Global payments:
One hospital's perspective

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Tufts Medical Center

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

Tufts Medical Center

BCSMA's "Alternative Quality Contract"

- 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)

BCSMA's "Alternative Quality Contract"

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**

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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**

Issues to consider

- 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!