VALUE BASED CONTRACTING
CONCEPTS FOR THE MEDICAL PRACTICE
Executive Summary
This paper describes the evolution from fee-for-service payment methodologies toward Value Based Contracting models.

It begins with driving forces and history, progressing through descriptions of various methodologies employed by government and selected private payers, then describes various economic impacts associated with implementation of these models and identifies critical success factors for medical practices.

Value Based Contracting models represent an evolution in clinical and payment methodologies that focus on creating quality outcomes, foster greater accountability and utilize substantial innovations in medical technology requiring a higher degree of risk from providers relative to payment for services. These models are in stark contrast to the current prevailing methodology of paying providers based on volume of services provided, regardless of quality and efficiency. These contract models intend to align incentives across providers, members, employers and payers to improve clinical outcomes and the patient experience, along with improving cost efficiency, potentially achieving the Institute for Healthcare Improvement’s “triple aim.”

Pay-for-performance contracts are emerging in markets across the United States and set the stage for a more integrated approach to provider/payer relationships involving Value Based Contracting. These types of contracts require deeper collaboration between providers and payers, as elevated levels of data sharing and operations management cooperation are necessary for high-quality and cost-effective outcomes.

This paper explores the economic impact of these programs and provides information provided around potential costs associated with operational and technology enhancements necessary for preparing, evaluating and implementing Value Based Contracting methodologies. Potential success in these contract methodologies is, in large measure, rooted in a provider’s willingness and ability to collaborate with payers, employers, patients and other providers through sharing data, analytics and enhanced communication, focusing on improving outcomes while minimizing health care costs.

Driving Factors and History of Value Based Contracting
According to the 2010 Economic Report of the President, health care expenditures in the United States are currently about 18 percent of GDP, and if costs continue to grow at historical rates, the share of GDP devoted to health care in the United States is projected to reach 34 percent by 2040. In addition, the Commonwealth Fund ranked the United States last in the quality of health care among similar countries, and notes United States health care costs the most. Together, such issues place the United States at the bottom of the list for life expectancy.

The trends in the American health care system relative to cost are clearly unsustainable. Effective reforms that address issues within the system are sorely needed. Americans have been attempting to overhaul the health care system since the introduction of Health Maintenance Organizations in the early 1970s with the passage of the Health Maintenance Organization Act of 1973, which required employers with 25 or more employees to offer federally certified HMO options if the employer offered traditional health care options. HMOs often required members to select a primary care physician (PCP), a provider who acted as a “gatekeeper” to direct access to medical services and patients needed referrals from gatekeepers to see specialists. Although many businesses pursued the HMO model for its touted cost containment benefits, some research indicates that private HMO plans don’t achieve any significant cost savings over non-HMO plans and in fact may be more costly.

During the 1980s, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended the Employee Retirement Income Security Act of 1974 (ERISA) to give some employees the ability to continue health insurance coverage after leaving employment. In the 1990s, the Clinton Administration attempted to incorporate universal coverage with cost control through managed competition among private insurance payers and other employer mandates, but the plan was never enacted into law. In 2001, during the Bush Administration, a Patients’ Bill of Rights was debated in Congress, but this effort failed.

In 2003, the United States National Health Care Act would have established a universal single-payer health care system. However, the bill in this form was never passed.

During the Bush Administration in 2003, the Medicare Prescription Drug, Improvement, and Modernization Act became law and represented the most significant overhaul to the Medicare system since its inception. Quality Reporting Initiatives became a focus in 2007, with pay-for-reporting programs including claims-based reporting of data on 74 individual quality measures. Starting in 2015, the program will apply payment adjustments to eligible professionals who do not satisfactorily report data on quality measures for covered professional services.

The American Recovery and Reinvestment Act of 2009 (ARRA), referred to as the Stimulus or the Recovery Act, was an economic stimulus package that included the Health Information Technology for Economic and Clinical Health Act, which...
established the Office of the National Coordinator for Health Information Technology and provided for Medicare and Medicaid incentive payments for “Meaningful Use” of “certified Electronic Health Record technology” by eligible professionals and hospitals. The adoption of the technologies necessary to meet the criteria for these incentives is a foundational component for Value Based Contracting, as measuring clinical quality data and capturing key patient data is critical for success. The implementation of this initiative is not just about technology but about improving health and transforming health care through meaningful use of health information technology.

Not until recent history has our healthcare system been challenged to undergo such a dynamic evolution in such a tight timeline. PPACA is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the United States health care system since the passage of Medicare and Medicaid in 1965. The PPACA is aimed at increasing the affordability and rate of health insurance coverage for Americans while reducing overall costs of health care for Americans. It provides a number of mechanisms — including mandates, subsidies and tax credits — to employers and individuals to increase the coverage rate and health insurance affordability. The PPACA requires insurance companies to cover all applicants within new minimum standards, and offer the same rates regardless of pre-existing conditions or sex. The PPACA has drastically changed the healthcare environment across the country and has redirected the focus of provider payment from volume based to value based.

**Government Models**

The PPACA established a range of models and programs to test and evaluate in the Medicare program.

- **Medicare Shared Savings Program/Medicare ACO.** An ACO is any organization that takes on the responsibility for achieving the triple aim — improving the quality, affordability and experience of care for the population it serves. A typical ACO can consist of primary care groups, multispecialty groups or integrated delivery systems, for example a multi-specialty hospital system. The key distinction is that the group directly provides or coordinates the majority of its patients’ care.

- **Comprehensive Primary Care Initiative.** The CPCI is a multiyear payer initiative fostering collaboration between public and private health care payers to strengthen primary care in select markets.

- **Medicare’s Bundled Payments for Care Improvement Initiative.** The Bundled Payments for Care Improvement initiative includes four payment models covering various elements of hospital, physician and post-acute services targeting 48 diseases and conditions. These selected participants agree to provide CMS a discount from expected payments for the episode of care and work together to reduce readmission, duplicative care and complications to lower costs and improve quality.

- **The State Innovation Models Initiative.** This model provides $300 million to state governments to design and test multipayer payment and delivery reform models for Medicare, Medicaid and Children’s Health Insurance Program populations.

- **Patient Centered Medical Home.** PCMHs, which can be certified through the National Committee for Quality Assurance, seek to improve overall patient and provider satisfaction, as well as quality and financial performance by matching patients with a team of health care professionals who will primarily deliver their care and become responsible for the care of a patient’s full range of health needs throughout their lifetime.

- **Health Insurance Exchange.** A health insurance exchange is a set of government-regulated and standardized health care plans from which individuals may purchase health insurance eligible for federal subsidies.

- **Value-based payment modifier.** The Department of HHS will implement a value-based payment modifier that, beginning in 2015, will impact payments to certain physicians and groups of physicians, and beginning in 2017, will impact all physicians and groups of physicians. The modifier will be budget-neutral for Medicare and will adjust Medicare Part B payments based on the quality and cost of care delivered.

- **Private Payer Models.** Most private major commercial payers in the United States have begun some form of Value Based Contracting. Blue Cross Blue Shields[1], United Healthcare, Humana, Aetna, CIGNA and others are deploying strategies and contract management methodologies. Private payers utilize claim data to assess mutually determined quality and/or efficiency metrics.
Economic Impact to Practices
The economic impact to practices in terms of Value Based Contracting is complex and can vary practice to practice based on size, market, technology foundation and potential Value Based Contracting risk-sharing arrangements. While some payers may provide financial incentives for early adopters in terms of additions to fee schedules or bonus incentives, others provide no upfront dollars to practices. The return on investment for these scenarios will likely take significant time to define.

One of the greatest challenges for any practice is working with payers to get claims paid. According to a recent poll conducted by the MGMA-ACMPE’s annual Practice Perspectives on Payer Performance, the study concluded that medical practices in the United States spent almost $70,000 per full-time physician to interact with health plans, which translates to a nationwide total of $23 billion to $31 billion annually. Payers are failing miserably in terms of overall satisfaction.

A recent study conducted by the MGMA evaluating member awareness of payment and organizational changes concluded that practices are far from ready for these new models. Groups do not consistently track cost per procedure, cost per patient or total cost for an episode of care. As we move forward with new models, providers need to have a solid understanding of the implications relative to their readiness to manage these new relationships.

Analyzing the Data
The ability to analyze data will become more critical for organizations as they move through consideration of new payment methodologies. Providers will need data that they may not readily have access to and purchasing data to identify the total cost by of care by category can be costly. Some commercial payers provide reporting information to providers containing episode of care costs and total costs per patient, but providers need to request this data and be proactive around meeting with payers to analyze this information. There is still a cost to this, as this data requires interpretation and administrative time relative to analyzing it, identifying areas to address, developing measures and collaborating with payers relative to data analysis findings. Developing the skills to analyze these data sets will increase in relevance as we move toward Value Based Contracting.

Trends suggest that data mining tools may become extremely beneficial for practices exploring these new methodologies. A critical piece for practices will be having analytical skill sets available to use these new tools, which indicate that organizations will need to hire, develop or contract with these types of resources. Working collaboratively with payers to define and monitor the key metrics and measures will be a key component for Value Based Contracting, as the foundation from which we are starting indicates that confidence in payer data based on prior experience is not optimum. Therefore, close monitoring of applicable measures and performance is crucial. Costs will be commensurate with organizational size, complexity, payer models being considered and sophistication of technology in place. In many cases, providers increase reimbursement for providers in Value Based Contracting models through management fees intended to offset additional practice expenses for necessary technology, analytical and clinic skill sets.

Providers who can demonstrate that they provide high-quality health care at affordable prices while maintaining high patient satisfaction will have the strongest positions with payers when it is time to negotiate contracts. It is up to providers to take a hard look at where they are currently relative to what is necessary for success and take strategic actions to prepare for the contracts of the future. Without investment in these areas, providers will be at a significant disadvantage when it comes to evaluating, implementing and tracking progress in terms of Value Based Contracting.

Success Factors
There are several critical success factors for Value Based Contracting, including trust between providers and payers, goal alignment, understanding the cost for providing services, analytical savvy relative to data analysis of methodologies/quality metrics and technological readiness for administering Value Based Contracts. Evolving payment methods are top of mind for practices as reported in “Medical Practice Today: What members have to say,” which identifies “preparing for reimbursement models that place a greater share of financial risk on the practice” as being members’ No. 2 priority, according to the Applicability-Weighted Intensity Index. There is great concern that most practices are not well prepared for these types of relationships, and without a sufficient foundation, providers may significantly struggle in this new environment.

To move toward new payment models providers need to evaluate current relationships with payers to determine appropriate partners with the highest probability for success. Providers must assess current payer relationships to determine which payers have acted with integrity, shared critical data, been responsive and have a solid track record with the practice when it comes to working through tough issues. Providers might consider exploring their side of the equation as well and work toward improving these relationships through face-to-face meetings with payers, inviting payers to tour the practice and invest in understanding payer data to set the stage for collaboration. Once potential partners are identified, ensuring that clinical, economic and administrative goals are aligned is essential.
Aligning clinical goals may involve agreeing on a potential focus area, measurement metrics and applicable evidence-based medicine guidelines. Additionally, providers and payers might also explore metrics relative to quality goals. Economic alignment may include parameters around financial incentives for population management programs, shared savings, incentives for attaining utilization goals and incentives for achieving agreed upon quality metrics. Lastly, administrative alignment should be focused on decreasing administrative burden for all involved, including the patient, payer and provider. Through focusing on developing trusting relationships and aligning core goals, providers can position themselves to have mutually beneficial relationships with payers through Value Based Contracting.

For these methodologies to be successfully employed, providers need to assess the cost for providing services. Understanding cost is imperative, as this new generation of contracts will require providers to understand the “budget” for an episode of care in contrast to the payment received for each unit of service. For a medical practice, direct costs are those that can be specifically traced to patient care and indirect costs are those that are necessary but not directly attributable to patient care. Fixed costs are those that are consistent regardless of the volumes of patients and variable costs ebb and flow with patient volumes. These costs are typically reviewed by the practice in terms of percentage of revenue attributed to the cost. Comparison of percentages of revenue by category is one data point that can be analyzed and compared to “Best Practices” by referencing the MGMA Performance and Practices of Successful Medical Groups, which is published annually. Additionally, cost per Relative Value Unit (RVU) can be derived by taking total practice cost and dividing it by total RVUs for a given time period. Comparing that information with reimbursement generated by payer can shed light on contract performance and add critical information relative to eminent negotiations.

In Value Based Contracting models, we can explore looking at costs from a different perspective, including per member per month (PMPM), per patient, per episode of care, per RVU or per visit/encounter. Simply take the expenses by category and apply the various potential denominators to the line item. In using this type of data, if the total payment proposal per patient is less, further investigation and/or negotiation may be appropriate. When information is reviewed in this way, areas of potential focus may be easier to identify, and the implications of revenue streams from various contracts can be compared through various angles. If the practice understands what its cost PMPM to keep the lights on is, evaluating these types of offerings and negotiating with payers will become more manageable, and moving through these scenarios with sound data will give providers a stronger position.

Analytical savvy and technology will play a key role for evaluation and implementation of Value Based Contracts. For example, in future payment models, payers may use predictive modeling to identify the highest-risk, highest-cost patients who could benefit from chronic-disease-management programs. Providers’ ability to participate in these types of analytics relative to patients might also play a more important role in population management data in the future. These types of analytics coming from practice management systems and EHRs will provide the ability for providers to determine the cost to treat a potential population or conditions, along with identifying potential issues within identified high-risk populations. These types of models will require merging data from practice management systems with EHRs and resources to convert this kind of information into meaningful, actionable material.

Care transitions are another example of future data needs. Care transitions are the process by which a patient’s care shifts from one setting to another and is an important part of care coordination and a way to reduce costly hospital readmissions. For providers, it requires the ability to track care transitions from various locations and monitor the care that was provided to the patients at each location.

Conclusion

Value Based Contracting efforts represent an evolution in clinical and payment methodologies that focus on creating quality outcomes, improved patient satisfaction, foster greater accountability and utilize substantial innovations in medical technology. These models intend to align incentives across providers, members, employers and payers to improve clinical outcomes and the patient experience along with improving cost efficiency. Understanding the new landscape and preparing for the future environment now will improve the likelihood of successful, thriving practices in the future.