Global payments: One hospital’s perspective

Ellen Zane
President and CEO, Tufts Medical Center
• Founded in 1796 by Paul Revere, Samuel Adams & other patriots – first permanent health care institution in Boston
• With 5,000 employees Tufts MC is the 6th-largest employer in Boston
• 439 beds, nearly 500 physicians including nearly 100 pediatric experts at Floating Hospital for Children
• Principal teaching hospital for Tufts University School of Medicine
Earlier this year, we became the first academic medical center in Massachusetts to agree to a new kind of managed care contract proposed by Blue Cross Blue Shield of Massachusetts.

The Alternative Quality Contract could be described as “budget-based capitation on steroids” with significant quality incentives embedded within it.

However, the AQC applies only to Blue Cross’ HMO product (not the more popular PPO).
Background:

– Meeting with BCBSMA early on, we agreed that payment reform – moving away from fee for service - should be part of our eventual contract
– Contract was to cover hospital physicians and several of our community physician groups within our primary care network
– Year-long negotiations became public
– Ultimately we were able to negotiate reasonable terms while still agreeing to accept considerable risk
– Implementing these contracts is BCBS’s primary business strategy right now – very high stakes for the insurer
– We expect to need adjustments to parts of the contract over time
Working to avoid capitation’s mistakes

Preventing inappropriate denials:

- **Significant financial incentives exist to improve approximately 32 quality measures.**
- **Focus on process, outcomes and patient experience measures**
- **Significant infrastructure dollars are available to enable us to design programs which will assist the physicians in meeting targets**

Quality measures aren’t just moving targets – real improvement **is** rewarded.
Working to avoid capitation’s mistakes

On the risk side:

- **AQC** is health-status adjusted, to deter cherry-picking the healthiest patients
- Isn’t perfect – doesn’t adjust completely, but attempts to avoid potential gaming by providers

BCBS has committed to providing us with all data we need to monitor the program – AQC cannot succeed without this provision
Other improvements over old-style capitation

• It recognizes our community physician network (NEQCA) as an actuarially stable group (but we still don’t share BCBSMA’s reserves)

• Money to keep patients well does shift focus away from “more treatment is better” to “appropriate treatment is better”

• Should decrease overuse and misuse
Still, significant concerns and stumbling blocks remain
Issues to consider

- In our market, PPO enrollment is growing while HMO enrollment is shrinking
  - No accepted way of connecting global payment to PPO members (huge part of the market)
  - Consumers prefer open-architecture products with out-of-network benefits
  - Tufts Medical Center and NEQCA have approximately 50% of their business in PPO
  - Medicare can minimize this problem by focusing growth on HMO products and away from PPO designs
Global payments should not build in market disparities by setting global budgets purely at historical levels

- Is it reasonable for a very low-cost provider system to be capitated at their historical costs with an aggressive multi-year medical trend?
- Not all systems are equally inefficient – a perverse outcome would include a system with higher adjusted total costs having more upside opportunity
- For global payments to work and for everyone to have the opportunity to earn a surplus, some redistribution will be required
Issues to consider

• Global payments will require more extensive integration by providers. To be held accountable, health systems need a reasonable scope of control. Barriers to this are substantial
  – Most provider organizations have a thin slice of control over the total costs of care, so:
  – Global payments must allow for adjustments for matters out of the control of accountable provider systems
Issues to consider

- Transferring risk from managed care organizations to providers raises a number of considerations:
  - MCOs still hold considerable reserves – should those be shared with providers who accept risk?
  - Forcing providers to purchase reinsurance from their global capitation funds is unfair double dipping.
  - Product design must enable global payments to work – responsibility must be shared by employers and members, and consumer expectations can not conflict with provider incentives
  - Insurers must not become merely transaction-based organizations transferring risk with little or no skin in the game
  - Providers cannot be expected to control all aspects of costs if MCO’s continue to design plans based around unlimited access
Our belief:

Experiments with global capitation payments may be fruitful while other bundled payment schemes are under development. However, a long-term solution will require an all-payor, all-provider, all-hands-on-deck dedication to address these issues to make sustainable change a reality.

There is no one-size-fits all silver bullet!