Defining "Value-Based Contracting" Requires More Than a Few Words

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Value-based contracting (VBC) is one of the most talked-about topics at conferences, in stewardship meetings, and in workers' compensation requests for proposal (RFPs). But for all the discussion around the term, one thing seems missing: a common definition. VBC seems fairly straight-forward to most observers and that might be part of the problem. Indeed, ask a half dozen people what value-based contracting means and you'll get as many answers.

In conversations with clients and providers during the past six months or so, I've heard value-based contracting variously described as relating to case rates, pay-for-performance, risk-based payments, risk-reward, bundled payments, and an outcomes-based payment model. To some degree, each is correct. Think of value-based contracting, or VBC, as a new name applied to several well-established concepts used in group health provider contracting on a risk-reward basis.

In its most basic sense, VBC focuses on paying for positive results, not process or fee-for-service. Value-based contracts would be more appropriately thought of as an umbrella term rather than a single idea. And there are several critical components to VBC.

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Four elements form a meaningful workers' comp VBC model

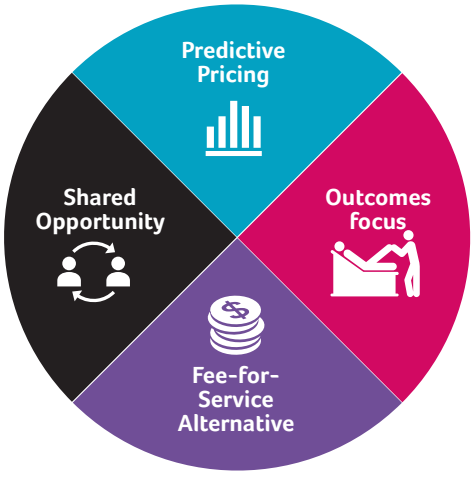
The variety of definitions industry watchers apply to VBC share the same objective: Each involves moving away from volume-based contracting or fee-for-service contracting by removing the financial incentive to treat more. A VBC model strips out the payment structures that reward activity over outcome.

There are several critical principles for constructing a sound VBC arrangement:

- **Predictive pricing for providers and payors:** This requires reaching agreement with providers on what it takes to treat an overall illness or injury and deliver the injured worker to the condition he or she was in prior to the injury.
- **Alternative to fee-for-service:** When a payment is rendered for each service there is a perverse incentive to do more in order to get paid more. Value-based payment models are designed to pay for better outcomes regardless of the services required to reach that outcome. That's best for injured workers and for payors.
- **Shared opportunity for the provider and the payor:** This concept centers on risk-reward and underscores the goals that provider and payor share. There is an upside and downside for both if the value isn't delivered.
- **Outcomes focus**: The model should be calibrated to deliver the correct mix of services so that an individual can achieve the best outcome.

If these core principles are intact, it is fair to consider the approach value based.

The 4 elements of VBC Models



Value-based contracting in group health

Value-based contracting has made much greater strides in commercial health care and government funded programs. The value-based ideals extend back to the origination of HMO models where medical groups or independent physician associations were paid per member per month to manage the wellness of members for whom they served as a primary care provider. This model has further evolved over the last few years under the Affordable Care Act and with the creation of Accountable Care Organizations (ACOs) in the provider market. These models meet the core VBC requirements because they pay a predictable price in which providers share in the upside and the downside for the health of their patient populations. Better outcomes meant patients didn't require added services. There are other value-based models that are finding success in the group health arena for enhanced quality of life. These include:

Case rates

Case rates are more of a hybrid contracting model than a pure value-based model. These rates cover the expenses of the outpatient facility or the ambulatory surgical center for a specific diagnosis or procedure (such as a meniscus repair, knee replacement, or shoulder repair) and do not cover the expenses billed by the surgeon, the lab or the radiologist. Because of this bifurcation, case rates are not a strict value-based model.

Pay-for-performance (P4P)

Pay-for-performance programs involve an incentive payment to providers (such as doctors and hospitals) for achieving a certain level of quality or efficiency. A set of cost and quality metrics determines whether a provider met the goals. Typically, the incentive payments are funded by holding back a portion of the provider's fees for services rendered.

Bundled payments

Bundled payments work by grouping a defined set of services into an "episode" of care. This might be a hip or knee replacement or relate to conditions such as diabetes and asthma. The setup establishes a single fee to be paid to cover all providers involved. Bundled payment rates are based on the costs expected for a particular treatment, including expenses for preventable complications that might arise. The targets are designed to ensure that a drive for low costs doesn't compromise quality of care.

Accountable Care Organizations (ACOs)

Accountable Care Organizations transform care delivery by paying health systems and doctors based on their success at improving overall quality and efficiency. ACOs are integrated health care systems — including alliances of doctors, hospitals, and other health care providers — that deliver and coordinate care for their patients.

Patient-centered medical home

The patient-centered medical home model provides additional compensation to primary care providers through a per-member, per-month fee to cover improved care coordination and health outcomes for the member. As a result, it is expected that more primary care evaluation and prevention visits will deliver savings and benefits in other areas of the health care system. In essence, it pays to solve a patient's health problem before it balloons into something more severe. In this model, the patient has an ongoing relationship with a personal physician. That doctor then leads a team that shares responsibility for the patient's care and, in some cases, arranges for care with other qualified professionals.

The common purpose of each of these models is to reward quality of care over quantity of services. That concept aligns with the principles of VBC though what succeeds in group health isn't always viable in workers' comp. Next we will dissect some of the differences between these models and VBC.

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Benefits and Challenges of Using Value-Based Contracting in Workers' Comp

Value-based contracting continues to attract attention through a wide-ranging dialogue focused on the need for health care reimbursements to reward outcomes over activity. While there are similarities between group health and workers' comp, there are significant differences too. Let us examine those disparities and consider the benefits of introducing VBC models in workers' comp.

The devil's in the data

While it might seem simple, the differences between a network-contracting entity and a paying entity can be confusing when it comes to VBC. In group health it is standard for an insurer or payor to be the network contracting entity. However, in workers' comp it is rare that the insurance company or payor is handling the contracting. This can make conducting the necessary data analysis more difficult. When you are not the payor it is hard to know if the services (during bill review or repricing activities) were reimbursed as recommended. This knowledge gap can make it difficult to determine the appropriate payment for a procedure such as a knee repair or a shoulder repair. That, in turn, could reduce the effectiveness of contract negotiations if the gap is not properly closed.

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Likewise, on the group health side, it is common that the health plan controls everything: the medical services, utilization review, and case management. In workers' comp that isn't always true. Often, the network company isn't the same as the care-management company. Without information from utilization review and case management, the network's ability to evaluate clinical outcomes can be diluted. In addition, readmission rates are harder to identify in workers' comp. And that information is critical to a solid value-based contract analysis.

The last challenge to VBC analytics relates to the types of care usually considered for these prospective pricing models. In group health, the common VBC services are knee and hip repairs or replacements, transplants, and other types of surgical procedures. With the large populations found in group health, high-volume procedures become a priority for VBC. In workers' comp, by comparison, surgeries are not as common as sprains, strains, contusions, lacerations, and even sutures. While surgeries are still costly, finding a significant sample size in the specified geographic area is a challenge.

State rules, regulations, and fee schedules

State rules and regulations add another layer of complexity. These include mandated reporting requirements, fee schedules, medical guidelines, and formularies. They also restrict whether and how you can encourage or direct care toward certain providers.

There are a handful of states without fee schedules, though most states rely on them. This means that each procedure code (e.g., for a surgical procedure, office visit, physical therapy, or diagnostic service) has an established reimbursement price. Historically, provider fees have been calculated at a discount off the state-mandated rate. The introduction of VBC into this model raises a number of questions to be asked prior to developing a model. These include:

- How does one review and price bills for prospective bundled services?
- How could bills submitted for payment prior to determination of a surgery be priced and reimbursed individually?
- Isn't it likely that complexity of these reimbursement models would require the network company to handle the bill review?
- Wouldn't re-billing/accounts receivable issues be a potential by-product of this model?

Workers' comp claims mentality

Today's claims environment is one in which everything is allocated to the claim file. Similarly the definition of network value has been attributed to "savings." Under a value-based model this mentality will have to change. For a value-based model to work, a progressive payor must be willing to throw out the old savings model and understand the goal extends beyond a particular bill. Part of the give and take of value-based contracting stipulates that providers

will make more than they charge on some cases in exchange for delivering the right services and guiding patients to better outcomes sooner. In other cases, providers will perform more services than expected to deliver that same level of care. Doing so might result in a financial hit to the provider.

Understandably, this is also going to be a difficult concept for workers' compensation payors to accept. It will take those payors progressive enough to reason that the risk is worth the reward. Part of the value is derived when injured workers get back to work sooner than expected, in better health than expected, and more often than expected.

The road ahead could bend toward great value

Given the differences outlined above, one might question whether to bother pursing a VBC setup. Regardless of the hurdles we might need to overcome as an industry, there is much to be gained if we can begin to evaluate and implement value-based models. This might only be possible in select states and for select procedures. Baby steps might be necessary. But the benefits that could flow from value-based models are too promising to ignore:

1. Providers incentivized by better health outcomes — and not the number of visits, tests, and procedures — can better treat injured workers without worrying about being fairly compensated.
2. Encouraging quality outcomes through VBC will result in predictable pricing, while also returning people to work more quickly and in better health. For payors, this translates to lowered indemnity costs, which can represent 50 percent of the expense of an injury.
3. Providers will become partners more closely aligned with workers' comp payors. They will benefit from the opportunity to deliver effective care for a cost below the value-based rate.
4. Network managers who arrange and negotiate strong value-based contracts will be seen as well-intentioned agents of change rather than simply recipients of savings gained through traditional fee-for-service arrangements.
5. An industry-wide culture could emerge in which employers, payors, managed care organizations, and providers all benefit from individuals returning to work and to their healthful pre-injury lifestyles.

Given the challenges and the benefits, it seems clear that value-based contracting merits further exploration in the workers' compensation market. Nevertheless, in discussions surrounding value-based contracting it is important to clarify expectations and make certain goals are understood. That is the surest way to safeguard a common desire for improving injury outcomes while containing costs.

To learn more about value-based contracting and Coventry's network development initiatives contact your account manager.