LITIGATION MINUTE: AVOIDING DISPUTES IN VALUE-BASED ARRANGEMENTS

PAYOR-PROVIDER SERIES: PART ONE OF FOUR

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WHAT YOU NEED TO KNOW IN A MINUTE OR LESS

Over the past decade, health care payors and providers have come together to revolutionize how health care services are reimbursed. Led by the federal government's initiatives in Medicare, both public and private payors are increasingly moving away from fee-for-service models (based on the volume of services provided) and toward "value-based" reimbursement models. For example, the Centers for Medicare and Medicaid Services (CMS) has set a goal that every traditional Medicare beneficiary will be in an accountable, value-based care relationship by 2030.[1] Nongovernmental insurers, as well as private equity organizations, are making major investments in the value-based space.

Value-based reimbursement brings significant potential for improvements in population health, with providers and plans incentivized to reduce health care costs, improve quality, and achieve better health outcomes for all people, including historically underserved populations.

However, realizing this potential has meant steadily increasing complexity in reimbursement models. Capturing qualitative ideas of "quality," "value," and "equity" into quantitative measures is an ever-evolving process. Coupled with that complexity, and beneath the aspirational aims of all parties, is the persistent truth that there remains a limited pool of funds to pay for health care services, and thus dangers remain for cooperative relationships between payors and providers to turn into competitive disputes.

In a minute or less, here are two key components of value-based arrangements that are especially prone to disputes.

The Crucial Role of Benchmarking in Value-Based Arrangements

There are myriad creative ways payors and providers can come together to engage in value-based care. However, a critical concept at the heart of many of these arrangements is the value-based "benchmark." As the name implies, the benchmark sets the financial standard a provider is measured against to assess value provided to patients and plans. There is no universal or predetermined way in which providers and plans set these benchmarks—this is open to negotiation as part of a value-based arrangement. However, the metrics often quickly become intricate, with numerous factors contributing to how a benchmark is set and updated, and how provider performance is measured.

Notwithstanding this complexity, it is imperative that providers not gloss over the details concerning benchmarking in a value-based arrangement. A provider's ultimate success, or failure, at achieving savings and value under an

arrangement is tied to these benchmarks. These details can result in dramatic swings in reimbursement, and prompt a number of questions, such as:

- If providers achieve savings in one year, will those savings lower the benchmark and make savings more difficult to achieve in future years?
- Is the benchmark set based on a provider's total claims across all service lines, or is it tied to the specific population covered by the arrangement?

Providers should be prepared to conduct a deep dive into reimbursement implications, ensuring that this analysis is not sacrificed in the interest of expediting execution of the arrangement. Contract disputes may also arise if the parties have left any ambiguity or uncertainty in place with regard to the factors that apply to the benchmark, as this uncertainty can lead parties to develop drastically different interpretations regarding performance.

Data Sharing Rights

Another area ripe with potential for disputes is the use of data to evaluate provider performance. Typically, payors are responsible for analyzing data and performing the calculations used to retroactively asses a provider and determine payment adjustments. For providers, it is imperative that this analysis not take place behind a black box. Since a multifaceted value-based approach to reimbursement presents complexity, these arrangements are prone to miscalculations and other payment errors. Providers should ensure that the arrangement allows for clear and timely insight into the data used to calculate performance, so the provider can understand and recreate those calculations and flag any areas that need correction.

FOOTNOTES

[1] Innovation Center Strategy Refresh, *Centers for Medicare & Medicaid Services (CMS),* 2021.

