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BY RON PRESENT

The ABCs of Value Networks©

Where do you fit in?

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By many accounts, one of the most controversial and discussed aspects of the Affordable Care Act (ACA) takes up only seven pages, or approximately a scant 0.3 percent of the nearly 2,500-page document.

In October 2011, the Centers for Medicare and Medicaid Services (CMS) released the final regulations for accountable care organizations (ACOs) under the Medicare Shared Savings Program (MSSP). An organization may apply to become an ACO for either an April 1, 2012 start date or a July 1, 2012 start date. Regardless of the selected start date, the performance agreement will last for three years, ending Dec. 31, 2015.

An ACO is a care delivery system that, by design, manages the care of an identified group of patients focusing on efficiencies and improved care with alternative reimbursement and payment options as part of a Shared Savings Program. According to Section 3022 of the ACA, The Medicare Shared Savings Program is designed to improve beneficiary outcomes and increase value of care by:

• Promoting accountability for the care of Medicare fee for service (FFS) beneficiaries,

• Requiring coordinated care for all services provided under Medicare FFS, and

• Encouraging investment in infrastructure and redesigned care processes.

The delivery of accountable care is not new; the theory behind accountable care has been around for years. However, today's ACOs are more complex and require a much more sophisticated operating and reporting IT system.

The ACO will be responsible for managing all of the healthcare needs of at least 5,000 covered lives for multiple years and must be able to share that information among and between providers that might not have been able to even work together historically. If the ACO is able to meet the 33 quality measures cost effectively, they would be able to keep a portion of the shared savings. The Department of Health and Human Services estimates that the first ACO initiative –Pioneer ACOs – could save Medicare up to $1.1 billion in the first five years.

Industry Consolidation

With potential start dates looming for new ACOs, providers and payors have been involved in a flurry of activity positioning themselves within their markets to develop and enhance an infrastructure to amass covered lives and control the delivery of cost-effective, quality services. One of the most visible actions has been the consolidation of providers and payors throughout the country.

According to Irving Levin Associates, Inc., the healthcare mergers and acquisitions market in the fourth quarter of 2011 generated 247 deals worth a combined total of $40.2 billion." This activity doesn't include all of the hospital and health system acquisitions of physician practices throughout the country.

Even though mergers and acquisitions are not new in the healthcare arena, the increase of vertical market affiliations is creating new and potentially powerful alliances including:

• Patients First Health Care of Washington, Missouri, a physician group with more than 80 physicians has agreed with Mercy, a health system in St. Louis, to explore integration of the two organizations;

• UnitedHealth Group Inc. will acquire the operations of the management arm of Monarch HealthCare, an Irvine, Calif.-based association that includes approximately 2,300 physicians in a range of specialties;

• Highmark, one of the nation's largest health insurers based in Pennsylvania, is in the process of affiliating with the five-hospital West Penn Allegheny Health System;

• Partners HealthCare System Inc., the largest hospital and physician network in Massachusetts, has signed a letter of intent to acquire Neighborhood Health Plan, a Boston-based not-for-profit insurer, which accounts for more than 240,000 members of mostly low-income residents; and

• Cleveland Clinic has acquired North Coast Cancer Care, a full-service cancer treatment center based in Sandusky, Ohio.

Much of the consolidation and development of ACOs within the industry was driven by organizations that have access to large amounts of capital to fund the acquisitions and the ACO development cost. But what if providers don't have sufficient capital to make acquisitions and aren't part of a system? How do they fit into the delivery of healthcare services within a market? To be able to compete, stand alone providers must be active in the development of what I call "Value Networks©."

The Value Network© Solution

Value Networks© represent a collective of similar minded providers within a market that provide measurable, quality outcomes at cost-appropriate levels by effectively providing high value to a provider network including ACOs. These Value Networks© will be critical in the delivery of care and should be positioned to contract with an ACO or similar organization.

Creating or joining a Value Network© can be challenging. However, the following are the ABCs that have proven valuable to clients in developing and participating in Value Networks©.

Awareness of the market. You must have intimate knowledge of the market and the strategies of what might be considered allies, competitors, referral sources and discharge recipients. If networks or ACOs are being formed and you aren't included, understand where you as a provider might fit in and fill a service gap, whether by geography, specialty, cost, technology or some other measure. Additionally, if other quality providers aren't being included, take the initiative to form your own Value Network© and approach the established ACO and networks as an additional network of providers.

Be able to tell your story. One of the challenges many providers have is their inability to share with others the value they provide to their patients, referral sources and payors. You must know and be able to show your value with data driven outcomes and quality measures, and concisely share those results with the providers and end-users that are making decisions about your role in the delivery system. Additionally, those measures that you're sharing should have meaning and relevance to those with whom you are communicating. If the measures show poor performance, change the way you're doing business and improve your story.

Collaborate. In addition to awareness of the market, you need to understand who the decision makers are for the provision of services. If you haven't already done so, begin networking with those people and communicate your value to lay the groundwork for collaboration. Although valuable, relationships with discharge planners, social workers and practice managers won't provide you the relationship results you'll ultimately need. Collaboration must be entered into and agreed upon at the C-suite level. Be prepared to meet, negotiate and ultimately collaborate with providers that might have been bitter competitors, but are now a part of a market-driven service delivery system.

There's also a very important D!

Dissect your costs. You need to completely know and understand your costs as a provider, down to the diagnosis level. I work with clients that often say their managed care reimbursement is too low. However, they can typically only compare it to Medicare reimbursement and really don't know whether it's profitable because they don't understand their true cost of care. If it has not already happened with bundled payment initiatives, you'll be faced with contracting decisions from other providers to be part of a Value Network©. If you cannot financially evaluate those proposals with a strong understanding of cost, you could enter into agreements that will be financially harmful. You cannot make up margin with volume if every patient that you treat is at a loss.

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