DSRIP Webinar - Governance

Agenda

1. Governance Considerations
2. PPS Governance Models
3. PPS Partners
4. Closing Thoughts

Purpose

The purpose of this webinar is to further explore the subject of PPS Governance and supplement the current Governance How-To Guide that is published on the New York State DSRIP web site. It is not the intent of this webinar to repeat or review the content of the How-To Guide.

PPSs should not rely on this material alone when building their governance model. Appropriate legal guidance is essential.

Governance Evolution

Governance models will differ among PPSs and evolve over time.

It is expected that PPS governance will evolve over the five-year DSRIP Program. Some of the governance elements that may evolve include:

- The degree of integration
- Legal structure
- The number and types of partners
- The operating agreement

DOH is not prescriptive on how each PPS needs to set up their governing structure.

- Each PPS has the flexibility to design what works best for them
- There is no one right answer

Governance Requirements

By April 1, 2015, PPSs are required to have essential elements of governance in place to enable them to initiate DSRIP projects.

In order to mitigate problems on April 1st, PPSs are encouraged to prioritize the development of the elements of governance along the DSRIP time line. Those that should be done first include:

- The ability to receive and distribute DSRIP funds
- The ability to make decisions
- Key positions are populated – the seats on the Executive Body and the Chairs of all Committees

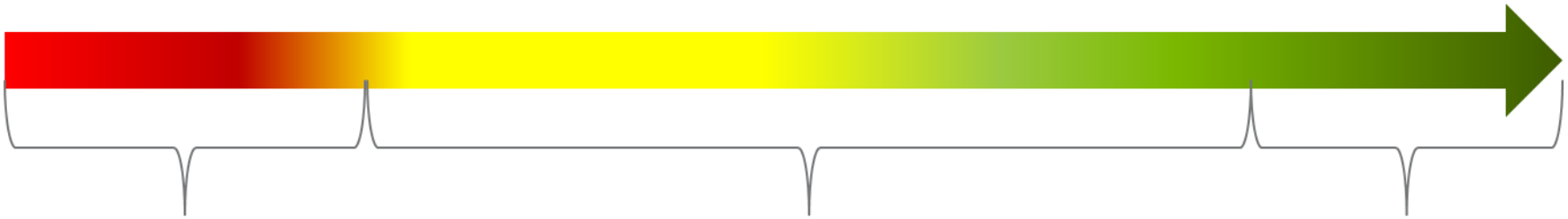
The governance elements that occupy the second tier include:

- The development of clinical pathways
- Decisions on the degree to which financially struggling partners are supported
- The finalization of the procedure to manage non-performing partners

Governance Requirements

While the development governance can be prioritized, by April 1st the PPS should have in place:

- **Form the Financial, Clinical and IT/Data Governance Committees**
- **Fill all Committee seats**
- **Begin Committee work**
- **Complete a Compliance Program**
- **Establish a dispute resolution process**
- **Document a process to manage non-performing partners and vendors**



Now until March 31st, 2015
Planning and Start up Stage

5 Year Program
April 1st, 2015 – Dec 31st, 2019
Operational Stage
Governance, agreements, capabilities should all be evolving

On-going After Jan 1st, 2020

Finance Evolution

PPSs will also need to consider additional financial, clinical, and IT/Data capabilities.

Additional Financial Governance capabilities that will be needed include:

- Methods to manage cost/revenue shifting
- Degree to which financially struggling Partners will be supported
- Budget development
- Financial reporting

Clinical Evolution

PPSs will also need to consider additional financial, clinical, and IT/Data capabilities.

Additional Clinical Governance capabilities that will be needed include:

- Clinical leadership development
- Clinical pathway development
- Selecting and reporting appropriate clinical metrics
- Oversight of clinical pathway dissemination and training
- Engagement of direct-care providers

IT/Data Evolution

PPSs will also need to consider additional financial, clinical, and IT/Data capabilities.

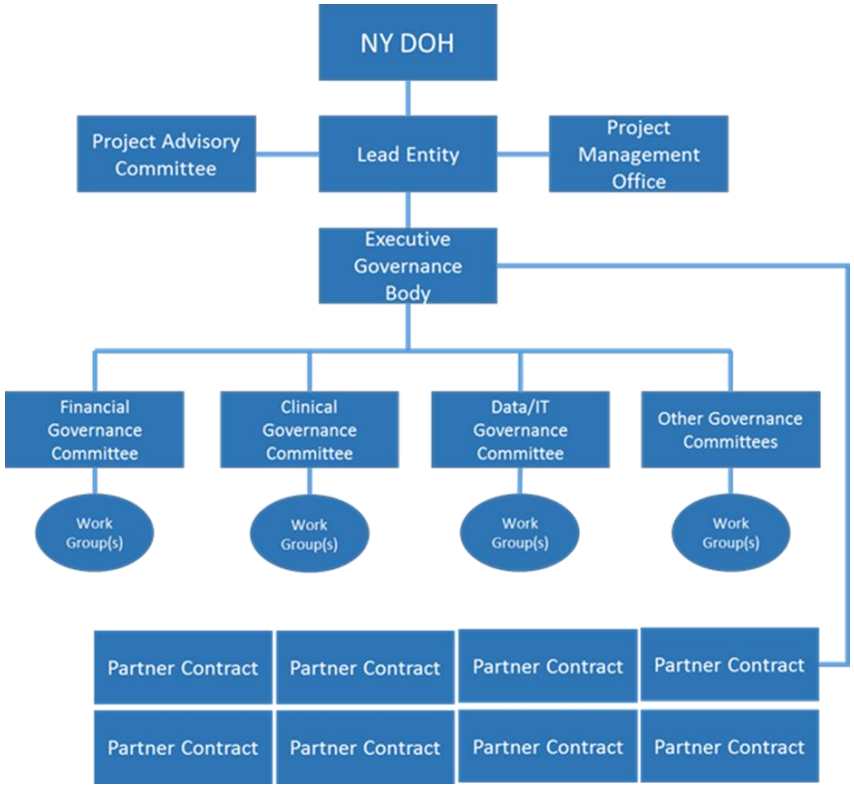
Additional IT/ Data Governance capabilities that will be needed include:

- Data sharing agreements
- Standardizing data definitions
- Oversight for data security and compliance
- The development of standardized performance dashboards and reports

Governance Models – Collaborative Contracting

The DOH Governance "How-To" Guide presents three sample governance structures to illustrate the range of possible approaches.

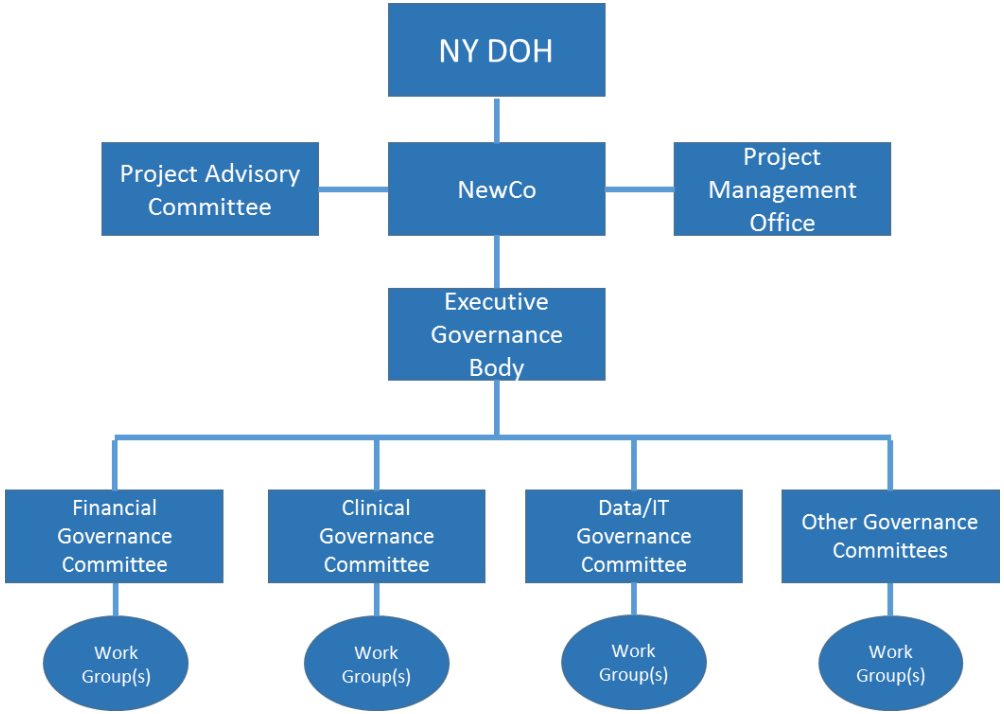
Collaborative Contracting – the Lead Entity establishes contracts with all other partners to stipulate roles and responsibilities.



Governance Models – Delegated Authority

The DOH Governance "How-To" Guide presents three sample governance structures to illustrate the range of possible approaches.

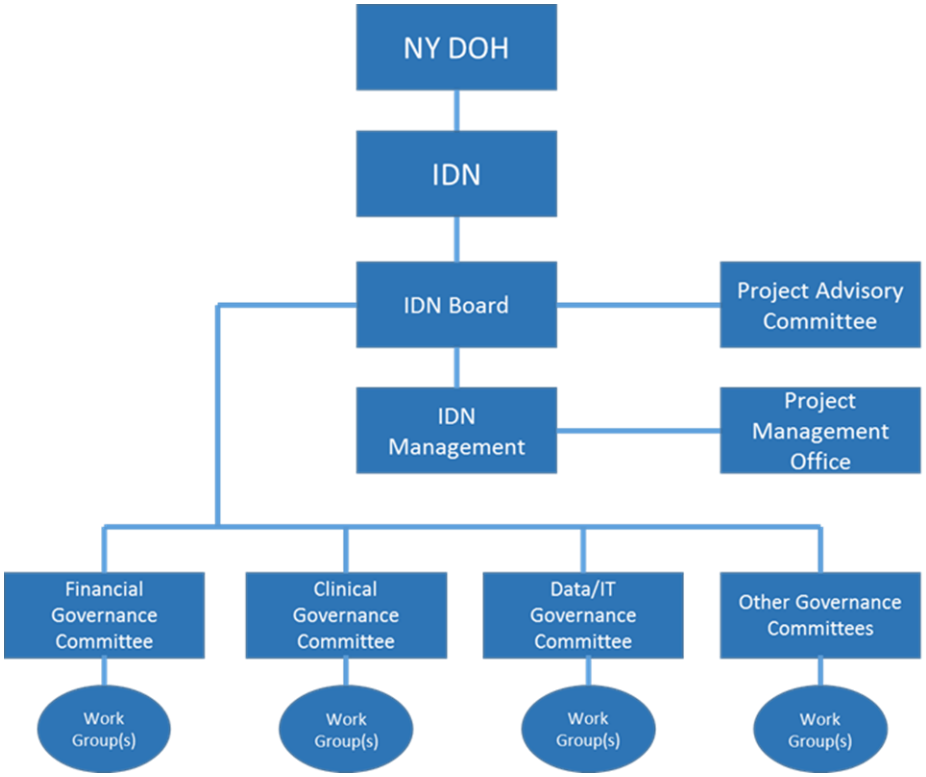
Delegated Authority – a new legal structure, often an LLC, is formed and the partners delegate certain authority to the new organization.



Governance Models – Fully Incorporated

The DOH Governance "How-To" Guide presents three sample governance structures to illustrate the range of possible approaches.

Fully Incorporated – the partners merge into a new, integrated delivery system and the work of the PPS becomes part of a single management and governance structure.



Governance Models – Comparison

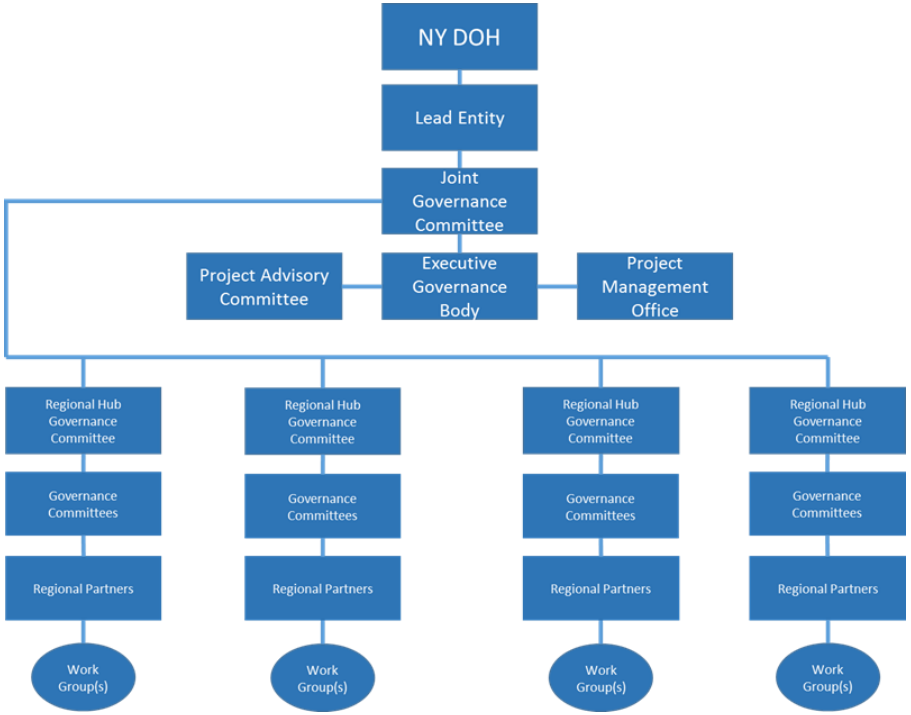
The three sample Governance Models present varying strengths and weaknesses.

Model	Strengths	Weaknesses	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 be unwieldy • Because decision making can be cumbersome, this governance structure often cannot deal well with unforeseen circumstances • Potential for conflicts when limits of contract 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 Mode	• 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*

Governance Models – Regional Hub Option

A variation that can be applied to all Governance Models uses "Hubs" to augment the organizational structure.

- The hubs can be geographic or functional or both
- In a rural environment, using geographic hubs pushes decision making closer to the sites of care and strengthens local engagement
- In an urban environment, using functional hubs such as acute care providers, nursing facility providers and the like helps to manage the large number of Partners and vendors



Governance Support

Regardless of the model selected, once the structure is decided each PPS will need to develop supporting documentation.

Supporting documentation includes:

- Operating Agreement
- Guidance for committee structure
- A process for collaboration
- A process for stakeholder engagement
- Decision rules
- Performance monitoring
- Liability
- Financial accountability and oversight

Partners

Like the variation in governance models, there will be variation in the types of partner involved with the PPS.

- **Capital Contributing Partner(s)** of an LLC or IDS
- **A Lead Partner(s)** who is responsible for fiduciary and project management control
- **Governance Partners** who are members of the Boards and Committees
- **Participating Partners** who are Partners by nature of the beneficiary attribution and act only in an advisory capacity
- **Affiliates** who might be direct-care providers or community based organizations

Conclusions

PPS governance models are crucial elements of the DSRIP program that will evolve over time. PPSs need a strong start in April to put themselves on the right path.

- **The governance model the PPS creates will guide the work of the PPS**
- **PPSs should expect to modify their governance structures over time**
- **The DSRIP application is expected to be thoughtful and complete regarding the choice of governance structure**
- **The governance goal for April 1, 2015 is to establish basic functionality**

Disclaimers

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