HINMAN STRAUB PC
ATTORNEYS AT LAW

121 State Street
Albany, New York 12207-1693
Tel: 518-436-0751
Fax: 518-436-4751

TO: **Memo Distribution List**

FROM: Hinman Straub P.C.

RE: DSRIP Governance Guidance

DATE: November 3, 2014

NATURE OF THIS INFORMATION: This information regarding the early stages of developing what will later become new requirements you will need to be aware of or implement. You will likely want to keep abreast of developments or provide your input so the final requirements are not a surprise.

DATE FOR RESPONSE OR IMPLEMENTATION: N/A

HINMAN STRAUB CONTACT PEOPLE: Sean Doolan, Meghan McNamara and Jonathan Gillerman

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #2 Providers and payments to them Suggested Key Word(s):
#3 Plan Management, operations and structure
#9 Medicaid and Medicare

The Department of Health recently released the DSRIP "How To" *Guide for Governance* (**attached**) ("the Guide") prepared by the DSRIP Support Team, KPMG. The purpose of the Guide is to provide guiding principles and considerations for Performing Provider Systems (PPSs) to use as a reference as they develop their governance structures. Each PPS must describe its governance structure in its Project Plan Application, due December 16, 2014, and a basic structure must be in place by March 31, 2015 that allows the PPS to accomplish necessary "day one" functions, such as the ability to distribute funds to partners.

According to the Guide, by March 31, 2015, PPS governance structures must be prepared to implement/execute, at a minimum, the following three components:

- An Operating Agreement, which sets forth an understood set of roles, responsibilities, and authorities among the partners of the PPS;
- An attestation that all governance positions are filled; and
- Mechanisms to distribute DSRIP funding.

In addition, on October 27, the Department released the final PPS Lead Financial Stability Test, which is being used to determine the qualifications of the PPS lead and demonstrate their financial stability through a three-phase financial analysis test that requires PPSs to provide information on their financial practices and any documentation of arrangements that would support the provider's financial stability by **November 10, 2014**. The test notes that in addition to providing the requested financial information, the application indicates that providers may also provide documentation of any arrangements that would support the provider's financial stability through the give year DSRIP demonstration period. However, such arrangements must either "be substantial in nature and supported by a binding agreement to provide financial support," or alternatively include a binding commitment by a qualified safety net provider to serve as the Lead in case of failure. For public providers, the State may also allow a governmental entity of which the PPS lead is a part of to exhibit support for the provider.

This memorandum:

- ✓ Highlights the principles and considerations set forth in the Guide for the formation of PPS governance structures;
- ✓ Identifies those components of PPS governance that *should* be operational by April 1, 2015;
- ✓ Summarizes the three governance models presented for PPSs to consider using as they form their own governance structures; and
- ✓ Identifies upcoming milestones.

Please contact us with any questions.

I. Guiding Principles and Considerations for Governance

❖ Overview

Each PPS is required to establish a governance structure that can:

- Determine how DSRIP funds will flow;
- Establish clinical metrics to be monitored and reported;
- Provide oversight for provider participation and accountability; and
- Oversee the execution of DSRIP projects.

Governance structures are expected to evolve from basic configurations designed to accomplish "day one" tasks (primarily, funds distribution) to more integrated and sophisticated systems by the end of the five year DSRIP program. According to the Guide, PPSs "will have to function as an integrated delivery system and be capable of managing population health with value-based contracts" by or before "Phase 3", which is considered the post-DSRIP Integrated Delivery System Phase.

In the "Guiding Principles" set forth in the Guide, DOH recommends that governance structures be representative; balanced; goal oriented; situation specific; simple (fewer and smaller boards, less layers); able to evolve into a high performing Integrated Delivery System, and legally sound. Guidance is provided with respect to specific situations that may influence how governance structures are created, including: the use of representative governance by providers for large networks of PPS partners; the delegation of authority to regional sub-components for geographically large or diverse PPSs; to the extent there are capital contributions, proportionate-voiced governance based on the size of the capital contribution; the type of organization structure (LLC and/or qualifying 501(c)(3); and how the diversity of the patient population may impact upon representation on governing bodies.

II. Key Governance Domains

The Guide sets forth the following three key governance domains, which it indicates *should* be operational by April 1, 2015.

- Financial Governance: The first and most important task that falls under financial governance is the creation of an *agreed upon* plan and framework for how the PPS will distribute DSRIP funds among partners and monitor the financial impact across the PPS. Other tasks and responsibilities that fall under the umbrella of financial governance include:

    - Initial funding: project and transition costs, performance awards and penalties for inadequate performance), funding of new, unforeseen initiatives, and compensation for lost revenue;
    - How to distribute funds among the clinical specialties and organizations along the care continuum;

- How to deal with shifts in patient flow changing the level of demand along the care continuum (thus shifting costs/revenues between partners); and
- Preparing for value-based payments (in future years).

- Clinical Governance: This domain focuses on both clinical quality standard setting and measurement and is responsible for:

  - full scale clinical performance evaluation, including the development of standardized structures, processes and outcomes that must be met to accomplish DSRIP goals;
  - prioritizing improvement areas and the development and implementation of evidenced-based, best practices to improve clinical and financial results;
  - developing care management processes/pathways and the clinical metrics to support accountability; and
  - evolving towards accountability for population outcomes.

- Information Technology and Data Governance: This domain includes responsibility for:

  - data sharing agreements;
  - working to ensure the interoperability of PPS partner platforms;
  - providing oversight of security and compliance; and
  - evolving towards joint performance management tools and reporting capabilities.

The Guide advises PPSs to place appropriate emphasis on developing IT and clinical governance, and not just focus solely on finance. PPSs will be required to develop mechanisms to address non-performing or low performing providers, and also develop dispute resolution procedures. The Guide notes that incorporating (at a minimum) a fourth domain—compliance/legal, should be strongly considered. DOH recommends that PPSs work with legal counsel on implementing their governance plans and provide their compliance committees with sufficient independence to carry out its oversight duties.

The Guide indicates that it is expected that the functions, roles, and responsibilities of each key governance domain will be carried out through a dedicated Committee that serves the PPS Executive Board. Members of the respective committees will be appointed by the Executive Board and receive support from subordinate workgroups. DOH expects that as these committees develop and central decision making for key topics begins to be delegated from the individual provider level to the PPS level[1], that PPS governance will likely become more integrated.

As this is occurring, the State expects the role of the Project Advisory Committee (PAC) to begin to expand, transforming from predominantly a representative body in DSRIP Phase 1 (year 0, the "planning phase"), into a true, advisory body that provides meaningful guidance and counsel to

[1] The Guide notes on P.8 that this is an important step in the evolution of a PPS governance process that will occur between DSRIP Phase 1 (Year 0: the "planning phase") and DSRIP Phase 2 (the "operational phrase"), which comprises the DSRIP project period from April 1, 2015 through January 1, 2020.

the Executive Board during DSRIP Phase 2 (the "operational phrase"), which comprises the DSRIP project period, April 1, 2015 through January 1, 2020. According to the Guide, by Phase 3 ("Post-DSRIP Integrated Delivery System Phase"), "the PPS will have to function as an integrated delivery system, and be capable of managing population health with value-based contracts." The Guide notes this integration may occur even sooner, as PPSs attempt to take advantage of potential shared savings arrangements through value-based contracting.

❖ Policies and Procedures

According to the Guide, PPSs will need to develop governance support in the form of policies and procedures, which must include:

- An Operating Agreement that defines the PPS Charter, roles and responsibilities, and key aspects of Governance among other items;
- Guidance for composition of committees that will meet DSRIP requirements and will identify the skills required;
- A process for collaborative planning, data sharing, human resource planning, etc.;
- A process for stakeholder engagement and communication;
- The decision making process that will be used;
- A description of the dispute resolution mechanism(s);
- A process for collaborative performance monitoring, reporting and management;
- A process for identifying and managing liability related to DSRIP; and
- The mechanisms for financial accountability and oversight.

III. PPS Governance Models

The Guide discusses the following three governance models that PPSs can use in modeling their own governance structures: 1) Collaborative Contracting Model, 2) Delegated Authority Model, and 3) Fully Incorporated Model.

"Collaborative Contracting" is the only model that contemplates tying the partnership together through the use of individual contracts between PPS partners and the lead applicant. The other two models contemplate the formation of a new legal entity to bind members. The Guide presumes that most PPSs will initially select to use the "Delegated Model" structure, though acknowledges that the collaborative contracting model requires the least amount of up-front work to meet day one expectations.

While the Guide does not explicitly endorse any one governance model over the others, it does note that DOH prefers "shared governance that allows providers to evolve into an integrated delivery system." However, the Guide also notes that the "most integrated" model is not necessarily the best model and each model could ultimately serve as the final model provided it allows the PPS to achieve its goals. Finally, the Guide states DOH is open to other governance models other than the ones described, including the use of hybrid models or completely new structures, again, subject to the proviso that the model allows the PPS to achieve DSRIP goals.

Below is an overview of the three models presented.

- Collaborative Contracting: Under this model, PPS partners contract with the lead entity that runs the PPS through an Executive Board. The contract sets forth the respective roles and responsibilities of the lead applicant and each individual PPS partner. The implementation of PPS projects is managed through a "Project Management Office". Partners maintain their relative autonomy and are not financially responsible for each other outside the terms of the contract. However, the lead partner may still be held financially responsible for less viable partners if necessary to realize a core goal of the DSRIP program. PPS partners are represented on the various sub-governance committees (i.e., clinical, finance, IT) but the lead applicant retains ultimate decision-making authority over the PPS and has final authority to act on behalf of the entire PPS when faced with over unforeseen circumstances.

  The Guide notes this is the easiest of the three models to implement, but DOH cautions that this model is more cumbersome than the others, could require multiple contracts and levels of reporting, and could slow down decision-making. DOH also notes that the organizational structure does not lend itself as well as other models towards advancement to DSRIP Phase III Integrated Delivery System functionality and being able to realize value-based contracts with managed care plans. As a slight variation to this approach, the State mentions that a "master joint venture agreement", signed by and binding on all participants, could be employed under this model, and would help alleviate the need for multiple contracts.

- Delegated Model: Under this model, PPS partners create a new legal entity, either a jointly owned LLC, partnership, or other structure and delegate authority to the new entity to manage the PPS. Ownership of the delegated entity will be determined based on proportional equity shares or partnership units. The Guide notes that this model does not contemplate that all partners will become members of the delegated entity, such as less integral partners, including community based organizations and other community based partners, who could instead serve in a non-governance capacity as affiliates with vendor contracts. The Guide notes there are likely to be significant variations to this model, including the use of regional delegations to decentralize responsibilities across geographic service areas. This model is endorsed for allowing greater efficiencies, centralized decision-making, and limiting the delegation of powers by a partner entity to only those aspects necessary for DSRIP; a non-existent feature under the fully incorporated model, discussed below.

- Fully Incorporated Model: Under this model, partners join together or are absorbed into a single, legal entity that is operationally and financially integrated beyond the scope of DSRIP. The governance structure for DSRIP thus becomes a function of the entity's everyday governance and management structure. This model builds off of the delegated model but includes all aspects of the care delivery system beyond DSRIP.

IV. Upcoming Milestones and Next Steps

DOH indicates that PPSs should select their governance models this fall and begin the process of educating stakeholders on the selecting model and the rationale supporting the decision to

employ the particular model chosen. In preparation for the December 16, 2014 DSRIP application submission date, the Guide also notes PPSs should begin drafting their governance sections of their project plan applications, and provide educational sessions for PPS partners to achieve a baseline understanding of governance functions. According to the suggested timeline presented, PPSs should begin Committee selection in November, and upon receipt of notice that a DSRIP Project Plan application has been approved in March 2015, complete the selection of all leadership positions, complete the rosters of all committees and begin prepared to begin PPS operations and implement the PPS governance structure on April 1, 2015.

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New York Delivery System Reform Incentive Payment Program

'How To' Guide – Governance

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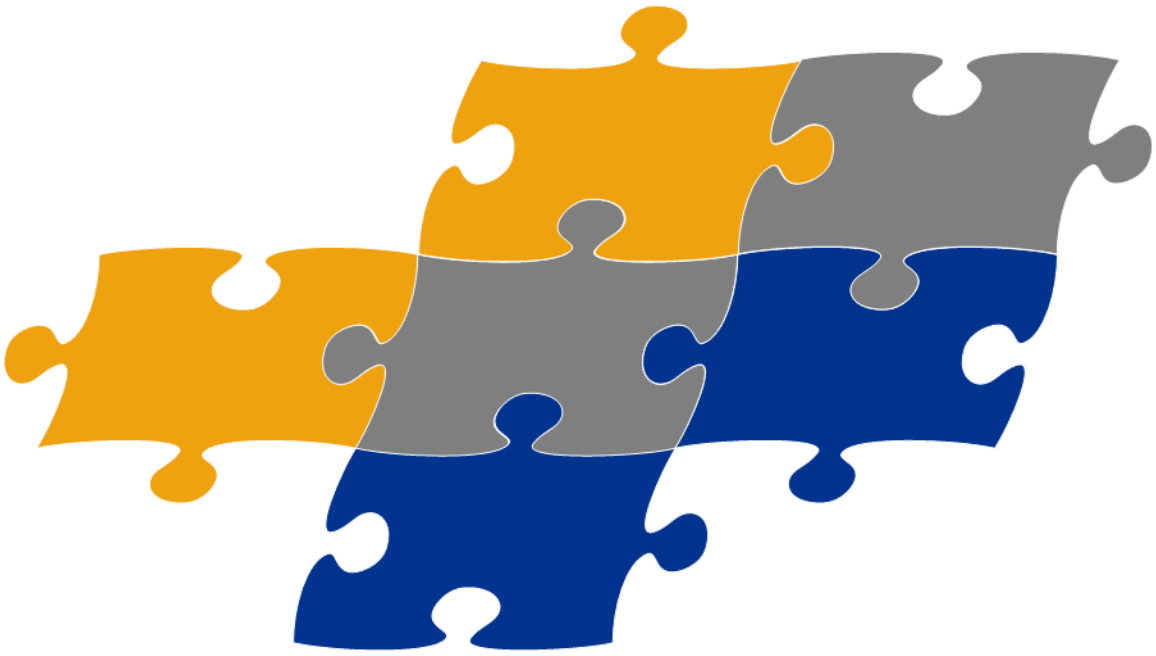

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Purpose of the Guide

This “How To” Guide for Governance is intended to provide direction and content for the Performing Provider Systems (PPS) as they assemble their governance structure under New York’s Delivery System Reform Incentive Payment Program (NY DSRIP).

The “How To” Guide will illustrate the considerations, functions and components of successful governance and how they apply to NY DSRIP. It does not address corporate structures or legal forms, nor does it address the regulatory approvals that some governance models will require.

Each PPS should work with its own counsel with respect to both planning and implementation as building these governance structures implicates Federal and State laws and regulations. (More information on implicated regulations and potential regulatory relief is forthcoming).

The “How To” Guide will not prescribe a single PPS governance structure, but rather will provide a process by which each PPS can design a governance structure that meets its unique needs while succeeding under the requirements of DSRIP.

Acknowledgement and Disclaimer

This guide has been prepared by KPMG with support of the JHD Group. We thank HANYS, GNYHA and others who have generously discussed the content of this How To Guide with us, and provided us with many useful insights.

Executive Summary

As of April 1st 2015, each DSRIP Performing Provider System (PPS) is required to have a documented and operational Governance structure and process in order to make decisions at the PPS level about funds flow, to establish the clinical metrics to be monitored and reported, to provide oversight for provider participation and accountability, and to oversee the execution of the DSRIP specific projects. In addition to PPS-wide governance, there will be at least three key governance domains that should be operational by April 1st:

- Financial Governance, including the distribution of DSRIP funds, and the monitoring of financial impact across organizations
- Clinical Governance, starting with the creation of standardized care management processes/pathways and the clinical metrics to support accountability, and then evolving towards accountability for population outcomes
- Information Technology and Data Governance, including data sharing agreements, and evolving towards joint performance management tools and reporting capabilities

The DSRIP program does not prescribe how to organize the Governance processes and structure(s) to accomplish this, but there are guiding principles that can be applied as appropriate to each PPS based on variables such as geography, participating partners, the existing level of integration among the partners, and other considerations.

This "How To" guide provides three basic models for Governance, with the understanding that the model selected by a PPS could be based on what is already in place in a region, or could be a blend of attributes from each model as determined by the participating providers, or could largely follow one of the example models provided in this guide. It is also the case that the initial Governance model in place March 31st, 2015 will likely evolve as circumstances change, and will become more integrative and sophisticated as the PPS moves more to Value Based Contracting with Medicaid Plans. The three basic models described in this Guide, which can be combined into many different hybrid forms, include:

- Collaborative Contracting: In this model each partner remains autonomous. Each PPS partner has an individual contract with the Lead Entity where the contractual arrangements stipulate roles and responsibilities. The Lead Entity retains ultimate decision making authority and is the contract partner for the State. Partners are represented in an Executive Body whose role is limited to coordination and oversight of the Committees for Financial, Clinical, and IT activities.
- Delegated Model: With this model, partners join together (often through a jointly owned LLC) and delegate key responsibilities for PPS Governance to a newly created legal entity. The Governance process directly oversees all aspects of Finance, Clinical, and IT governance with accountability to an Executive Governance Body representative of the partners.

- Fully incorporated Model: In this model, the PPS partners have combined into a single legal entity with full ownership of the care delivery system except where contracted out to specialty providers (i.e. Therapy Services, Home Health, etc.). With this model there is close integration of the care delivery processes, unified governance in a corporate structure, and a single management team to drive performance.

The remainder of this document describes an overview of how Governance can be developed to be responsive to the needs of DSRIP, the major considerations and principles, and the three sample governance models. Any Governance model that meets the principles of good governance, satisfies the DSRIP requirements, is responsive to the local considerations, and enables the PPS to succeed at the goals of DSRIP….will be a good model.

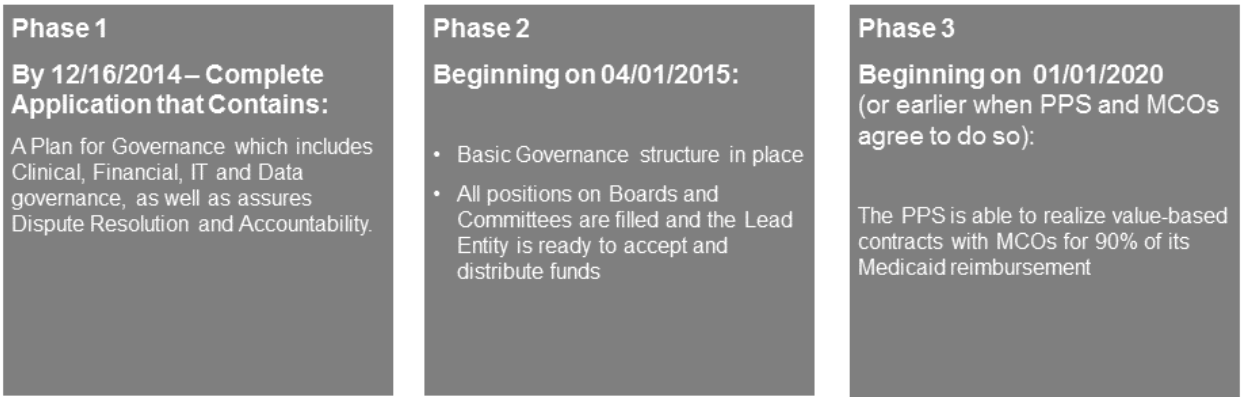
DSRIP Governance Development Steps

The fundamental goals of governance are to guide the organization with timely decision making and to ensure accountability of performance. Within DSRIP, it will be key for the PPS to be able to make decisions about funds flow, the use of data for accountability, and to have agreements between the partner organizations within each PPS coalition. This implies that in some way or form, the partner organizations relinquish some of their own decision making authority to the PPS level – whether through contractual agreements or a new legal entity.

It is necessary that the Governance structure be in place in some form after the DSRIP application has been approved, but no later than March 31, 2015. The "Day One" PPS Governance structures can be a relatively simple – able to do what needs to be done starting April 1st, such as distributing funds, but not necessarily more. The governance structure can evolve over the five DSRIP years based on the needs to respond to oversight requirements, the evolution of cooperation between the partners, and the practical experience of what best fits the needs of the partners and supports the final delivery of the DSRIP goals as embraced by the PPS in the Project Plan.

Timeline: The Evolution of PPS Governance

The DSRIP program will be implemented in three phases: Phase I, which is the planning, application submission/remediation/approval and organizing phase, Phase 2, which is the initial operation and the beginnings of transitioning to managing populations, and Phase 3, which is "Post DSRIP" when the PPSs should be able to successfully manage population health and receive 90% of their Medicaid reimbursement through Value Based Payments.



Each of the three Phases has different demands on PPS governance, which are described below.

Phase 1: DSRIP Year 0: Planning Phase

This is the current phase where the first major milestone is the completion of the DSRIP Project Plan Application. When the Application is submitted, it will be

scored by the Independent Assessor, and, based on the scoring, will be subject to approval, remediation, or disapproval.

Once the application is approved, but no later than March 31, 2015, the PPS will need to implement its Governance structure as described in the application which will include at least three components:

- An understood set of roles responsibilities and authorities among the Partners which is documented in a PPS Operating Agreement
- The people designated to serve in Governance are determined and attestation that all Governance positions are filled
- The mechanisms to distribute DSRIP funding

Phase 2: DSRIP Years 1-5: Operational Phase

In this phase a PPS will build-out and operationalize the decisions made in the Planning Phase. Phase 2 focuses on establishing, operationalizing, and evolving the capabilities of the PPS into a system capable of value-based contracting. Moving from Phase 1 to Phase 2 is an important step where, for key topics, decision making authority is delegated from the individual partner's level to the PPS level.

An important part of this phase is evolving the Governance processes and structure to fully achieve the DSRIP goals by:

- Developing out the Finance, Clinical and IT/Data Governance Committees
- Applying the oversight process to PPS care delivery including monitoring and reporting
- Establishing processes for refining and/or redirecting the care processes based on results achieved
- Assuring timely decisions

A PPS may be led by the Lead Applicant, or it may create a new entity governance structure, such as an LLC, which is jointly owned.

By the end of Phase 2, the PPS will need to have most of its contracts in place with non-partner affiliates. However, the structure of the PPS is likely going to evolve over the DSRIP five years toward a more integrated system and structure.

Phase 3: Post DSRIP: Integrated Delivery System Phase

In this Phase (or earlier, if the PPS and the Medicaid Plans wish to do so), the PPS will have to function as an integrated delivery system, and be capable of managing population health with value-based contracts. *It is likely that PPSs will want to move to value-based contracting earlier than the post-DSRIP phase because of the possibility to realize shared savings arrangements.*

The next section describes the fundamental requirements for Governance under DSRIP.

DSRIP Governance Requirements and Guiding Principles

DSRIP Governance Requirements

The requirement for the governance structure that needs to be in place on March 31, 2015 is that the PPS will need to be able to make decisions on, and be accountable for:

- Financial governance, including the distribution of funds and budget development
- Clinical governance, including the development of standard clinical pathways and monitoring and managing patient outcomes
- Data/IT governance, especially data sharing among partners and reporting and monitoring processes

Decision making should be both efficient and representative, and there will need to be mechanisms for managing non-performing providers. Dispute resolution procedures will also have to be developed, and a process for addressing lower performing partners in the PPS has to be in place.

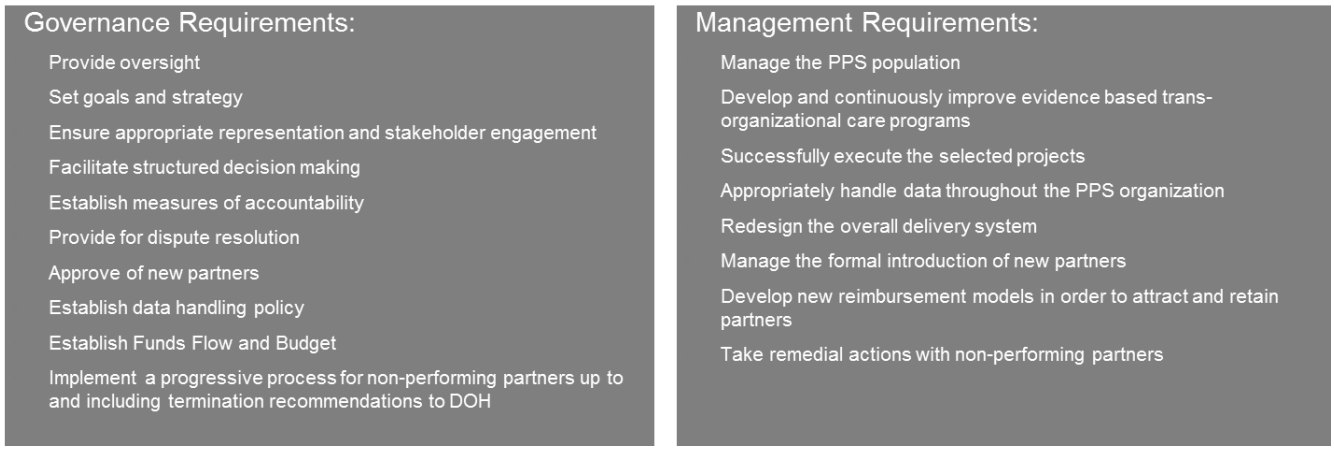
Governance vs Management

During the early development of the PPS, the PPS is likely to have centralized Governance to assure oversight of the DSRIP program, but delivery management is likely to be distributed among the participating providers/partners. As the PPS evolves more of an ability to fully manage populations through a truly integrated delivery system, it is likely that a single management team will develop for the core DSRIP roles. For clarity, we have provided a summary of the difference between Governance and Management to guide PPS development.

Governance represents the vision of the owners of the organization. It addresses the question – What are we going to do to fulfill the Mission and Vision? Governance decides on direction, sets priorities, sets policy, selects and oversees management, and evaluates the performance of the organization as a whole

Management exists to carry out the functions of the organization. It addresses the question – How are we going to accomplish the goals and objectives? Management sets procedures, implements processes, provides the governing body with information, and evaluates the performance of the parts of the organization against targets

Within the context of DSRIP, the distinction between Governance and Management can be illustrated as follows:



Project Advisory Committee (PAC)

During Phase 1, all PPSs will need to establish a PAC, which in some cases encompasses the decision making body and other committees. During Phase 2, the PAC will likely evolve from a representative body into a true advisory role – advising the Executive Governance Body, for example, rather than making decisions itself.

Governance Guiding Principles

Considering the different options, key guiding principles for framing the Governance structures to be put in place should be:

- Representative: All partners and constituencies have an appropriate and proportionate voice in the governance process
- Balanced: PPS governance recognizes individual partner autonomy only in so far as doing so does not prevent effective and timely decision making
- Goal oriented: The different bodies and processes of the governance structure all have a clear and necessary role in the realization of the PPS's goals
- Situation Specific: The best model for any given PPS will be determined by its history, the specifics of the region and the nature and organizational form of the providers. No single model will fit all PPSs
- Simple: A simple governance model increases the opportunities for effective decision making and reduces the chance of wasting energy. Fewer and smaller boards and committees are better
- Able to Evolve: The overall organizational and governance structure of the PPS is expected to evolve over time from a group of affiliated providers into a high performing Integrated Delivery System
- Legally Sound: PPSs should work with knowledgeable Counsel to ensure that their proposed models are legally sound

Additional considerations

In addition to the guiding principles, there are a number of considerations around the specific situation for each PPS that will influence the governance structure. Examples include:

- The size of the PPS will influence how the governance seats are filled
    - A PPS with a large number of partners will need to limit the number of participants on Boards and Committees while maintaining representation. This can be realized through representation per provider-type, for example.
    - A PPS with a large geographic area, (e.g. spanning several counties/boroughs), may consider delegation to regional sub-components ('regional hubs')
    - Although community-based organizations will be represented in the PAC, they may also be included in other (decision making/oversight) parts of the governance structure
    - A small PPS with few partners may not have sufficient experienced leaders or subject matter experts available at the outset. It may be necessary to limit the number of positions to be filled until the participants can be trained or located
- The goals of the PPS can influence the complexity, such as if the PPS is seeking to meet the minimal requirements of DSRIP, or is seeking to leverage the DSRIP to transform the organization of the care delivery system
- The extent that there will be capital contributions, the form of those contributions and the impact on participation in Governance, such as proportionate voice based on the size of the contribution
- The type of organization structure, such as an LLC and/or a qualifying 501(c) (3)
- What kind of entities are included as Partners, such as hospitals, IPAs, independent physician groups, FQHCs, ancillary, post-acute providers, etc.
- The different capabilities brought to the PPS by the Lead Entity and the partners
    - A PPS with depth of experience and a history of cooperation may be able to realize a more developed governance structure from the beginning
    - If a critical function is not available, the PPS may need to create a working body, such as a committee, to create the missing capability
- To what extent the Partners want the compliance and finance function of the Governing Board to be independent from the Lead Entity to ensure checks and balances
- Dispersed service areas (rural) may have different demands on governance than overlapping service areas (urban)
- The diversity of the patient population may impact upon representation on the governing bodies
- The nature of the physician network, in that well organized large physician groups may want to be directly represented in the governance structure, and/or may want an ownership interest

Governance Support

To support any of the governance models, each PPS will need to develop the following supporting policies and procedures

- An Operating Agreement that defines the PPS Charter, roles and responsibilities, and key aspects of Governance among other items
- Guidance for composition of committees that will meet DSRIP requirements and will identify the skills required
- A process for collaborative planning, data sharing, human resource planning, etc.
- A process for stakeholder engagement and communication
- The decision making process that will be used
- A description of the dispute resolution mechanism(s)
- A process for collaborative performance monitoring, reporting and management
- A process for identifying and managing liability related to DSRIP
- The mechanisms for financial accountability and oversight

Addition information on Governance Support can be found in the Reference List in the Appendix of this Guide.

The Key Domains of DSRIP Governance

The key domains that will need to be handled at the PPS level – and that will thus require decision making capabilities at the PPS level – are Financial Governance, Clinical Governance and Information Technology and Data Governance.

Each of these are more fully explained below.

Financial Governance

At the start of DSRIP Year 1 (April 1, 2015), the PPS will need to have in place the decision making process and agreed upon framework how to distribute DSRIP funds among the partners, including:

- Initial funding: project and transition costs, performance awards (and penalties for inadequate performance), compensation for lost revenue. Also the funding of new initiatives (not foreseen during the writing of the project plan)
- How to distribute funds among the clinical specialties, such as primary care vs specialties, and, among organizations along the care continuum, such as SNFs, LTACs, and Home Care
- How to deal with foreseen or unforeseen shifts in patient flow changing the level of demand along the entire care continuum (thus shifting costs/revenues between partners)
- How to fill in further details in the framework, and adapt the framework when circumstances change

In preparing for Value-Based Payments, the tasks of the Financial Governance Committee will likely expand to include:

- Measuring the total cost of care for the attributed population
- Identifying and preparing novel ways of paying for the new service arrangements with the Medicaid MCOs and within the PPS
- Overseeing the financial transition, and its impact on the partners, as the shift from Fee-for-Service to Value-Based Payments accelerates

Clinical Governance

The overall role of clinical governance focuses both on clinical quality standard setting and measurement, and the clinical care management process itself including the use of evidence based pathways and compliance with care standards. Ultimately, the PPS will be accountable for its population's health outcomes. The Clinical Governance Committee will establish and oversee the clinical leadership of the enterprise within each PPS by fulfilling the following functions:

- Setting the standards of clinical care delivery (structures, processes and outcomes) which need to be met or exceeded to accomplish NY DSRIP goals and objectives (e.g. translating the overall DSRIP goals into actionable steps and outcomes for the PPS)

- Within the project areas selected, determining, based upon the clinical performance evaluation process, which areas of care delivery should be the focus of improvement efforts
- Prioritizing the creation, implementation, oversight and continuous improvement of those best evidence based medical practices that will most contribute to closing the identified clinical performance gaps and improving clinical and financial results
- Developing and overseeing the creation of the infrastructure (committees and subcommittees) within the clinical component of the PPS necessary to undertake the development and implementation of these best evidence based practices

It is crucial to realize that effectuating these responsibilities requires not just the effort of professionals, but also the creation of the organizational infrastructure to perform the clinical performance evaluation, to measure and report the outcomes, to staff the committees, and so forth. In other words, effective clinical governance assumes an organizational effort that is much wider than the clinicians and other professionals' efforts alone.

Information Technology/Data Governance

Successful Data/IT Governance will align the IT strategy and resources with the strategy and goals of the PPS by:

- Working to ensure the interoperability of PPS partner platforms in order to share data
- Standardizing data definitions to facilitate timely, accurate, and informed clinical and business decision making
- Prioritizing allocation of IT resources and joint IT investments
- Recommending the selection of applications and IT approaches
- Providing oversight of:
    - Security and compliance
    - Data storage and usage
    - The appropriate use of data at the individual and organizational levels
    - The cost of IT and data services

Each PPS may elect to have additional Governance domains. One of the probable candidates will be a Compliance/Legal Governance Committee in the initial governance structure. The partners may elect to give such a committee sufficient independence from the PPS lead organization to effectively establish and enforce operating "rules of the road" and transparency.

Whatever the domains of governance that the PPS believes need to be established, they will take shape as Committees reporting to the Board/Executive Governance Committee, and will be providing oversight, monitoring, and evaluation of each of the domain areas (i.e. Finance, Clinical, IT, etc.). The committees will be appointed by the Board/Executive Governance Committee, will draw on the support of "Working Groups", and will be

populated based on a combination of representation and area of expertise. The Committees oversee the "operationalization of the PPS.

Experience shows that organizations often tend to spend much time on the legal and financial aspects of governance, and pay relatively little attention to IT and especially clinical governance. Because DSRIP is first and foremost about structurally improving clinical outcomes, PPSs should be especially aware to prevent this.

PPS Governance Models

DOH has not mandated specific PPS governance structures, but has expressed a preference for shared governance that allows providers to evolve into an integrated delivery system. Local history, preferences and the specific configuration of each PPS will determine which governance model will work best. The final structure selected is less important than the ability to make efficiently the decisions necessary to achieve the goals of the PPS.

Different types of Partners

Not all partner organizations in the PPS will play similar roles in ensuring the PPS's goals. To create a workable Governance structure, it is especially important to acknowledge and explicate the differences. Depending on the exact model chosen, the following roles can be distinguished (this nomenclature is not prescriptive):

- When a new legal entity is created, there may need to be **capital contributing partner(s),** who would also by definition be Executive Partners Lead Partners
- When there is no new legal entity, a PPS requires a **Lead Partner** who is responsible for fiduciary and project management control
- **Governance Partners** who are a member of the Executive Governance Committee/Board of Governance and/or sub-committees including members of the Finance, Clinical, or IT/Data committees
- **Participating Partners** who are Partners by nature of the beneficiary attribution but are not a part of the Governance process or ownership. These Partners may be represented on the PAC or other *advisory* bodies.
- **Affiliates** who might be providers or community based organizations that do not, by themselves, attribute lives, but are otherwise important for the success of the PPS. Affiliates may be represented on the PAC or other *advisory* bodies.

Contracts and Organizational Structures

In forming their governance structure, the PPS has two basic tools for tying together the components of the PPS:

- Contracting between the PPS members
- Legal structures which bind the members

These two tools can be combined to form a variety of governance structures. The following Governance Models are examples that demonstrate the range of possible structures. On one end of the spectrum is a model based solely on contracts (Collaborative Contracting). On the other end of the spectrum is a model based solely on the legal structure (Fully Incorporated Model) to achieve integrated delivery. And between them is the model that combines the tools (Delegated Authority) where there is a newly created integrating legal entity (NewCo) without full integration of the Partners.

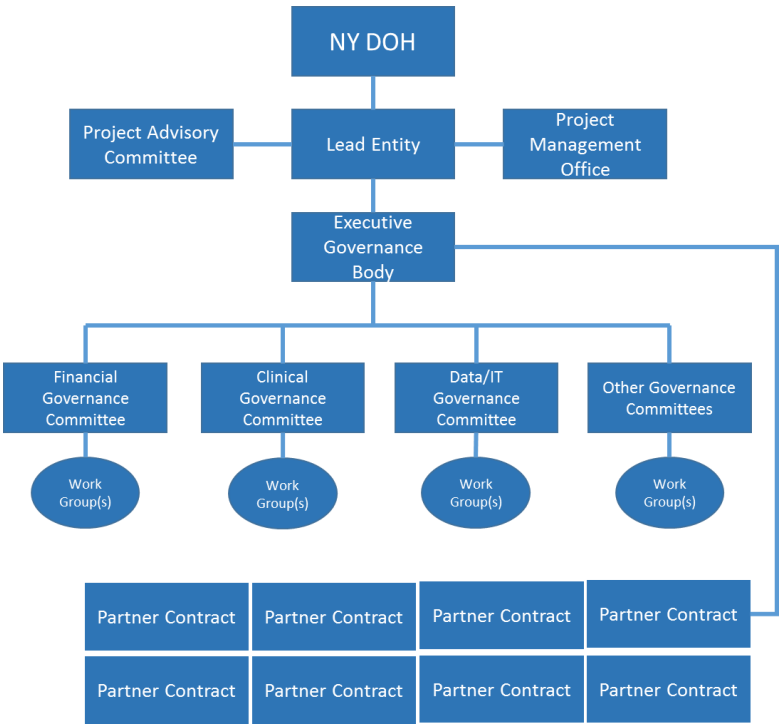
The Collaborative Contracting model is an early model that assembles partners under the umbrella of a Lead Entity (the lead applicant) without impacting the organizational autonomy of the participants. Because the number of contracts can be large, and because it is complex to delineate roles and responsibilities to the extent required in contracts, this model can end up being unwieldy.

Although we have ordered them from 'less' to 'more' integrated, and although most PPSs will follow some trajectory along this path, the 'most integrated' model is not by definition the 'best' model. Each model could, if the PPS demonstrates the ability to meet its goals, represent the final governance structure.

Every model has its own pro's and con's, which we will discuss below. All models can have a more decentralized version (a 'regional hub' variant), which we will discuss at the end of this section.

Collaborative Contracting Model

In the Collaborative Contracting Model each PPS partner has an individual contract with the Lead Partner. The contractual arrangements stipulate roles and responsibilities, delineate the funds flow, the data sharing, clinical governance arrangements, how dispute resolution will be handled, and so forth. (Alternatively, a Master Joint Venture Agreement, signed by and binding on all participants, could address these topics without creating a new legal entity). With non-governance Participating Partners or "Affiliates" who are less 'core' to the PPS's organizational transformation agenda, basic 'vendor – buyer' contracts will be sufficient. The Lead Partner retains final decision making authority, is the contract partner for the State, and will be held accountable for fulfilling the terms of the contract. The diagram below depicts a sample "Collaborative Contracting" model.



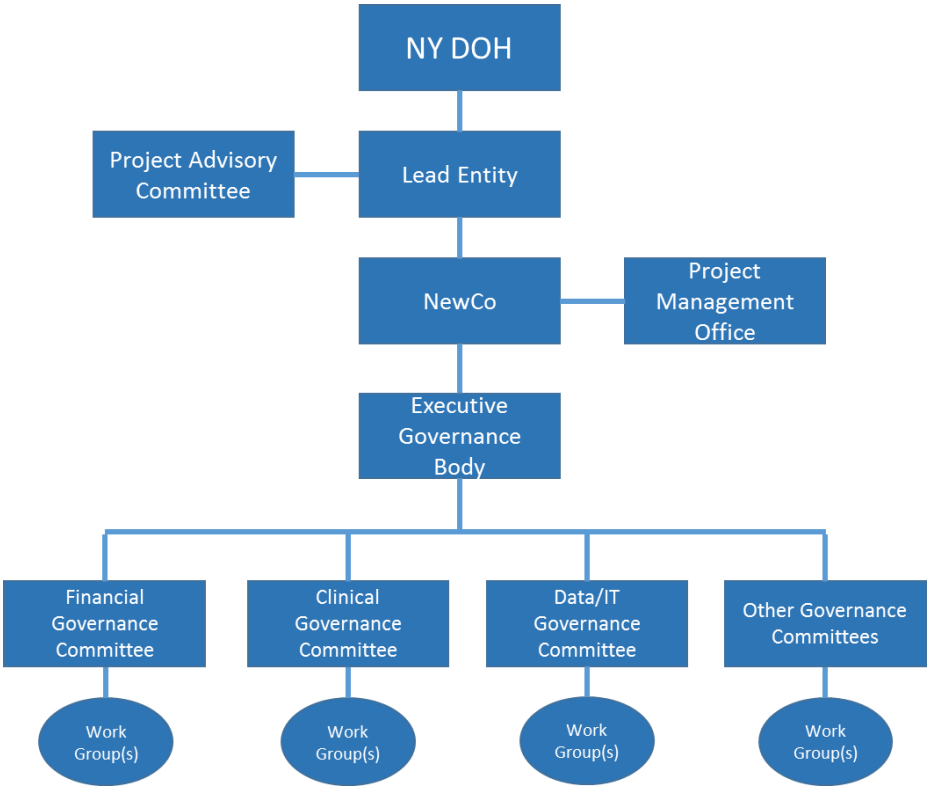
The other characteristics of this model are:

- No new legal entities need to be created
- The partners conduct the "work" of the PPS and retain their own decision making authority on all matters except those addressed in the contracts
- The Executive Governance Body provides oversight of the execution of the contracts and sets the high-level standards which the contracts must adhere to.
- The Committees of the PPS set standards, monitor the work being done by the partners, and report results to the Executive Governance Body – all within the scope delineated by the contracts
- When unforeseen circumstances arise that are not covered in the contracts, the Lead Entity (in this model this is the Lead Partner) has the final authority
- Questions need to be addressed (primarily through the contracts) such as:
    - Will types of partnerships will be created? Will the contracts between Governance Partners and non-Governance Participating Partners be different? Will there also be vendor-like contracts with Affiliates? What will the contractual differences be?
    - How many seats will be on the Executive Governance Body and what will be the basis of Executive Governance Body representation (i.e. attribution, function, etc.)?

    - What is the exact decision making authority of the Executive Governance Body?
    - How will the Governance Committees be created?
    - Will there be term limits?
    - What subcommittees will be formed, and how?
    - What constitutes a quorum?
    - What will be the “Conflict of Interest” policy and process
- The Lead Partner manages the implementation though a Project Management Office
- In this model, each partner or participating entity retains its financial and operating autonomy. Partners are not financially responsible for one another outside of the terms of the contracts between the partners. However, because the Lead Partner is responsible for fulfilling the terms of the contract, the Lead Partner may be required to support financially less viable partners if that appears necessary to realize a core goal of the DSRIP program.

Delegated Authority Model

The Delegated Authority Model is the most likely structural starting point for most PPSs. With this approach, a new legal entity is created (NewCo) to which the partners delegate decision making authority. A typical structure is depicted below.



An example of the Delegated Authority model is the Noble Health Alliance in the Greater Philadelphia area. Noble Health Alliance (NHA) represents four independent health systems coming together voluntarily and collaboratively to meet the needs of the patients in their respective and joint communities. NHA is managed by both non-clinical and clinical/physician executives through a council.

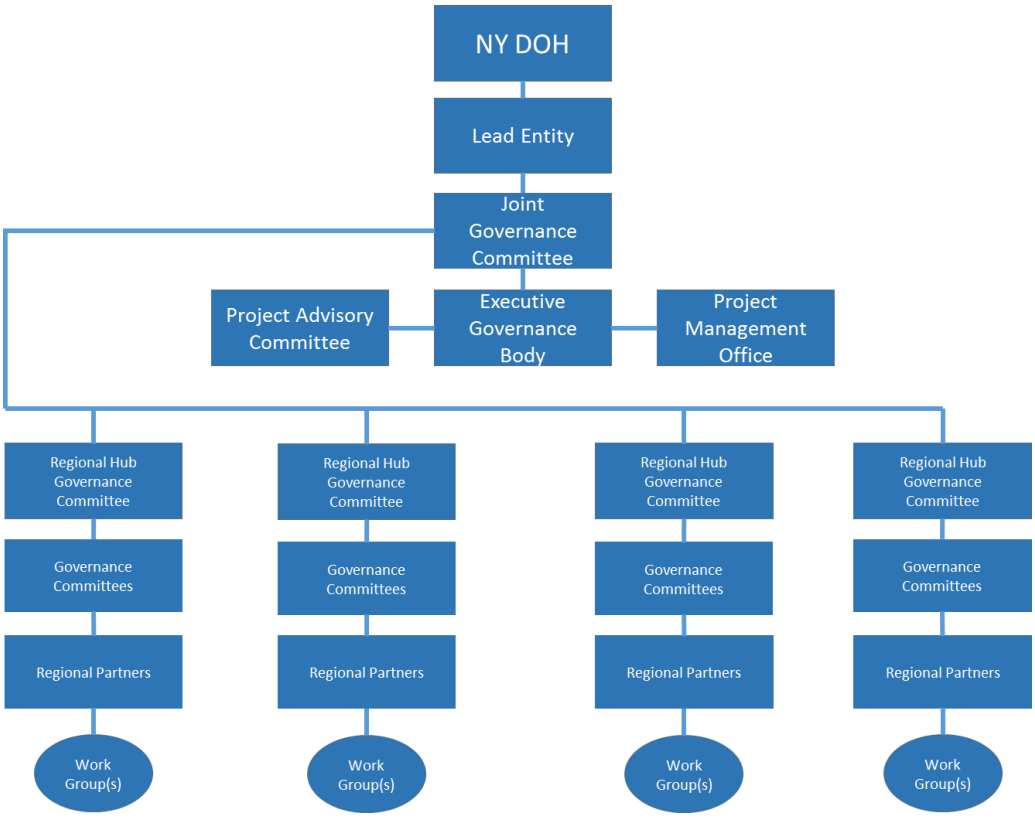
The other characteristics of this model include:

- The legal structure is often an LLC, or an LLC that is qualified as a 501 (c) (3), but it could also be e.g. a business corporation, LLP or benefit corporation. It is important to carefully select the type of corporate entity to enable optimal alignment of the founding organization's missions, regulatory and tax purposes, and so forth. Adequate legal advice is crucial.
- An Operating Agreement will need to be developed that addresses questions such as:
    - Will NewCo be for-profit or not-for-profit?
    - Will there be more than one level of participant? What will it be based on?
    - Is there a minimum contribution necessary in order to join?
    - How many seats will be on the Executive Governance Body and what will be the basis of Executive Governance Body representation (i.e. revenue, attribution, function, etc.)?
    - Who has authority over operating expenditures, capital expenditures, and taking on debt?
    - How will the Governance Committees be created?
    - Will there be term limits?

    - Is an Executive Committee (a subset of the Executive Governance Body) needed to deal with emergencies and/or make decisions quickly?
    - What constitutes a quorum?
    - Which issues can be decided by a majority vote and which require a super-majority (and what constitutes a Super Majority)?
    - What will be the “Conflict of Interest” policy and process”
- The entity can be funded by regular assessment of the Partners, and/or through a capital contribution methodology
- The PPS Board/Executive Governance Body is composed of representatives from the partners based on a mix of funding provided, role in the PPS and/or patient attribution
- The Committees provide specific oversight (i.e. clinical) and the actual work is done by specialized “Working Groups” reporting to their respective Committee
- NewCo manages the implementation of the PPS through a Project Management Office and manages the provider network for the PPS
- The actual management of the care system can largely be delegated to the participating members, or be a mix with some central management such as IT/Data, and decentralization of the care delivery
- Not all providers need to be part of the NewCo structure. Many providers and community-based organizations may best serve in the role of non-governance Participating Partners or “Affiliates” with vendor type contracts
- In this model, outside of the PPS activates, each partner or participating entity retains its financial and operating autonomy

There are likely to be significant variations on the “Delegated Authority Model”. The most likely is the use of “Regional Hubs” to decentralize responsibilities which may be appropriate for geographic areas with unique and/or otherwise differentiated constellations of Partner (and/or Provider) entities in defined sub-divisions of the PPS service area.

In the example below, a Joint Governance Committee is added to oversee the regional hubs, with an Executive Governance Committee to oversee the specific Domains and projects.

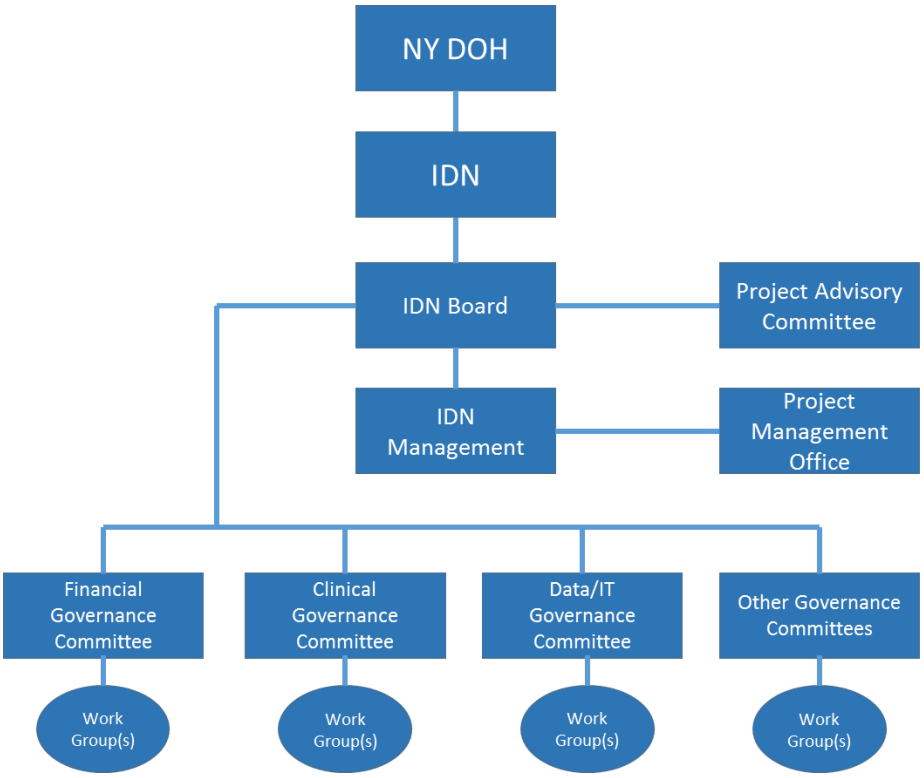


During the early years of DSRIP, it is likely that various forms of the Delegated Model will be the most prevalent approach to governance for the PPSs. In the longer term, it may make sense for the PPS Partners to start consolidating into a single Clinical Enterprise with a single management structure for efficiency and agility.

(The Regional Hub model could also be a variation of the other models discussed)

Fully Incorporated Model

In the Fully Incorporated Model, the partners join together or are absorbed into a single legal entity and are operational and financially integrated beyond the scope of DSRIP. The functions of PPS implementation, managing the delivery system, and the work of the Committees becomes part of the new entity's, or an existing entity's, Governance and Management structure. A typical model for a Fully Incorporated Model is depicted below.



A well-known example of the Fully Incorporated Model in the Northeast is Geisinger Health System, which has a more unified and centralized governance structure. Also in the Northeast, New York Presbyterian Healthcare System in NYC, the University of Pennsylvania Health System and the Johns Hopkins Health System, which are academic health system variants, are a confederation of institutions, clinical centers, and faculty practice plans.

The characteristics of the Fully Incorporated Model include:

- This model builds on most of the attributes of the "Delegated Authority Model"
- Governance now includes all aspects of the enterprise and the care delivery system, beyond the DSRIP program, and is supported by a single integrated management team
- Representation in Governance is preferred but not essential
- The clinical entity has a single management control structure and is financially integrated, with a consolidated financial statement for all operations

Governance Model Comparison

	Strength	Weakness	Comments
Collaborative Contracting	• Can be set up relatively quickly • No new entities need to be created; partners retain their individual autonomy	• Number of contracts can become unwieldy • Because decision making can be cumbersome, this governance structure often cannot deal well with unforeseen circumstances • Potential for conflicts when limits of contracts are reached • Rigidity of structure • Difficult to fully realize value based contracts with MCOs with this structure	• This is a possible early governance model because initial buy-in of provider partners is relatively easy
Delegated Authority	• Can be more efficient by centralizing decision making • Can limit delegation of powers to the new entity to those aspects directly necessary for DSRIP	• Potential to lose buy-in of partners • Can be a challenge to agree on what is delegated	• Will require an effort to maintain transparency
Fully Incorporated Model	• Most efficient decision making	• Partners lose autonomy • Partners may not want to join, making functional completeness difficult	• May ultimately be the best model to tie in non-facility partners

Each PPS should work with its own counsel with respect to both planning and implementation as building these governance structures implicates Federal and State laws and regulations. (More information on implicated regulations and potential regulatory relief is forthcoming)

Individuals will come and go. What sustains great governance is the structures and processes that are put in place.

Building the Governance Structure – Timeline and Milestones

Each PPS must have its governance structure described in the Project Plan Application due on December 16, 2014, and must be able to operationalize the governance structure by March 31, 2015.

Achieving a functioning governance structure requires attention to two parallel work flows:

- Assembling the components of the governance structure
- Educating and communicating to the stakeholders

A suggestion for the major mile stones and an associated time line is shown below. *At all key decision making moments, make sure to work with knowledgeable Counsel to ensure that proposed models are legally sound.*

Target Date	Governance Structure	Suggested Internal Education and Communication
September 2014	Discuss and decide what issues will require PPS level decision making for April 1, 2015 Conduct an initial forum of PPS partners to discuss and consider governance models. May take more than one session Discuss the dimensions of governance structure (clinical, financial, data/IT)	General communication to PPS stakeholders Conduct educational sessions on the DSRIP Program as needed, including the time line for building the governance structure
October 2014	Conduct partner forum to discuss and consider governance models Select a governance model Designate a working group to write the governance section of the Application	Provide communication to all stakeholders that provides the discussion at the forums and the selected governance model and the rationale supporting the decision Conduct educational sessions for PPS partners to achieve a baseline understanding of governance functions

	The designated work group develops a functional organizational chart that includes roles and responsibilities Populate the Executive Committee, including officers, through negotiation among the PPS partners	and the strengths and weaknesses of the selected model Conduct basic educational sessions for PPS partners on Funds Flow, Performance Management and the functions of the Committees
November 2014	Qualify and vet candidates for Committee leadership with PPS partner management input Committee leaders begin to identify Committee members and the need for Sub-Committees Prepare meeting agendas to achieve a December 16th delivery Begin development of Committee Charters and necessary Policies and Procedures	Provide regular periodic updates Conduct basic educational sessions for PPS partners Value-based contracting and Population Health Management
December 2014	Submit Project Plan on December 16th	Inform PPS partners when Project Plan is submitted
March 2015	Upon receiving notice that the Project Plan has been approved: • Complete the selection of all leadership positions • Complete the rosters of all Committees Executive Committee approves all Committee Charters, goals and time lines Conduct a final forum for the PAC to review the approved Project Plan	Inform PPS partners when complete
April 1, 2015	Begin PPS operations	

Concluding Thoughts

Given the opportunity, several books can be written (and have been written) on how to approach Governance. By way of concluding thoughts for this "How To" manual:

- There is no one right approach to Governance, there are a series of Guidelines and DSRIP requirements which have been described in this document. Each PPS needs to take these guidelines and requirements and apply them to their specific goals and situation.
- Whatever Governance model is initially adopted, expect it to evolve over time as a result of:
    - Increased focus on what is getting results
    - The evolving relationship of competitors to true collaborators
    - Adopting change based on trial and error
    - Streamlining for efficiency
    - And a range of other possibilities
- Remember Mr. Charles Darwin: *"It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change."* Be effective in adapting to change.

References and Helpful Links

Update: 09/15/2014

1. 50 Practices of Top Performing Boards; Integrated Healthcare Strategies & The Governance Institute; (2009)
2. Caldwell, C, Karri, R; Organizational Governance and Ethical Systems: A Covenantal Approach to Building Trust; Journal of Business Ethics, 58: 249-259 (2005)
3. Koliba, C, Meek, JW, Zia, A; Governance Networks in Public Administration and Public Policy; CRC Press; Boca Raton, FL (2010)
4. Tyler, JL, Biggs, E; Practical Governance; Health Administration Press; Chicago, IL (2001)
5. Drucker, PF; Lessons for Successful Nonprofit Governance; Wiley Periodicals, Inc; (2006)
6. McCambridge, R; Underestimating the Power of Nonprofit Governance; Nonprofit and Voluntary Sector Quarterly 2004 33: 346
7. Maassen, GF; An International Comparison of Corporate Governance Models; Rotterdam School of Management; Rotterdam, NL (2002)
8. Governance of Not-for-Profit Healthcare Organizations; Moody's Investor Service; New York; June, 2005 http://www.healthlawyers.org/Members/PracticeGroups/blg/ExecSumms/Documents/Moody_Report.pdf
9. Prybil, et. al., Governance in High Performing Health Systems: A Report on Trustee and CEO Views; Grant Thornton, LLP; Chicago, IL (2009) http://www.nonprofithealthcare.org/resources/GovernanceInHigh-PerformingCommunityHealthSystems.pdf
10. The More I Know, the Less I Sleep. Global Perspectives on Clinical Governance (KPMG) http://www.kpmg.com/Global/en/IssuesAndInsights/ArticlesPublications/clinical-governance/Documents/clinical-governance-v3.pdf
11. Readings in Healthcare Governance; Chubb Group of Insurance Companies; Warren, NJ (2005) http://www.chubb.com/businesses/csi/chubb3821.pdf
12. Competency-Based Governance: A Foundation for Board and Organizational Effectiveness; American Hospital Association Center for Healthcare Governance; Chicago, IL (2009)
13. Great Governance: A Practical Guide for Busy Board Leaders and Executives of Nonprofit Healthcare Organizations; Alliance for Advancing Nonprofit Healthcare; August, 2011 http://www.nonprofithealthcare.org/resources/Alliance-GreatGovernanceGuide.pdf
14. http://smallbusiness.chron.com/difference-between-corporate-governance-corporate-management-61799.html
15. http://www.unisa.ac.za/ungc/Striving%20for%20the%20perfect%20partnershipGovernance%20vs%20Management_p.html
16. http://siteresources.worldbank.org/EXTGLOREGPARPROG/Resources/grpp_sourcebook_chap12.pdf