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## INTRODUCTION

With the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, it is clear that the transition from a fee-for-service (FFS) reimbursement model, based on volume, to a fee-for-value (FFV) approach or value-based reimbursement model, based on quality and cost, is well underway. At its core, value-based reimbursement inherently will require providers to manage the health of certain populations of patients, rather than managing the health of one patient at a time (as under the FFS reimbursement system). With value-based reimbursement linking provider payment to outcomes, providers and payers should be aware of new transaction types and characteristics relevant to value-based reimbursement. Under contemporary models, much of the financial and clinical risk shifts from the payer to the provider and providers are held accountable for leading the care continuum. Providers are rewarded based on the quality and efficiency of the care they deliver, as well as their ability to contain costs.

### EVOLUTION OF VALUE-BASED REIMBURSEMENT

If value is defined as quality per unit of cost, it is logical to assume that improving both quality and cost would improve value. This proposition is the focus of health reform. Generating higher value through quality enhancement and cost reduction defines value-based reimbursement. Value-based reimbursement and population health management foster innovation, which leads to cost control and quality/patient safety improvements, scientific advancement of medical knowledge, free-market competition and consumer choice, and more preventative care. Ultimately, these efforts should promote better care at lower costs, thereby enhancing the value proposition over the long haul.

Meanwhile, value-based reimbursement prevents rationing of care (which stifles innovation), the commoditization of care (which leads to consumer and provider dissatisfaction), control by non-providers (who lack the knowledge to make nuanced but meaningful change), continued fragmentation, dis-coordination, lack of communication, and cost inflation within the healthcare system.

Secretary Sylvia Burwell announced on January 26, 2015, that the Department of Health and Human Services (HHS) was setting explicit goals for Medicare reimbursement to shift from volume to value, initially tying 30% of FFS Medicare payments to quality or value through alternatives models by the end of 2016. In March of 2016, HHS announced the early achievement of its initial 30% goal nearly a year ahead of schedule.<sup>1</sup> The goal of HHS is to

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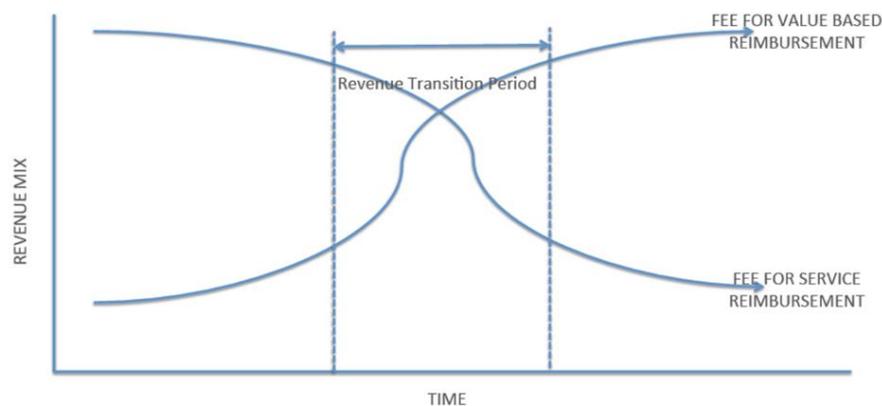
<sup>1</sup> HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule, U.S. Dep't Health Hum. Serv., (March 3, 2016) <https://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>. Accessed April 5, 2017.

gradually tie 90% of Medicare reimbursement to value-based payment models that incentivize the management of population health by 2018.<sup>2</sup> Industry-wide adoption of FFV payment models may be in the near future for the U.S. healthcare delivery system, as a number of commercial payers have similarly developed payer contracts that reward providers for value of care rather than service volume.

#### HYBRID FEE-FOR-SERVICE AND FEE-FOR-VALUE

The movement towards an FFV reimbursement system requires an evolution of improved patient outcomes, reduced costs, and care coordination. The complexity of the transformation requires time and a deep understanding of patient populations. Engaging providers to change their practices can prove to be difficult, as value-based contracts alone will not alter the delivery system. Value-based payment incentives are key, but thus far, increases in revenue available to providers through value-based reimbursement have been gradual. Conversely, lucrative financial rewards associated with the current predominantly FFS system make providers reluctant to change and forego what has been, up until this point, a profitable enterprise (albeit increasingly challenging). See Exhibit I.

#### Exhibit I - Hybrid FFS and FFV Model to Generate Revenue<sup>3</sup>



<sup>2</sup> Burwell, S. (2015). "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value." Department of Health and Human Services. Press release.

<sup>3</sup> Brown, B., Crapo, J. (2014) "The Key to Transitioning from Fee-for-Service to Value-Based Reimbursement."

## BUNDLED PAYMENTS

Perhaps the best example of volume-to-value shift in healthcare is occurring in the realm of bundled or episodic payments for services. Before the advent of the Affordable Care Act (ACA), The Brookings Institution studied a variety of reimbursement models to determine which payment mechanism was most likely to bend the proverbial cost curve successfully. Their results clearly showed that bundled payments were superior to shared savings programs, capitation arrangements, and other models included in the study.

As a result of the Brookings' study and other reports, the bundled payment care initiative (BPCI) was launched by the Centers for Medicare and Medicaid Services (CMS) Center for Innovation in 2013. Over the course of BPCI, over 100 healthcare provider organizations have voluntarily tested bundled payments across 48 different episodes of care.

In 2016, CMS launched its first mandatory bundled payment program, The Comprehensive Joint Replacement (CJR) program, which involved approximately 800 hospitals in 67 geographical areas. The CJR program now encompasses hip fracture cases in addition to total joint replacement and is expected to expand to other areas and organizations in the coming years.

Finally, in December of 2016, CMS launched episodic care models for acute myocardial infarction (AMI or heart attack), coronary artery bypass surgery (CABG), and cardiac rehabilitation services. These mandatory payment models will be rolled out to select geographies and organizations in July of 2017.

CMS appears intent on expanding the bundled payment model. The expectation is that many more procedures and clinical episodes soon will be paid for using this mechanism. Further, ambulatory bundles are soon likely to appear for procedures such as cataract surgery and colonoscopy.

It is also notable that the bundled reimbursement models described above all include quality metrics and thresholds that must be met for savings to be shared between CMS and providers operating under bundled agreements. This criterion, then, makes bundled payments, along with those payment mechanisms mandated by MACRA, the first truly at-risk, value-based reimbursement methods to be widely implemented across the U.S.

The ramifications of the widespread roll-out of bundles are many and include the following:

- New organizational structures within which providers of various types, hospitals, physicians, post-acute care providers, etc., must work together to deliver the kind of coordinated, high-quality, low-cost care demanded by a bundled payment agreement are likely to become more prevalent. These organizational/structural entities, whether clinically integrated networks (CINs), accountable care organizations (ACOs), clinical co-

management programs (CCMPs), or others will dramatically change the way providers interact and jointly go to market.

- The distribution of bundled payments or the shared savings bonuses that may accompany bundled payments will require participating providers not only to band together into new structural entities but also to develop formal and codified methodologies for calculating and distributing revenues received for rendering bundled services or performing to the level that warrants bonus payments.
- The tracking of quality and cost data will require much more sophisticated information technology (IT) systems than are now available. Quality measurement in healthcare remains a nascent science, and the cost accounting systems in most provider organizations are woefully inadequate for the challenges inherent in the accurate pricing of services under a bundled payment agreement.
- Billing and collection activities under a bundled model will be significantly different than those now used within a more traditional FFS revenue cycle operation. Not only will quality, cost efficiency, and other performance data need to accompany the bills, but more complex compliance risks may also arise, e.g., falling afoul of the False Claims Act (FCA) by submitting inaccurate quality data.
- Clinical care delivery in the current system is rarely scrutinized as to its adherence to evidence-based best practices, its quality and cost outcomes, and whether it is provided in a patient-centered, coordinated fashion. Care processes under bundled payments will need to be systematically re-tooled by teams of front-line clinical and non-clinical caregivers to ensure that novel reimbursement models like bundles are matched with equally innovative and continuously refined care processes and procedures.
- Bundles will inevitably disrupt the culture of the healthcare delivery system. The current hierarchical, physician-centered care model likely will be replaced with a more patient-centered, team approach that may leave some providers out of the loop, as all care delivery is subjected to vigorous scrutiny as to which services are truly value-add. In fact, this may be the ultimate rate limiting step regarding the broad acceptance and utilization of bundled payments. As the adage says, “culture trumps strategy every time,” and this may be a case in point regarding that saying.

## CONCLUSIONS

Value-based reimbursement requires optimal allocation of resources, clinical and financial risk management, measurement of quality and cost, and technology-driven mobile/remote care delivery, and care coordination. As the industry shifts from “volume to value,” many changes in the industry affect the payer, provider, and patient – literally, everyone receiving, providing, or paying for care. Payers are incentivized to bend the cost curve (i.e., premiums), improve physician network relations, and improve quality, outcomes, and financial performance. Providers, however, are incentivized to maximize revenue generation via physician and hospital alignment, improved quality outcomes, and utilization of reliable quality and cost data to drive

improvements. At the same time, many patients have been incentivized to obtain coverage through high-deductible, catastrophic health plans.

Bundled payments serve as an excellent example of how value-based reimbursements will drive dramatic changes in the provider, payer, and patient arenas. These changes won't be easy, and indeed the promise of moving to a bundled payment strategy may not result in the desired outcomes. Time will tell. However, those healthcare providers who choose to wait until the verdict is fully in regarding bundled payments, in particular, or value-based reimbursements, in general, may not survive to find out how this all plays out.

Providers would be well-advised at this juncture to note the rapid adoption of the value-based reimbursement model most favored by the country's largest payer, i.e., CMS, and make those changes now that ensures they won't be left behind as the volume to value shift continues.

Some of the recommended changes have been mentioned, while others are outlined below.

## **ALIGNMENT STRATEGIES BEST SUITED FOR VALUE-BASED REIMBURSEMENT**

Physician-hospital alignment often is viewed as the precursor to clinical integration, which has been linked to the long-term success of provider organizations in the new value-driven healthcare industry. As healthcare organizations continue to recognize the importance of both alignment and integration in this new "accountable care era," there is often a misplaced belief that the adoption of one particular model (such as employment) is the answer. However, multiple alignment models exist that can advance the agenda for provider organizations to remain viable and autonomous in a shifting reimbursement landscape.

### **ALIGNMENT STRATEGY #1: DEVELOPMENT OF AND PARTICIPATION IN CLINICALLY INTEGRATED NETWORKS**

Various alignment strategies and incentive compensation models are available to organizations that seek to prepare for the transition from FFS to FFV. One such alignment strategy is the formation of the CIN.

Although the concept of clinical integration has been around for several years, its application has evolved over time. The growth of managed care during the 1980s and 1990s gave physicians strong incentives to negotiate jointly with health plans. The earliest clinical integration models centered on competing physicians organizing through independent practice associations (IPAs) and physician hospital organizations (PHOs) to negotiate jointly with health plans in response to health plans' initiatives to control payment rates with the threat of selective contracting—that is, excluding providers from networks. By risk sharing through physician-driven organizations like IPAs and PHOs, physicians tried to gain leverage in payer negotiations and secure sufficient volume and resources to manage financial risk.

Healthcare organizations and government regulators may define clinical integration differently, with degrees of variations and nuances. Clinical integration of providers encompasses the following:

1. Working together across multiple entities to share clinical data to ensure the greatest value (defined as quality per unit of cost) possible to patients;
2. Establishing and applying best practices and processes in patient care; and
3. Deploying an integrated IT infrastructure.

The benefits to implementing or joining a CIN are many, including:

- Patients/Community
  - Access to high-quality, coordinated, and comprehensive care;
  - Potential for lower costs associated with healthcare services received;
- Providers
  - Access to greater financial initiatives;
  - Opportunity to drive healthcare quality and value;
  - Opportunity to engage in hospital-physician alignment;
- Hospitals
  - Opportunity to cut costs and deliver improved patient-centric care; and
  - Opportunity to engage in hospital-physician alignment.

Physician-specific models utilize payments such as FFS, management revenue, and performance-based payments. While a CIN negotiates with the payers for their members' services, FFS payments received from payers may be distributed to participating providers in amounts reflecting the amount of payments received by the network with respect to the provision of service by such participating providers. Medical management or consulting fees received from payers may be distributed to participating providers on a per-member-per-month (PMPM) basis consistent with the amounts received by the CIN. Additionally, payments based on the performance of quality measures, outcomes, and value as in shared savings, bundled payments, and capitation received from payers by the network may be distributed to participating providers consistent with their performance under such program. While "pay-for-performance" (P4P) incentives have existed for many years, these are advanced forms of value-based payments, which will require significant adjustment, due to their potentially becoming the primary form of reimbursement.

## ALIGNMENT STRATEGY #2: DEVELOPMENT OF AND PARTICIPATION IN ACCOUNTABLE CARE ORGANIZATIONS

Another alignment tool that drives value in healthcare is the ACO, the development of which were prompted by the Medicare Shared Savings Program (MSSP) under ACA.<sup>4</sup> “An ACO is a network of doctors and hospitals that share financial and medical responsibilities for providing coordinated care to patients in hopes of limiting unnecessary spending.”<sup>5</sup> ACOs are meant “to allow doctors to better coordinate patient care and improve the quality, help prevent disease and illness, and reduce unnecessary hospital admissions.”<sup>6</sup>

Under the MSSP, Medicare beneficiaries are attributed to an ACO based on their utilization of primary care services. In turn, providers within the ACO integrate their efforts across the continuum of care with respect to their assigned Medicare beneficiaries with the goal of providing more value to their Medicare populations.<sup>7</sup> If providers within the ACO meet certain cost and quality of care benchmarks, they receive additional compensation CMS, the governmental arm responsible for administering the Medicare program.<sup>8</sup> Failure to adequately reduce costs could require the ACO to pay a penalty to CMS.<sup>9</sup> To achieve savings, the providers within the network must work together to coordinate a patient’s care by sharing patient information, avoiding unnecessary tests and procedures, and working as a team in treating the patient’s illness.<sup>10</sup> ACOs are similar to CINs except that CINs are primarily used for value-based contracting with commercial payers, while ACOs are for value-based contracting with government payers (such as CMS).

ACOs and CINs share a common purpose of delivering services that meet the growing consumer demand for reliable high-quality and low-cost care; however, they do differ in many ways. ACOs and CINs differ in sponsorship and targeted population markets. Under the MSSP, Medicare provides financial incentives to ACOs (and their participating providers) that agree to manage the care for defined populations and to accept risk for clinical quality and efficiencies in cost.<sup>11</sup> While the Medicare ACO structure is relatively new, many health systems in the U.S. have already formed CINs with commercial payers to stabilize insurance premiums and maximize health outcomes. Whereas the ability to share in cost savings is a central feature of ACOs under

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<sup>4</sup> See Patient Protection and Affordable Care Act of 2009, 111 Pub. L. 148, § 3022, 124 Stat 119 (2009).

<sup>5</sup> Jenny Gold, Accountable Care Organizations, Explained, Kaiser Health News, (September 14, 2015), <http://khn.org/news/aco-accountable-care-organization-faq/>. Accessed April 4, 2017.

<sup>6</sup> Key Features of the Affordable Care Act by Year, U.S. Dep’t Health Hum. Serv., (August 12, 2016) <http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html#>. Accessed April 4, 2017.

<sup>7</sup> Gold, *supra* note 4.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> Reiboldt, M., et al. (2015) “ACO & CIN Readiness.” Coker Group

the MSSP, CINs can engage commercial payers under a variety of value-based incentive models. ACOs focus on providing the right services at the right time to the right patients. Providers determine budgets with accurate cost accounting of well-designed care processes and transparent price setting based on true costs. ACOs are informed with best practices and leverage advanced technology to measure outcomes and managed care.

There are several benefits of CIN participation for providers. Benefits to providers include access to greater financial incentives, the ability to achieve provider stability, an opportunity to drive healthcare quality and value, engage in hospital-physician alignment, maintain autonomy while engaging in an accountable care strategy, expand their patient base and collaborate with local providers, and ease burdens with recruitment. Participation in multiple CINs enhances these potential benefits.

As stated, value-based care design and production must be the primary activities of a CIN, a process that will necessitate dramatic changes to providers' cost structure at various points along the continuum of care. The CIN recognizes that these changes are best managed by the front line clinical experts who can make such adjustments without degrading quality, patient safety, and other clinical outcomes.<sup>12</sup>

ACOs and CINs represent examples of how ACA can specifically reward the development of new care models. These new care models provide innovative changes in the reimbursement system and associated regulatory mandates for demonstrating quality and cost efficiency (i.e., value) as well as provider accountability for the same.

### [ALIGNMENT STRATEGY #3: MORE PREVALENT USE OF THE GROUP PRACTICE SUBSIDIARY EMPLOYMENT MODEL](#)

In the value-based reimbursement era, providers also can meet their operational and financial needs while driving value to their patients by aligning with hospitals through a group practice subsidiary (GPS) employment arrangement. Under this specific type of employment model, the hospital (Hospital) establishes a subsidiary entity, which then employs the physicians of the former private practice (Legacy). The Legacy entity remains intact despite its physician becoming employed by the subsidiary of the Hospital. The Hospital remits a global payment to the subsidiary, which is then distributed among the employed physicians (in a manner established in advance under a Stark compliant methodology). Commercial and government payers reimburse the Hospital (or sometimes directly the GPS) for the professional services rendered. The Hospital acquires the ancillary services. The physicians participate in the governance structure for the GPS and contribute to the overall operations and strategic planning of both the Hospital and the GPS. Typically, the Legacy retains general structure and IT during a transition period from private practice to "owned" practice.

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<sup>12</sup> Knight, M. (2013) "Value-Based Care Process Design – A Hospital / Physician Strategy for Success" Coker Group.

This model is relevant in the value-based reimbursement era because it ideally helps the parties set and collaboratively achieve mutual goals, including both quality and cost goals. In fact, as the tightest form of alignment (i.e., employment), it arguably creates the most natural relationship for working together to achieve a common end. The compensation paid to the physicians (through the Hospital controlled entity) under the GPS model can be productivity-based. However, more often it includes significant value-based payments and bundled payments that align directly with the established quality and cost goals the physicians are helping the Hospital to meet. The key difference is that in the GPS model, the physicians, building upon the relationships and success they have had in private practice, have a slightly greater amount of operational autonomy to achieve these goals than they would in a traditional (individualistic) employment model.

#### ALIGNMENT STRATEGY #4: USE OF HIGHLY SPECIFIC CLINICAL CO-MANAGEMENT AGREEMENTS

One alignment model that is often discussed but whose relevance is regularly masked by the broader strategy (i.e., employment, professional service agreements, and/or clinical integration) is the Clinical Co-Management Agreement (CCMA). CCMA's are a moderate form of an alignment and represent an arrangement wherein providers become actively engaged in setting and managing the clinical direction of a particular service line. CCMA's are frequently consummated between hospitals' service lines and their medical staff members, whether they are employed or contracted, but can be accomplished between other institutions, such as skilled nursing facilities, dialysis centers, etc., and their private physician partners.

The CCMA can be categorized into four general structural types:

- **Traditional CCMA.** This model consists of a management agreement between an existing physician professional corporation and a hospital (usually on behalf of a particular service line). Management services are provided by the existing professional corporation and the hospital's service line. Frequently, this CCMA model is the easiest to implement because it does not require the creation of a new legal organization. This model is often used when there is one physician group providing the totality (or the vast majority) of services to a hospital within a particular service line. In these cases, contracting directly with that group, as opposed to another entity (as is considered in some of the other structures detailed below), may be the most logical and typically the most expedient. For organizations that seek to align more closely with a private practice, this model is a straightforward path to establishing the CCMA.
- **New-Created Entity CCMA.** In this model, a new legal entity is created, which then enters into a management agreement with a hospital (for a particular service line(s)). Management services are provided by the newly-created management entity to the service line in exchange for a fair market value management fee. This CCMA model allows for more flexibility in that there is less rigidity surrounding the physician

composition of the newly-created management entity. In this CCMA structure, not all the physicians of a practice (or even of the service line) would be required to be a party to the transaction and thus could choose to participate in the CCMA at a later date (or not at all). Additionally, this model could allow for the participation of physicians from multiple practices. Finally, it would allow for a simple distribution of funds to those physicians providing the CCMA services.

- **Joint Venture CCMA.** In this model, a physician (or more likely, a set of physicians) and a hospital establish a joint venture management entity that, in turn, enters into a management agreement with a hospital for a particular service line. It is important to note that participating in a joint venture requires the satisfaction of stringent legal regulations and often involves the longest preparation and implementation time. Thus, this model is the least commonly utilized; and, in the limited cases where it is, its use is only for a very specific purpose that cannot be met by the previous structures. This model signifies a more permanent alignment between the hospital and physicians, as the management entity is owned jointly by the two parties.
- **Joint Oversight CCMA.** A Joint Oversight CCMA structure consists of two or more physicians (which may be from the same or different medical groups) who, with their hospital partner, collectively comprise a Joint Oversight Committee. There are still management agreements in place between the hospital and the physician/group, but central to this relationship is a body with representatives from all parties that work together to meet the clinical, operational, and administrative needs associated with a given service line. While the administrative leaders have an equal partnership in the CCMA, the clinical leaders are empowered with oversight and input on the vital issues. This model also represents the potential for multiple practices to participate.

The CCMA structure is only as useful as the metrics that support it. A comprehensive, collaborative, and diligent process should be undertaken to ensure the establishment of relevant metrics. These metrics should be rooted in a joint effort between both the healthcare system and the physicians to emphasize quality improvement, provider accountability, and value-based goals. When defining measures, it is important to note that these metrics can be based on quality, cost, citizenship, and leadership. While the metrics must be verifiable and objective, they must also become more aggressive over time. During the initial roll-out of the CCMA, the metrics should include more attainable targets, with the targets gradually increasing over time so as not to continually reward the same level of achievement. Additionally, the metrics should allow for scalability (both in terms of volume growth within the service line and an increasing number of provider participants).

Historical performance data is necessary to consider when developing quality incentives. As evidenced in several pilot (and now permanent) programs, lawmakers have mandated that incentive payments consider the health system's historical data in establishing the appropriate

baselines. Thus, to determine that quality metrics have been achieved, it is necessary to include the historical data baseline. Additionally, historical data can accurately reflect where there is a need for improvement. It is important to note that benchmarks and quality goals continuously change; thus, the CCMA metrics should be regularly assessed to ensure alignment with current market trends and the goals of the organization.

CCMA compensation typically is comprised of two components: a base fee and variable, incentive-based compensation. The base fee, which is a fixed annual fee consistent with fair market value (FMV), values the physician's time and effort to the service line development, management, and oversight. Compensation typically is focused on hourly-based services rather than accomplishments.

In addition to this base compensation, physicians have the opportunity to earn compensation for meeting or exceeding certain mutually agreed-upon metrics associated with quality, cost, or operational goals. These incentive payments should take into consideration the historical baseline and target levels of the hospital that the parties are agreeing to work toward achieving.

Examples of applicable metrics include:

- Patient access
- Panel size
- Outcomes
- Use of extenders
- Care coordination
- Medical home concepts

The advantages to implementing a CCMA are numerous:

- The CCMA can be structured as an add-on or wraparound to an existing or new, overarching alignment/integration strategy, such as employment or professional services agreement (PSA);
- The CCMA advances key goals/objectives of the organization that relate to the quality, cost, and management of services;
- The CCMA is easily customizable to address the preferences of all parties involved;
- The value of the CCMA can range from relatively insignificant dollars to material figures;
- The CCMA better prepares all organizations to meet the increasing demands of the Accountable Care Era; such as the acceptance of mandatory bundled payment arrangements.
- The CCMA can offer a win-win solution for both physicians and hospitals wherein physicians are given an opportunity to participate in FFV reimbursement models without investing significant amounts of capital, and hospitals can utilize physician influence and clinical insight to control costs and improve quality; and

- The CCMA allows for scalability and supports the development/success of models, such as ACOs, patient-centered medical homes, and CINs.

CCMAs can be a useful approach to advance “value-centric” initiatives and create an interdependence between partnering groups, which are crucial elements for clinically integrating and assuming risk under population health models. However, CCMAs require careful planning as their structural details can impact the interplay between clinicians and administrators. In the balance, the CCMAs are often viewed as a more palatable proposition for physicians to partner with their larger institutional counterparts than many other approaches that may seem too aggressive. However, traditionally, the CCMA is not a tactic that can carry the success of partnering organizations on its own, particularly for the longer term.

## CONCLUSIONS

Alignment, in some form, is critical to meeting the present (and potential) demands of value-based reimbursement. It provides the foundation for developing shared goals and meeting change head-on. The models mentioned are intended to bridge the FFS and FFV environments. Further, they are likely to increase in relevance once the FFV climate gains strength.

## OPERATIONALIZING ALIGNMENT STRATEGIES THROUGH THE CARE PROCESS DESIGN SYSTEM

At its core, volume-to-value transformation starts with physicians at the point of care. A care delivery system that rewards patient or population health will increase provider satisfaction and attract the “right” kind of people to the medical profession. The Care Process Design System (CPDS) is a tool for redesigning the care delivery model from being strictly volume-based to one that also generates value and integrates accountability measures for ensuring the same. CPDS goes beyond the alignment and engagement stages of clinical integration and describes a system for the transformational stage of clinical integration. This vector is where value production begins to occur.

The CPDS, a systematic transition from volume to value, focuses on the following six major components:

1. Identify targeted care processes/procedures and formation of multi-disciplinary, physician-led teams;
2. Implement a modified lean process mapping technique;
3. Account for the true costs of care delivery using time-dependent, activity-based cost accounting (TDABC);
4. Secure best practices/evidence-based input from team;
5. Measure clinical quality and cost efficiency outcomes; and

6. Monitor outcome measurements, continuously refine the process to ensure ongoing value production.

As value-based reimbursement becomes more the standard, the CPDS will provide organizations with the knowledge necessary to set prices accurately for bundled payments and to mitigate the risks inherent in providing population health management services. To minimize risk, clinical and financial aspects must be taken into consideration. To minimize clinical risk, the CPDS focuses on provider-led, risk bearing, clinically integrated entities; optimal allocation of clinical resources and; continuous care process design to improve quality and cost efficiency. On the other hand, to minimize the financial risk the CPDS focuses on the use of reinsurance markets, sound actuarial analysis, and financial projections. Most importantly, the CPDS recognizes that clinical risk management is perhaps the biggest driver of financial risk mitigation and that placing the responsibility for managing both types of risk in the hands of a provider organization may result in the lower risk across all categories.

## CONSIDERATIONS FOR PHYSICIAN COMPENSATION AGREEMENTS

The value-based reimbursement era also will require hospitals to consider the manner in which they pay their physicians, regardless of the alignment model used. Before value-based reimbursement, it was a rather simple calculation. Professional fee revenue less direct expenses equaled physician compensation. With new forms of revenue, the calculation becomes a bit more complicated, but it still follows the same pattern. That is, revenue (which is no longer exclusively based on professional fees but may also involve quality-based incentives) less expenses equals physician compensation. The benefit of this approach is that the model accepts all forms of reimbursement. For example, ACO distributions can replace professional fee revenue easily with no change in model structure.

The key is then managing expenses based on the various forms of revenue available for generation. Thus, the model is very adaptable to moving toward value-based reimbursement. The key challenge with this model is that it is the hardest to implement in a hospital-employed environment for a variety of factors. One factor is the higher expense structure in hospital-employed setting, due to higher wage scales, occupancy costs, and other overhead items. Further, variances in payer mix and fee schedules across providers and markets make it difficult to identify a single market rate for physician services. These and other factors can result in the private practice style model not resulting in market compensation, and thereby it is perceived as untenable in a hospital employed environment.

All of the information above serves to highlight the following:

1. The market has changed dramatically.

2. Compensation structures in hospital employment arrangements do not mirror that in private practice.
3. As a result of points one and two, real work is required to mesh current compensation models with the new emphasis on quality and efficiency under contemporary reimbursement structures, as is further described below.

There is an overwhelming sense in the market that as value-based reimbursement ramps up, wRVU-based models will go by the wayside. While this may be true a long time into the future, wRVUs will have a place for many years to come in hospital-employed compensation models. This matter is especially the case for specialty care, where other than certain episodic initiatives, such as the CJR program or certain bundled payment pilots, FFS reimbursement is still predominant. If wRVUs is still the primary means of reimbursement to align incentives, the compensation structure should be no different. Thus, until the market moves to a largely fully-capitated model, wherein the capitation payments also include specialty care services, wRVU-based production will likely continue to play a role in the compensation strategy.

While primary care is somewhat different, wRVUs still play a role. Concerning primary care, wRVUs are being balanced out by a focus on patient panels. Patient panels are typically defined as unique patients seen by a physician in the last 18 months. A standard panel for a primary care physician averages roughly 1,800 patients. Panel-based models are synonymous with capitation, wherein the revenue generated is not necessarily based on how much you do but how many patients you manage. While there are pockets of capitation throughout the market, it is not yet a dominant reimbursement mechanism.

Thus, it would be a bit premature to move a primary care model to panel size. With this in mind, the incentive structure reverts to wRVUs once again, as volume is still driving reimbursement. That does not mean that a panel cannot play a role in wRVU-based compensation models. In fact, it should begin to play a predominant role to 1) recognize the non-wRVU generating activities that are much of a primary care physician's practice today, and 2) to prepare practices for reimbursement models that are different than FFS. Thus, many physician compensation structures will heavily weight wRVU, but use panel size as an additional component. The trick will be to continue to balance these two elements as the reimbursement model morphs over time. Even if we wake up and find ourselves in a fully-capitated market, that dynamic does not mean that wRVUs will go away. While they may not be the primary driver of incentive in a compensation model, it would still be reasonable to use them to measure what a physician is doing for the population of patients he or she is managing. Thus, while the application of wRVUs to physician compensation use is evolving, wRVUs will continue to play a role for the foreseeable future.

As stated, the previous compensation formula before value-based reimbursement was rather simple. The numbers of wRVUs performed by a physician were multiplied by a market-based conversion factor per wRVU ratio to derive total compensation. (However, some models used

more complex calculations.) Thus, the only factor influencing compensation was how much a physician did, measured in wRVUs. With value-based reimbursement, such as bundles, this is no longer the case. While bundles still focus on how much a physician does, total reimbursement is ultimately impacted by how well the work is performed. Thus, there are additional hurdles to jump through that affect ultimate reimbursement.

As a result of bundles and other value-based reimbursement arrangements, instead of the rate per wRVU being a constant, it is influenced by how well a physician performs in certain key non-productive areas. In this regard, value-based reimbursement models, such as bundles, are a game changer with respect to reimbursement and should have the same effect on compensation arrangements. The effect of bundles and other value-based arrangements are causing health systems to redesign their compensation arrangements in a variety of ways, which mostly focuses on rebalancing the focus on production and performance. The appropriate balance is largely predicated on local reimbursement dynamics, with more aggressive markets pushing health systems to put more in the value/performance bucket, with the opposite not moving as quickly in this direction.

The rationale for focusing on panel size is that it is indicative of the population of patients a primary care physician is responsible for managing on a day-to-day basis. Many payers are focused on how well the primary care physician cares for this population of patients and their overall health. Further, regardless of whether the physician is seeing these patients regularly in the office, the physician is nonetheless responsible for managing their care (e.g., prescription refills, referrals to specialists, etc.).

The goal of including panel size in compensation models is multi-faceted, as outlined below:

- **Encourage Access.** Incentives tied to panel size encourage physicians to maintain open panels, which helps to ensure that patients have access to primary care physicians in their market and forces physicians to look at alternative means to expand access. This expansion often is achieved by reliance on advanced practice providers (APPs), who can supplement what the physician is doing. In most panel incentives, the APP panels accrue to the physician to recognize their management of said panel. Alternatively, it can be through adding evening or weekend hours to make it more convenient for patients to come to see the physician.
- **Recognize Non-wRVU Producing Work.** Most primary care physicians probably would agree that the amount of non-patient facing work has grown tremendously over the last several years. This work largely involves dealing with paperwork and other related matters all tied to patient care but may not yield corresponding gains in reimbursement. By nature, the amount of this administrative work grows as the panel size grows. Thus, including panel size in the compensation arrangement helps to recognize this added work, especially if it is in addition to a wRVU-based incentive.

- **Introduce Capitated Arrangements.** As mentioned, panel size is in many ways synonymous with capitation. Thus, including panel size in compensation arrangements will introduce physicians to the concept of managing patient populations, so that if/when capitation grows, it will not be a shock. Further, much work goes into tracking panel size. Accordingly, adopting panel size as a component of compensation will force health systems and physicians to manage populations by tracking and monitoring their patients throughout the continuum of care to maximize their quality and efficiency results and, in turn, their compensation opportunities under risk-based reimbursement models.

Panel size can be introduced into compensation arrangements in a variety of ways. Some have a large impact on compensation with others having a smaller impact. The following are some options where panel size plays a role.

- **Derivation of Base Pay.** Some models let panel size drive the majority of compensation. For example, total compensation pay could be derived based on a PMPM payment amount. For instance, total compensation could be calculated using a PMPM amount of \$10.50. Thus, a 1,800-panel size would equate to total compensation of \$226,800. Of this amount, potentially \$9.00 (approximately 85%) could be guaranteed, with the remaining \$1.50 at risk based on performance metrics. Panel size would be reassessed quarterly with base pay reset for the following quarter. Such a model likely only makes sense if the reimbursement environment is largely capitated.
- **Small Add-On Component.** In other models, the panel size incentive is a small add-on component of compensation, representing 5%-10% of total cash compensation. In these models, the economics of the panel size component is either established as an entirely separate component of pay or allocated as part of the overall value of pay. With the former, it is simply a reduced calculation of that explained above. As an example, the panel component could be \$1.50 PMPM, with this simply being an additional component of pay.

## CONCLUSIONS

As the market changes with a greater focus on value-based reimbursements, the manner in which providers are compensated will ultimately also need to evolve. This evolution will require abundant planning, modeling, and education to ensure the understanding of any changes (and their unintended consequences) before they are implemented.

## HEALTH SYSTEMS, PHYSICIANS, AND PAYERS WILL BE THE MAIN DRIVERS OF VALUE-BASED PAYMENT REFORM

### HEALTH SYSTEMS

The transition from FFS reimbursement to value-based reimbursement will present different challenges for health systems, physicians, and commercial payers. Health systems must deal with one primary challenge: the health system must be able to track a high number of quality measures efficiently.<sup>13</sup>

Value-based reimbursement requires the health systems to track a number of quality-related measures. The measurements of quality should fall into three tiers. Tier one measures a patient's achieved health status--not just mortality rates but also activities patients can perform through the different stages of their recovery.<sup>14</sup> Tier one measures generally fall into those now used in health risk assessments (HRAs) performed by most health plans, but rarely are they used to allocate resources based on the needs identified. Measurements in the second tier relate to the patient's care cycle and recovery.<sup>15</sup> These measures include emergency room readmissions, the amount of pain experienced during the recovery process, and when a patient can resume regular activities.<sup>16</sup> The last tier of criteria relates to how long a person can expect to remain healthy or whether they will need subsequent procedures to maintain their ideal level of functionality.<sup>17</sup> Note that the last two tiers of measures relate to outcomes as opposed to process compliance measures, which dominate the quality metrics in use today within the healthcare system. Patient self-reported outcome measures, perhaps assessed via mobile technology, such as smartphones or tablet devices, are a likely source of outcome measures that will need to replace process measures if quality measurement overall in the healthcare industry is to improve.

Next, a health system must adequately measure costs relative to the treatment of the patient's underlying condition.<sup>18</sup> Many health systems struggle with being able to measure costs relative to conditions since most hospital accounting systems are based on a particular department and

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<sup>13</sup> Bobbi Brown, *The Key to Transitioning from Fee for Service to Value-Based Reimbursement*, Health Catalyst, (last accessed January 3, 2016), <https://www.healthcatalyst.com/hospital-transitioning-fee-for-service-value-based-reimbursements>. Accessed April 4, 2017.

<sup>14</sup> Michael Porter, *What is Value in Health Care?*, 363 NEW ENG. J. MED. 2477, 2479 (2010); PORTER ME, TESIBERG EO, *Redefining health care: creating value-based competition on results* (HARV. BUS. SCH. PRESS, 2006).

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> Michael Porter and Thomas Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV., (October 2013), <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

not on a patient's full cycle of care.<sup>19</sup> Further, most patient record systems measure charges and not the resources used to provide a full cycle of care for each patient.<sup>20</sup> Current patient record systems prevalent in small medical practices focus on the charges incurred for a particular procedure and are thus problematic in a value-based reimbursement environment since FFS payments are continually decreasing.<sup>21</sup> One possibility is for health systems to transition to a TDABC.

TDABC involves "managers directly estimat[ing] the resource demands imposed by each transaction, product, or customer rather than assign resource costs first to activities and then to products or customers."<sup>22</sup> This requires two measurements: "the cost per time unit of supplying resource capacity and the unit times of consumption of resource capacity by products, services, and customers."<sup>23</sup> Providers who are blind to the amount of resources used when providing care for an underlying condition will be unable to accurately determine the value received by the patient during his or her course of treatment.

The preceding example demonstrates that a significant role for health systems in value-based reimbursement is to make the necessary investments in the necessary IT systems that will be essential in being able to measure quality.

Along with IT investments, the health system must also provide administrative, logistical, and technical support to the individual providers in the health system. The health system must be vigilant about recognizing trends and devising new methods for individual providers to continue to provide value to their patients. Hospitals must instill a culture that promotes quality and value in the provision of medical care rather than promoting the FFS mentality (i.e., higher volume of procedures equals more revenue). Without instilling a culture of providing more value in the provision of care, the organization will fail to realize their revenue potential provided by the value-based payment reforms of the ACA and MACRA.

## PHYSICIANS

Along with health systems, physicians play a major role in furthering the transition from FFS reimbursement to value-based reimbursement. Studies have shown that patients experience more positive outcome when they are personally involved in the provision of their health care.<sup>24</sup>

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<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> Steven Anderson and Robert Kaplan, *Time-Driven Activity-Based Costing*, HARV. BUS. REV., (November 2004), <https://hbr.org/2004/11/time-driven-activity-based-costing>. Accessed April 4, 2017.

<sup>23</sup> *Id.*

<sup>24</sup> James Pizzo, et. al., *Ready, Set, Go: Helping Physicians Move to Value as MACRA Begins*, 61 *Journal of Healthcare Management* 396, 406 (November/December 2016).

Therefore, because patients are more likely to achieve better outcomes when they become involved in their care, providers should focus on involving patients in their care.

Further, individual providers must engage in teamwork training and team-based care because integrative care (i.e., team-based care) is the hallmark of value-based reimbursement. Providers should collaborate with one another on a frequent basis to discuss various treatment protocols and how these and other protocols may be utilized to increase the value provided to their patients. No longer can the providers only concern themselves with the treatment they alone render to a patient. Instead, the provider must also consider the totality of care that patients will receive from multiple providers and how each treatment will affect and fit into the patient's overall care management plan.

### COMMERCIAL PAYERS

The role commercial payers play in value-based reimbursement obviously differs from that of individual providers and health systems. Commercial payers have access to a swath of data that is not available to providers. Payers can use this data to help providers achieve their potential under value-based reimbursement.

Commercial payers should partner with providers. A great start to this partnership is for the commercial payers to provide clinical decision support to providers so that the providers have the tools necessary to drive value-based care to their patients.<sup>25</sup> "These tools include computerized alerts and reminders to care providers and patients; clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support, and contextually relevant reference information, among other tools."<sup>26</sup> These tools allow providers to have a guide on the best practices for medical care, as well as which practices will allow the providers to eliminate waste in fraud in the provision of their health care, all of which feeds into better quality and value-based measures.

### VALUE-BASED REIMBURSEMENT UNDER THE TRUMP ADMINISTRATION AND THE GOP-CONTROLLED CONGRESS

The election of Donald Trump as the 45<sup>th</sup> President of the United States has led many to question what changes lie ahead for ACA and value-based reimbursement as a whole. Value-

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<sup>25</sup> Vera Gruessner, *How Payers Should Prepare for Value-Based Reimbursement*, HealthPayer Intelligence, (last accessed January 3, 2017), <http://healthpayerintelligence.com/features/how-payers-should-prepare-for-value-based-reimbursement>. Accessed April 4, 2017.

<sup>26</sup> *Clinical Decision Support*, HealthIT.gov, (last accessed January 3, 2016), <https://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds>. Accessed April 4, 2017.

based reimbursement measures will likely survive a repeal (partial or complete) of ACA for a number of reasons.

First, the idea of value-based reimbursement was around much earlier than the passage of ACA in 2009.

Over the period from 1995 to 2000, several quality improvement initiatives, task forces, and sentinel reports were initiated and published. The IOM launched the comprehensive quality initiative, the Joint Commission established the sentinel event policy, the Quality Interagency Coordination Task Force (QuIC) was established, the Leapfrog Group was founded, and the IOM published the transformative article “To Err is Human” followed by “Crossing the Quality Chasm.” The National Quality Forum (NQF) was created. The NQF is a nonprofit organization established in 1999 with a mission to improve the quality of U.S. healthcare.<sup>27</sup>

Further, in 2003 the Surgical Care Improvement Program was established, which sought to reduce the number of complications and mortality rate from various surgical procedures. Finally, in 2006, the Physician Quality Reporting (PQR) Initiative was established, which was established to provide payments “in the form of a 1.5% bonus on total Medicare Part B fee for service charges for successful reporting on a minimum of 3 quality measures, or for 1 of 14 measure groups.”<sup>28</sup>

Second, repealing ACA in its entirety would result in the elimination of the CMS Innovation Center, which is the governmental arm for testing certain initiatives that promote innovation in healthcare. “The Innovation Center has fostered ACOs, implemented voluntary and mandatory bundled-payment programs and rolled out a slew of other initiatives. HHS says more than 4.7 million people enrolled in Medicare, Medicaid, and CHIP have gotten care through the models.”<sup>29</sup> However, both the Democratic and Republican parties have agreed that Medicare needs to be reformed, and the CMS Innovation Center appears to be the best way to test different healthcare reform models.<sup>30</sup>

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<sup>27</sup> Youssra Marjoua and Kevin Bozic, *Brief History of Quality Movement in US Healthcare*, National Center for Biotechnology Information (December 2012), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3702754/>. Accessed April 4, 2017.

<sup>28</sup> *Id.*

<sup>29</sup> Elizabeth Whitman, *Will Value-Based Payment Initiatives Continue Under Trump?*, Modern Healthcare (November 11, 2016) (last accessed January 3, 2016), <http://www.modernhealthcare.com/article/20161111/MAGAZINE/161109907>. Accessed April 4, 2017.

<sup>30</sup> *Id.*

Experts believe the Trump Administration and the GOP-led Congress are not looking to gut the value-based payment reforms, but are mainly seeking to reform the health insurance exchanges, the Medicaid expansion into the states, and the premium tax credit.<sup>31</sup>

Finally, the value-based payment transition was furthered by the passage of MACRA, which received overwhelming bipartisan support in Congress. Even in the unlikely event that the ACA were to be repealed in its entirety, MACRA would likely survive any attempts at reform. Thus, for the preceding reasons, we believe that value-based payment reforms are here to stay despite the repeals promised by the new presidential administration.

## CONCLUSIONS

While a change in the White House will come with many alterations, the belief that it will suspend all further movement toward value-based reimbursement is unfounded. Organizations need to continue to prepare for, and adapt to, an FFV world, as it is unlikely to revert (to any significant degree) based on the Trump presidency.

## CASE STUDIES

### CASE STUDY #1: CIN DEVELOPMENT

A large non-profit hospital and several large specialty and primary care practices formed a CIN in the Southeast. The CIN was designed to achieve certain economies of scale, operational advantages, purchasing power, and high-quality care through the affiliation of many different clinical professionals representing a broad range of specialties. Ultimately, the CIN was comprised of private practitioners, hospital employed physicians, and faculty employees of the local medical school. The hospital developed a committee to address comprehensive topics to prepare for the CIN development. Topics discussed included projects and other planning facilitation functions such as financial, operational, technology, personnel, etc. There was a specific focus on capital funding (despite the hospital's support), development of IT infrastructure, and income distribution plans for physicians.

As a result of the development of a hospital sponsored CIN, it now has over 600 physician participants representing all major specialties. Additionally, a majority of the participants are using a common electronic medical records (EMR) system and are linked via a health information exchange (HIE). The physicians manage the health of over 30,000 lives and demonstrated more than \$2M in cost savings in the first two years of operation.

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<sup>31</sup> *Id.*

## CASE STUDY #2: CCMA DEVELOPMENT

A small orthopedic private practice (Practice A) in the Midwest offering comprehensive orthopedic services with no ancillaries seeks to improve its financial state. Practice A has two main hospital affiliations: the first hospital (Hospital A) is the region's major health system with numerous orthopedic service line alignment and integration initiatives underway. Its employed orthopedic group is the only other large consolidation of orthopedists in the area aside from Practice A. The second hospital (Hospital B) is a smaller health system and Hospital A's major competitor.

Practice A, desiring to remain independent but improve its financial health over the long term, decided to discuss alignment options with its hospital affiliates. While there were various pros and cons between the two Hospitals, Practice A was seeking direct impact on the organization. Thus, they approached both Hospitals with the concept of a CCMA, which Hospital B was somewhat averse to accepting. Hospital A continued to evaluate the various alignment/integration strategies and agreed to Practice A's request to align via a CCMA. Practice A's decision to accept Hospital A's offer was predicated by realizing the following:

1. The opportunity for an additional stream of revenue from Hospital A's cost/quality control initiatives that are inherent to the CCMA.
2. The ability to segue more easily into a full form of alignment/integration.
3. The capacity to continue providing services at Hospital B.

Key physicians and administrative leaders from both Hospital A and Practice A met via a series of Working Group meetings to discuss CCMA models and corresponding performance measures. The parties also discussed prospective cost reduction initiatives, which included a surgical implant standardization effort. Hospital A included Practice A's physicians into an overall Management Services Agreement that memorialized the CCMA's principal terms and conditions. Practice A's physicians and Hospital A's orthopedic surgeons were then able to collaborate to improve the value proposition for Hospital A's orthopedic service line.

## CONCLUSION

The passage of ACA and MACRA officially ushered in the era of value-based reimbursement. In order to provide value to patients, providers will need to align in various manners. Due to their flexibility, greater value to patients and providers, reliance on CPDS care delivery, alignment via the CIN, ACO, GPS employment and CCMA models is becoming a best practice. Doing so will allow the providers to drive the most value to their patients and will maximize their opportunity to receive the most reimbursement offered by popular value-based reimbursements to include MACRA and Bundles.