FEATURE

Patients and Providers Can Benefit from Collaboration Under Value-Based Payment Arrangements

One of the overarching goals of health reform is to reduce U.S. healthcare costs and spending while improving healthcare quality and outcomes. One major effort in achieving this is by transforming the Medicare and Medicaid reimbursement and delivery systems.

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On January 26, 2015, the U.S. Department of Health and Human Services (HHS) announced its goals and timeline for shifting Medicare reimbursement from volume-based payments (based on the quantity of services provided) to value-based payments (based on the quality of services provided). By 2016, 30% of Medicare payments must be in alternate payment models (e.g., ACOs and/or bundled payment models). By 2018, that proportion must climb to 50%. In addition, in 2016, 85% of Medicare payments must be tied in some way to quality and value (e.g. Hospital Value Based Purchasing and Hospital Readmissions Reduction programs), with an increase to 90% by 2018. At the same time, HHS will intensify its work with states and private payers to support adoption of alternative payment models, attempting to exceed the Medicare goals and timeline.

Restructuring the healthcare payment system is a monumental change. Under a value-based payment (VBP) system providers will be financially incentivized based on how well they manage the care of patients instead of how many services they provide to patients.

How VBP Works

Value-based payment methodologies include bundled payments and population-based payments. A bundled payment initiative links the payments for multiple services a patient receives during an episode of care. In a bundled payment arrangement, a payer such as Medicaid makes a single payment for all provider services related to an "episode" of patient care such as diabetes treatment or congestive heart failure. Episodes of care that are eligible for bundled payment plans are predetermined. VBP holds providers accountable for patient care as a group and motivates them financially to work together on behalf of the patient and to eliminate duplication and waste.

In a population-based payment model, providers are accountable for the total cost of care of a defined patient population. This would include services delivered directly by the provider and services delivered outside of the provider. Again, the result is a financial incentive for providers to work together to manage the care for a group of patients.

The overarching premise of the VBP model is founded on the concept of managing the total care of the patient. In practice, this means that physical and behavioral healthcare providers could collaborate on behalf of the patient and band together in integrated care networks. As competition for patients among these networks increases, various provider-types could collaborate to broaden the scope of services their integrated care network could provide. Furthermore, participants in the integrated care network would likely initiate shared service-type arrangements designed to provide patients with high quality services at a reasonable cost.

Another significant aspect of a value-based payment system is that specific success metrics for patient care – such as preventive care visits and other wellness initiatives – are monitored and tied to the reimbursement the integrated care network receives. The network is rewarded by achieving designated patient care metrics.

VBP Care Networks

Two examples of integrated care networks forming under VBP arrangements are Accountable Care Organizations (ACOs) and Independent Practice Associations (IPAs). ACOs have already embraced many of the tenets of the VBP model including collaboration

among practices and tying financial performance to the quality of patient care. IPAs would negotiate and manage contracts under a VBP system, but individual practitioners would retain their independence instead of formally joining an integrated care network.

The VBP Payment Model

Value-based payment arrangements contain a hybrid of several different types of payment models that are tied together to incentivize the managed care of the patient. The key components of a VBP arrangement include:

1. Base compensation model (e.g., fee for service, partial capitation, per member per month care management)
2. Incentive payments for quality of care (may be process or outcome driven)
3. Global payments/budgets (based on surplus sharing, risk sharing with global capitation)

Key to this payment model is the fact that participants in the VBP structure share in any surplus funds earned against predetermined expense benchmarks designated by the payer as well as any deficits generated. As an example, if actual expenses for a defined set of patients were $9.7 million versus a benchmark of $10 million, and the network negotiated a 30% shared surplus arrangement with the payer, the network would earn $90k on the surplus.

Actual Expense vs. Benchmark	Scenario A	Scenario B
Total Expense	$9,700,000	$10,500,000
Benchmark (MLR; PMPM)	$10,000,000	
Surplus/(Loss)	$300,000	($500,000)
Shared-Surplus Arrangement (30%)	$90,000	N/A
Risk-Sharing Arrangement (50%)	$150,000	($250,000)

Conversely, risk sharing arrangements are also negotiated. If the network had a 50/50 risk sharing arrangement with the payer, and actual fees/expenses for services exceeded the benchmark, the network would take a 50% loss on the fees/expenses that exceeded the benchmark.

Benefits of Collaboration under a VBP System

Given the aforementioned HHS goals, the healthcare system's conversion to a value-based payment system model founded on "total patient care" is inevitable. The volume-driven, fee-for-services model is becoming obsolete and wrought with inefficiency. Patients and providers are looking for a system that is accountable to the well-being of the patient while contributing revenue growth to healthcare practices — enabling them to maintain the level of care their patients require. A collaborative model under an emerging VBP system offers numerous benefits to providers, including:

- access to a larger population of patients and increased market penetration
- diversification and expansion of services that can be provided to patients
- economies of scale that will enable them to keep pace with healthcare reform changes
- a pooling of expertise in support of patient care
- co-branding and other marketing initiatives
- sharing in the financial rewards and risks

Employing a Collaborative Structure

There are a many different collaborative structures that healthcare practices may consider in light of VBP. Some retain the autonomy of the individual participating providers and others require changes in the governance structure. Today, more and more providers are

forming ACOs and IPAs to position themselves strategically for the transition to a value-based payment system. Other providers are looking at options that allow for more efficient deployment of resources which are commonly coupled with corporate reorganization. Here are four:

Merger: When two centers, often of about the same size, agree to go forward as a single "new" entity rather than remain separately owned and operated (often referred to as a "merger of equals"). The "new" entity must satisfy the Health Resources and Services Administration (HRSA) Program Requirements and are often characterized by a new Board of Directors and management team that are composed of individuals from the originating two health centers. This form of affiliation involves significant legal and regulatory hurdles.

Acquisition: There are essentially two forms. The first occurs when one health center will assume the operations of another health center and, as part of the deal's terms, allows the acquired health center to proclaim the action as a "merger of equals". This generally occurs when both CEOs agree that joining forces is in the best interest of both health centers and the regulatory hurdles and cost in creating a new entity are high. The second type of acquisition is generally an unfriendly deal when one health center assumes responsibility of another health center's program and federal grant due to HRSA administrative actions concerning serious financial and/or leadership/management non-compliance issues.

Parent-Subsidiary: This is similar to a merger or acquisition transaction. However, instead of forming one entity, the entities remain intact with one entity controlling the other through governance documents. This type of collaborative arrangement is often done for political, marketing, licensing, financial and other reasons (e.g., timing). In the HRSA grant world, a parent can be established as the grantee for both entities and the subsidiary is considered a "sub-recipient."

Shared Services Organization (SSO): This collaboration occurs when two health centers wish to retain autonomy and governance but want to share services to gain economies of scale and the ability to attract increased expertise. The development of an IPA with a Management Services Organization (MSO) has a similar effect, enabling the two centers to market and negotiate collectively with third party payers.

Payers are increasingly looking to partner with a provider that can:

- Achieve specified quality metrics which, in turn, can result in the MCO receiving a quality incentive premium bump from a governmental or commercial payer;
- Help manage the total cost of care of a patient and reduce overall healthcare expenditures below spending targets, thereby generating surpluses, and
- Deliver a high-value, low cost proposition.

On their own, most providers are unprepared to deliver the majority of services required by their patients. The best approach to meeting the needs of both patients and payers is for providers to work together. In a healthcare system transitioning from fee-for-services to value-based payments, providers should benefit greatly from collaborative agreements, IPAs and ACOs, or through other combinations of organizations or services. ◆

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