Joint Ventures Between Payers and Nonprofit Providers: The Goldilocks Solution for The Transition from Volume to Value

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The affordability crisis is causing unprecedented changes in health care. Fundamental economic forces responding to that crisis are blurring the definitional lines between providers and payers. The two sides are moving closer to the point of interconnection and aligning their efforts to redress the unsustainable costs of health care delivery.

One of the most significant innovations at this point of interconnection—if not the most significant innovation—is the transition from the current volume-based, fee-for-service model to value-based reimbursement. Surveys indicate that nearly all payers and more than 80% of providers are already using some form of value-based reimbursement.[1] And the U.S. Department of Health and Human Services (HHS) recently established goals for alternative payment models for Medicare. HHS seeks to link 30% of payments to quality or value through Accountable Care Organizations (ACOs), bundled payments, or other value-based reimbursement models by 2016, increasing to 50% by 2018.[2] On top of that, a major part of the recent Medicare Sustainable Growth Rate repeal includes a greater push toward value-based reimbursement.[3]

Value-based reimbursement pushes providers and payers to bear greater responsibility for areas of overall performance that previously resided largely or exclusively with the other. Providers bear financial risk for patient populations; payers take on forward-looking responsibility that their value-based contracts support clinically appropriate care. Each must develop or rely on the historical expertise of the other for this to work. In essence, the efforts and goals of providers and payers are converging.

Our views, developed below, reflect the belief that full integration of existing providers and payers will best fulfill the promise of this convergence: continued delivery of high quality care with improved affordability. Structural impediments endemic to our health care delivery system may impede that integration in some circumstances, but absent full integration, significant integration through joint venture becomes an attractive solution.

Naturally, pursuing these options presents a number of legal issues, both internal to the parties (such as issues of corporate control) as well as external (such as compliance with regulatory requirements). Antitrust considerations may, in some circumstances, require particular attention. The economic incentives driving convergence would be dramatically reduced if providers and payers become insulated from competitive decision making as a result of their convergence.

Before describing some of the major guideposts for pursuing this convergence, we turn first to why a tentative approach to such convergence through mere contractual arrangements seems unlikely to succeed in transforming health care delivery.

Contractual Efforts

Most of the early activity in this transition to value-based reimbursement has focused on contractual arrangements to achieve convergence. This is perhaps because contracting seems easier. Notably, it lacks full and long term commitment, it is easier to negotiate and exit, and it does not require the parties to re-examine their fundamental approach to health care delivery.

Shared savings contractual programs offer providers the opportunity for financial gain but generally also eventually include risk of loss. There are many variations but the basic structure involves a provider system or group of providers (generally organized as an ACO) contracting to provide care for a patient population at a set price while meeting certain quality and cost benchmarks for a specified period of time. If the care costs for the patient population are lower than the predetermined threshold, then the provider group shares in the savings with the payer. But if the care costs exceed the threshold, then the provider group "shares" the loss. The goal is to align economic incentives around lowering the cost of care while maintaining or improving the quality of care. The best known shared savings programs are the Medicare Shared Savings Program and Pioneer programs run by Medicare, although there are several commercial payers who also offer their own versions of shared savings programs. Efforts in a commercial insurance setting are fragmented and sporadic but trending.

Payment bundling for a well-defined episode of care is also gaining traction. The Centers for Medicare & Medicaid Services' (CMS') program for bundling payments, called the Bundled Payment for Care Improvement (BPCI) initiative, continues to grow. Many BPCI entrants are in the risk-bearing phase, with many more in the preparatory phase awaiting successful completion of screening and review by CMS. Next up from CMS in the BPCI initiative is the Oncology Care Model for physician group practices that furnish chemotherapy.

Other value-based reimbursement techniques being implemented include:

- pay for performance, where physicians are given financial incentives for better health outcomes;
- pay for reporting, where providers receive additional compensation for reporting additional clinical or quality data (*e.g.*, the CMS Physician Quality Reporting System, which allows physicians to receive bonuses just for reporting on the program's measures, regardless of treatment outcomes);
- pay for use, where providers are incentivized to use certain technologies, such as electronic medical records;
- certification/recognition programs, where providers are certified or recognized for meeting certain standards or accomplishing certain achievements; and
- readmission management and hospital never events, which are essentially a denial or a reduction in payment for avoidable hospital readmissions or events such as hospital-acquired infections or surgical errors that should never have happened.[4]

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In all of these structures, the payers are essentially passive participants in the program. They may provide some basic data to support assessment of the providers' activities and even some analytical information to encourage improved performance. But otherwise, they simply provide the funding mechanism for the effort. Indeed, the value-based contract may largely insulate the payers from the results of poor performance by the providers, and simply enable the payers to share the upside if the providers improve performance. Their focus remains largely financial.

Experience suggests that all of these contractual arrangements between providers and payers will at best be sporadically successful, often only after a long slow slog through the inevitable organizational resistance that often accompanies transformational change. At worst, the contractual arrangements will simply make improvements at the margins and add to the bureaucratic lip service paid to cost management.

Particularly in a commercial setting, contractual arrangements suffer from the adversarial negotiations and other bad habits that have defined the relationships between providers and payers for decades. The sharing of accounting losses or gains under contract, where each party largely unilaterally makes its own decisions on performance, does not create the relationships or processes that drive fundamental change. Unless the contractual relationships effect a long-term commitment, no basis or mandate for organizational change is created. The behavioral change, organizational restructuring and information technology, and other investments necessary to truly achieve the cost control and quality goals of value-based reimbursement, may fall prey to the lack of assured return on investment over an extended period of time.

For value-based reimbursement to truly achieve the laudable goals of simultaneous cost control and improved efficiency and quality, a mandate for organizational change is critical. This is true regardless of the particular arrangement between the provider and the payer. The arrangement must be more than "just a contract," and must move as far across the deal spectrum as the business, financial, and legal structures of the provider and payer can allow.[5]

Implicit in the foregoing is the idea that the scope of the effort must be significant, not only in terms of institutional commitment, but in terms of the breadth of the financial commitment. Put another way, a contract between one provider and one payer covering 10% or 15% of the provider's commercial business and putting some marginal percentage of that business "at risk" is not going to incent organizational change. Additionally, attempting to manage care across a small percentage of the patient population in a community will likely lead to an unpredictable and potentially unacceptable risk profile or unacceptable outcomes, thus limiting the intensity of commitment that the parties are willing to make. To address that concern, providers and payers will necessarily look to cover larger populations within their integrated effort.

We flag this scale point regarding population health management here because it highlights another reason why contractual arrangements are less preferred. As the scope and intensity of the commitment increases, payer and provider integration may involve parties whose combination raises potentially significant antitrust issues. A fuller and clearer commitment to an improvement in the affordability of care can help mitigate antitrust concerns. That is not to say that otherwise anticompetitive integration efforts would be allowed based on pursuit of the laudable goals of more affordable health care delivery, but rather that structures and commitments that have a real promise of achieving those goals are less likely to be questioned.

Impediments to Mergers & Acquisitions (M&A)

While M&A activity has increased significantly, most has been focused on vertical integration within providers or payers, and not integration across the provider-payer divide. This can be explained by expected and typical justifications like wariness due to past animosity and distrust, organizational resistance to change, fear of cannibalization of profitability, management entrenchment, and other similar reasons. Yet even when those issues are resolved or set aside, there are real business, financial, or legal hurdles that often will rule out an organizational combination of a nonprofit provider and a for-profit insurer.

Most providers operate in a political, regulatory, and business environment that requires the constant nurturing of several constituencies: patients, physicians, employees, and

governmental authorities (federal, state, and local), to name just a few. Satisfying all of the interests of all of those disparate constituencies may be impossible or impractical. But even when a pathway can be found through those interests, the financial or legal hurdles may still be insurmountable. Tax-exempt status is often the killer, but other hurdles are also identified that just as easily make a combination impossible (although too often such a conclusion is reached without creative consideration of approaches to address those impediments).

We also do not think it is practical to expect most providers or payers to vertically integrate on their own to any substantial degree. True, some providers have set up their own insurance entity, a few with success, but most with only a limited role that is insufficient to achieve the goals of value-based reimbursement. Quite a few have stalled due to the intense and often unexpected requirements of capital and business expertise that insurance operations require and the internal competition for capital against rising needs of the provider's health care delivery system. Those insurance arms can be a useful part of a joint venture structure to achieve value-based reimbursement objectives while also freeing up capital and management attention for other demands. But most providers who take a partial step into the payer world soon realize that there are economies of scale and expertise that they are not able to achieve on their own.

This is where a joint venture can bridge the gap caused by the organizational differences of the provider and the payer. By preserving the pre-existing organizational integrity of each party, while aligning their economic interests and integrating their operations, a joint venture can position the parties to transform the usual provider-payer paradigm and realize the potential of the value-based reimbursement movement by integrating care and cost into one relationship for the patient and establishing a mandate for cost control in care delivery.

Joint Venture Structure

The primary structural component of the joint venture is a newly formed or acquired insurance company jointly owned by the nonprofit provider and the insurer. That is the vehicle through which the parties will share the profits and losses of the enterprise. The organizational documents or agreement documenting the relationship will establish:

- the goals and objectives of the joint venture;
- the scope of the joint venture's business and operations;
- the initial and continuing capital and other contributions of the parties, in money or in-kind services;
- the commitment of each party to the operations of the joint venture, including the transfer, seconding, or time allocation of key employees;
- a new provider and/or network access agreement, typically involving a trade by the provider of reduced rates in exchange for a share of the profits;
- governance, including board and management, often involving a balance of each party's leadership as members with a coalition of each party's personnel participating in the management of the joint venture, and including a mechanism for resolution of disagreements;
- selection of the joint venture CEO;
- the initial term of the joint venture including automatic extension absent action by a party and provisions setting forth the basis for termination for cause during the term or without cause at the expiration of the term;
- terms and conditions for unwinding the joint venture in the event of a termination (akin to a prenuptial agreement), including run off of existing business; and
- the exclusive product line and scope and target market of the joint venture, including marketing and branding.

The specific terms of the joint venture will vary from deal to deal, depending on the relative market position, leverage, and commitment of the parties.

Other structures to achieve similar business, financial, and legal alignment of the provider and the payer are possible, including reinsurance arrangements backed up by contractual commitments to operational integration. But such alternatives to a joint venture may suffer from a lack of real engagement and commitment by the parties to the enterprise.

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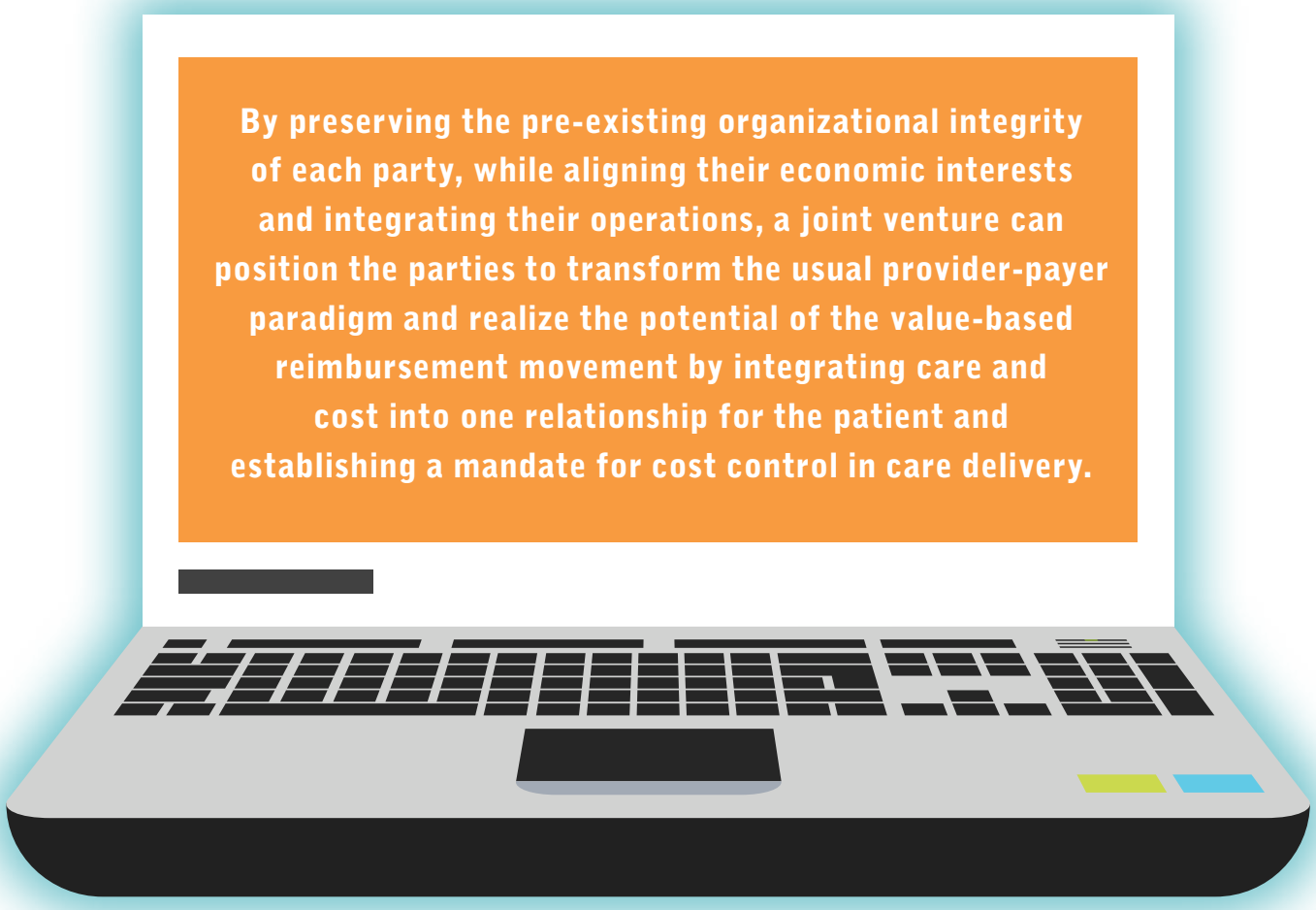
Legal Issues

The following issues need to be considered carefully in the pursuit and formation of the joint venture:

- Because provider systems with substantial market share and their largest insurance company payer are generally identified in each party's strategic analysis as the ideal partnership, antitrust concerns are a key gating consideration and must be carefully navigated throughout the negotiation, implementation, and operation of the joint venture.
- Insurance licensing, risk-based capital requirements, and other insurance regulatory rules would need to be analyzed and addressed (as providers are learning as they take on more risk and act like or become insurers).
- Because the tax-exempt status of the provider is generally considered by the provider to be something that must be protected from any risk whatsoever, special care must be taken to structure the joint venture to avoid those risks and reduce any unrelated business income tax and related risks.
- Affiliated or ancillary physicians are a necessary component for the joint venture's success, but they also invoke the need to address federal Stark law and other applicable physician self-referral laws and regulations.
- Similarly, the federal Anti-Kickback Statute and regulations should be analyzed to appropriately organize the joint venture to fit into an available safe harbor.
- Particularly thorny issues that may require extensive legal analysis but also careful consideration of the business implications to each party are the extent to which the parties will share data and information, and whether the joint venture will invest in its own information technology and retain its own data and information.
- Network adequacy and mandated benefits laws and regulations should be evaluated to ensure that the joint venture avoids unwanted scrutiny of its network and benefits.

In addition to the foregoing, the parties will need to approach the joint venture as if it were a combination. That is, they will need to perform due diligence to ensure that entering into the joint venture does not trigger termination or violation of existing contractual or other arrangements, or undermine the ability of a party to otherwise meet its contractual or other obligations in such arrangements or in the joint venture.

By preserving the pre-existing organizational integrity of each party, while aligning their economic interests and integrating their operations, a joint venture can position the parties to transform the usual provider-payer paradigm and realize the potential of the value-based reimbursement movement by integrating care and cost into one relationship for the patient and establishing a mandate for cost control in care delivery.



Conclusion

Value-based reimbursement has the potential to transform health care delivery for the better, simultaneously reducing overall costs and improving efficiency and quality. Yet to be truly effective, real commitment and meaningful integration of providers and payers is needed. Wherever structural or other impediments preclude full integration, joint ventures are the best alternative.

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Endnotes

1 *The State of Value-Based Reimbursement and the Transition from Volume to Value in 2014*, McKesson Corporation p.5, *available at* http://mhsinfo.mckesson.com/rs/mckessonhealthsolutions/images/MHS-2014-Signature-Research-White-Paper.pdf.

2 HHS Press Release, *Better, Smarter, Healthier: In Historic Announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value*, January 26, 2015.

3 Eric Cragun, The Advisory Board Company, *The Most Important Details in the SGR Repeal Law*, April 20, 2015.

4 McKesson Corporation, p.18-35.

5 Todd Van Tol, Tomas M. Kuckis, Josh Michelson, Julia Goldner, *Payer-Provider Partnerships: The Future of Insurance Products*, July 2015, p.5.

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