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One-Fifth Of BC/MA's Network In Incentive-Based Contracts

BY RIC GROSS

Blue Cross Blue Shield of Massachusetts is continuing its push to re-shape the way providers are paid, moving away from traditional fee-for-service to a new, incentive-based system revolving around global payments. The state's dominant health plan, enrolling more than 2.2 million commercial members, is more than a year into its effort to ink providers to its voluntary Alternative Quality Contract, and just signed a deal with Caritas Christi Health Care, the largest community-based hospital network in New England.

Caritas Christi includes approximately 1,100 physicians affecting close to 60,000 BC/BS members and brings the highest number of physicians from any organization into the AQC to date. With the addition of Caritas Christi, 20 percent of BC/BS' provider network is now in the AQC—providing care for more than a quarter of the insurer's Massachusetts-based HMO members.

Caritas Christi Health Care and Caritas Christi Network Services, the tenth-largest employer in the Commonwealth, are comprised of more than 400 physician sites and six hospitals: The deal was estimated at around \$1.5 billion over four years in a *Wall Street Journal* article. It is a significant change from traditional fee-for-service contracts and gives physicians the flexibility to allocate healthcare resources based on what will have the greatest benefits to patient health.

The voluntary option combines two forms of payments: a global or fixed payment per patient, per year, adjusted for the health of patients, covering the full range of services; and substantial performance incentives tied to nationally accepted measures of quality, effectiveness and improvement of care. Deb Devaux, executive director of community transformation for BC/BS, said signing Caritas Christi to the deal is an important step in the contract's evolution.

"We look at the importance of the contract somewhat differently for each of the groups coming in," Devaux said. "Of course, Caritas Christi is a very important relationship as it is a large network and covers a large geographic market. They operate in six communities that are very different from each other, and the challenges in these communities are very different. A key value to the Caritas Christi deal relates to the question we are often asked about the AQC. Is this contract only for large, integrated, multi-specialty groups already with the infrastructure in place to effectively manage?"

"We can answer 'no' to that, and Caritas Christi is a good example. Caritas Christi has physicians who practice in the community, not as employees of the hospitals or part of one large group, and they are not highly

integrated already,” Devaux said. “To me, what this says is, this model can work from a community-based practice perspective that is not an urban, multi-specialty group.”

Table 1-1: Overview Of Healthcare Payment Models

Payment Type	Description
Fee- for- service	<ul style="list-style-type: none"> » Payment for individual services performed » Charge- based, cost- based, or prospective » If prospective, no incentive to increase unit cost but incentives to increase volume of services, provide more costly mix
Episode-based payment	<ul style="list-style-type: none"> » Prospective payment for clinical episode of care » Payment may be adjusted for severity or performance » Limited provider risk: cost of care, not occurrence » Incentive to constrain unit costs, volume, service mix
Global payments	<ul style="list-style-type: none"> » Fixed payment per patient, per month » High provider risk, for cost and occurrence » Strong incentives to constrain unit cost, volume, service mix » May be adjusted for severity or performance

Source: Mathematica Policy Research

Avoiding The Pitfalls Of Capitation

BC/BS officials say in devising the plan, they wanted to combine the best features of capitation and pay-for-performance. Officials believe coupling the global payment with financial incentives based on performance against quality measures guards against the possibility of under-treatment or doctors possibly withholding care.

Global caps are not new—health plans began replacing the traditional FFS system with capitation in the 1990s as a centerpiece of managed care, funneling the financial risk of patient care to primary-care physicians. The idea was that paying PCPs a flat fee per member, per month would provide incentives to coordinate patient care and make sure all ordered services were medically necessary. But capitation didn’t prove to be the financial panacea reformers had intended. Primary-care physicians complained their reimbursements weren’t sufficient to cover costs and discouraged doctors from taking on difficult or complex patients.

Capitation may have worked with larger practices that could spread the risk among a large patient load, but in smaller practices, the system rewarded physicians who saw the healthiest patients. BC/BS officials say the new system avoids these pitfalls, and encourages such practices as e-visits and group visits for patients with chronic illnesses through the quality incentive program.

Mario Motta, M.D., president of the Massachusetts Medical Society, has been following the BC/BS AQC contracting methodology, as well as efforts by the state to transform Massachusetts’ payment system into a global payment-based structure. The latter idea will have to work its way through the Legislature, but it has parallels to what BC/BS is already implementing.

“This is a complicated subject. Potentially, moving in this direction can be a good thing and eventually may be the best way to pay, as long as it is done properly,” Motta said. “I know nobody wants to make the same mistake of the ’90s [in regard to capitation]. But if it is set up properly, it can be a good model. As a provider group, you will need to have a good IT system, good management and high quality, and if you don’t do good work and your patients keep returning, you are asking for failure. For those that are ready to do it, they should do it now. For many others, it will take a lot of infrastructure work.”

Under the AQC, Caritas Christi will increase its focus on preventive care while optimizing quality and access. In order to maximize the potential of the AQC model for the benefit of its diverse patient population, Caritas Christi has overhauled several corporate structures as well as made key strategic partnerships and investments. Investments include the implementation of an electronic health system, capital investments, and physician network development to increase quality of care and help reduce unnecessary costs.

Table 1-2: Hospitals, Provider Groups Signing On To BC/BS Of Mass.’s Alternative Quality Contract

» Mount Auburn Hospital and the affiliated Mount Auburn Cambridge Independent Practice	» Lowell General Hospital and the affiliated Lowell General Physician Hospital Organization
» Hampden County Physician Associates, LLC	» Atrius Health
» Tufts Medical Center and the affiliated New England Quality Care Alliance	» South Shore Hospital and the affiliated South Shore Physician Hospital Organization
» Signature Healthcare Corporation, including Brockton Hospital	» Caritas Christi Health Care

Source: BC/BS of Massachusetts

The contract’s global payment covers all services received by a patient, including primary, specialty, and hospital care. That includes outpatient services such as imaging, as well as prescription drugs. The thinking is that when a doctor spends more time with a patient, improves their care and helps the patient avoid unnecessary hospitalization, the doctor and hospital have the potential to receive performance incentives, and the overall costs are less.

“The benefit to providers is that they will be reimbursed based on what they can deliver in terms of quality and efficiency. We realize providers don’t want to just be known as a cost-effective provider, but want to be known for their quality of care as well and be paid for that. This model allows that to happen,” Devaux said.

As with the medical home concept, more effective drugs will win and comparatively less effective ones will lose. But that’s balanced against the behavior of better-educated patients. Expect patients to be better informed, and as a result, more compliant with their regimens and less likely to be candidates for abandonment.

AQC Gaining Momentum In Marketplace

“The adoption rate has occurred faster than we would have thought,” Devaux said. “I think the timing was right in the sense that physicians and hospitals were realizing healthcare reform [more than likely] will occur, and wanting to be in the forefront of driving that. I also think many of the physicians are realizing the only other options are for the health plans to develop additional methods to manage utilization and costs, and that is not physicians’ preference.”

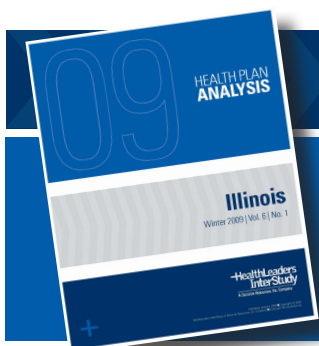
Devaux said she expects more providers to come on board in 2010, although it does take a certain kind of provider group to be able to take the risk. For example, it would be tough to make the system work without an electronic health record system of some kind.

“Although we have seen provider groups [be] effective at managing cost and quality without an EMR, I think all would agree it does make management much easier, especially in regard to creating tracking mechanisms for working with patients,” Devaux said. “The most important key to being successful under this contract is having a culture willing to take on this change. That gets back to the leadership of the organization, and a commitment to quality and efficiency.”

Outlook

Movement toward payment reform is continuing in Massachusetts, as costs rise and threaten to torpedo the state’s burgeoning near-universal healthcare reform. However, any movement that direction on a

statewide level must go through the Legislature, and don't expect that to happen any time soon. Therefore, BC/BS's Alternative Quality Contract can be viewed as a good laboratory to see how providers fare under a global cap system. ■



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