing arrangements qualify as APMs. They will likely include Medicare Shared Savings Program (MSSP) Tracks 2 and 3 ACOs, Next Generation ACOs, Oncology Care Model (OCM) at-risk models, and Comprehensive Primary Care Plus (CPC+) for certain practices. As proposed, MSSP Track 1 ACOs will not qualify as advanced APMs. Providers in qualifying APMs will receive an automatic 5 percent upward adjustment on their qualifying Part B payments each year from 2019 through 2025.

To qualify for the payment adjustment, providers must meet thresholds for payments or beneficiaries through the APM. These include:

- **2019–2020:** 25 percent of Medicare payments (Medicare Option)
- **2021–2022:** 50 percent of Medicare payments (Medicare Option) or 50 percent of total payments regardless of payer, and at least 25 percent of Medicare payments (All-Payer Combination Option)
- **2023 and beyond:** 75 percent of Medicare payments (Medicare Option) or 75 percent of total payments, and at least 25 percent of Medicare payments (All-Payer Combination Option)

To achieve the APM bonus, providers need to take risk and must derive a substantial portion of their revenues from an APM program, and may need to push multiple payers in the same direction. Like the MIPS component, this seems designed to move the market and providers toward population health.

Some organizations may be tempted to pursue the eligible APM track due to the guaranteed 5 percent annual bonus. However, it is critical to assess both the MIPS and APM options prior to accepting risk for Medicare Parts A and B. If your organization does not have much experience managing downside risk, moving to this type of model prematurely could be detrimental to financial performance and relationships with providers.

Strategic Implications and Action Items

Many independent physicians and small medical groups will not have the resources to meet MACRA performance measuring and data reporting requirements. This can create integration opportunities to facilitate access to capabilities and the systems necessary to be successful as part of a critical mass of aligned providers.

Consider the following issues regarding the MIPS and APM options:

- How do MACRA options align with our assumptions about the longer-term outlook for payment from Medicare and other payers?
- How does each option align with the context and vision for our population health strategy?
- Identify and evaluate APMs that currently exist in the market. Could a competitor qualify to become an APM first and use it

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Key Board Takeaways

Under MACRA, physician performance measurement is tentatively scheduled to begin on January 1, 2017. The data collected in 2017 will determine how much a physician will be reimbursed for Medicare services starting in 2019. MACRA offers strategic opportunities to further align with physicians by:

- Providing access to information technology and connectivity
- Expanding clinical integration capabilities and resources
- Training and educating physicians to lead clinical integration and care redesign efforts
- Providing operating structures and data reporting mechanisms to track, organize, and use data to improve patient care and optimize financial reimbursement