Risk-Based Contracting: Lessons Learned from Tufts Medical Center

Experience with the BCBSMA Alternative Quality Contract (AQC)

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October 14, 2011
Overview

- Tufts Medical Center and the Floating Hospital for Children
- New England Quality Care Alliance (NEQCA) Physician Network
- BCBSMA Alternative Quality Contract (AQC)
- Tufts Medical Center Local Care Organization
- Contract Performance
- Lessons Learned
- NEJM Report
- Future Challenges
About Tufts Medical Center

- A world-class, academic medical center, including a full-service children’s hospital, Floating Hospital for Children
- The principal teaching hospital for Tufts University School of Medicine
- Ranks in the top 15% of independent hospitals nationwide receiving National Institutes of Health research funding
- Ranked 6th in the nation in quality by University HealthSystem Consortium (UHC)
- Adult and pediatric physicians provide advanced medical science and services in every major specialty and subspecialty
- Located in downtown Boston at Chinatown and Theatre District
Tufts Medical Center
FY 2011* At a Glance

• 21,104 inpatient discharges
• 40,900 emergency department visits
• 349,610 clinic visits
• Case mix index: 1.7
• 415 beds (excludes 24 bassinets)
• Approximately 570 physician faculty
• 441 interns, residents and fellows
• Approximately 1/3 of trainees remain in the local area to practice

* Volume data – nine months annualized, Oct.-June, Tufts MC Key Operating Indicators Report
Tufts MC Network
NEQCA and Hospital Affiliates

- Lowell General Hospital
- Lawrence General Hospital
- MetroWest Medical Center
- Quincy Medical Center
- Signature Healthcare Brockton Hospital
- Morton Hospital
- Jordan Hospital

NEQCA*
- ~1,513 Physicians
  - 471 PCPs
- Autonomous, solo, and group practices who recognize the need to work together to improve health care quality and efficiency
- Committed to “local care stays local”
- Desire to maintain a significant voice in the governance of their organization
- Committed to the current need to invest in and use health care technology
- Driven to success within a competitive and outcomes-driven managed care payer environment

*Source: NEQCA, data as of June 2011
Laying the Foundation
Distributed Academic Medical Center™

Our Vision
Creation of a regional comprehensive, clinically integrated system that can deliver, direct, and create access to health care in a cost-effective, high quality manner

• NEQCA is the platform for physician alignment and system integration
  – Contracting
  – Population Health Management Tools:
    • PCMH
    • EHR
    • Quality
    • Care Management Protocols
NEQCA 3 to 5-year Vision—Achieving the Triple Aim

NEQCA Approach

- Information Technology
  - EHR & Reporting
- Culture of Quality
  - Physician Leadership
- Delivery System Redesign
  - PCMH
- Contracts
- Aligned Incentives

Triple Aim

- Improved Health of Population
- Improved Individual Experience of Care
- Limited Increase in Per Capita Cost

Delivering the Triple Aim: NEQCA Value Proposition to the Health Care Market.
NEQCA—Making the Triple Aim Concrete

- Improve Population Health
  - Process Measures
  - Patient Experience
  - Outcomes Measures

- Patient Experience Improvement
  - MHQP Survey Scores used as Baseline for training initiatives

- Reduce Cost Growth Rate
  - Utilization Meetings
  - Data
  - Incentives
NEQCA HIT Initiatives

• Selected eClinicalWorks as the electronic health record vendor of choice for the network
• Secure e-mail for all providers in the network
• Selected Healthcare Data Services (HDS) to provide robust financial and quality reporting
NEQCA Is Focused on Improving the Health of the Population, the Patient Experience, and Managing Costs

• Standard and Poor’s *RatingsDirect* publication recently cited NEQCA as an example of a provider system that has already developed the ideal ACO infrastructure (working through the details of cost and revenue sharing):
  – Disease management programs
  – Care systems designed for population health management
  – Fully deployed executive information system and patient registry (HDS)
  – A seasoned health informatics leadership team with a progressive technology strategy
NEQCA Identified an Integrated Approach to Manage Change—bridge Between Deployment and Ongoing Support

One team, one mission—achieve meaningful use, optimal use, PCMH recognition

PCMH Care Team—
- Integrated Care Manager (RN & LPN)
- Health Coach
- Clinical Pharmacist
- Consultative Behavioral Health Clinician

Meaningful Use

PCMH

Optimize EHR

Source: NEQCA Senior Administration
Future Model is Interdependent and Enhances Capabilities

**Integrated Support Team functions:**

- EHR deployment
- Post-deployment application support
- Meaningful use and P4P support
- PCMH work flow training and support

**Advantages:**

- Single team facing the practice, relationship development, reduces confusion/disruption
- More efficient use of practice time, building on previous work
- Consistent messages to practice, LCO and Network
- Deeper knowledge of practice patterns and patients
- More efficient to deploy
- Customized support plans by provider

Source: NEQCA Senior Administration
### Selected NEQCA Accomplishments

- Provider-centric, resulting in rapid growth since its formation in 2005
- Harvard Pilgrim Health Care 2010 Honor Roll with distinction for Adult and Pediatrics
  - 5 year history of being named to the HPHC Honor Roll
- e-Health Business Organization of the Year Award
- Provider network linked electronically through the establishment of network required business/IT integration standards

Source: NEQCA Senior Administration
NEQCA: Our Path

- Current Path
  - Individual Physician Practices
  - Local Care Organizations
  - Physician Network
  - Integrated Physician Network
  - Fully Integrated & Delivering High Value to the Market

Source: NEQCA Senior Administration
Before the AQC was negotiated
- Most NEQCA primary care physicians had solo agreements with BCBS
  - *Original NEQCA PCPs, formerly known as Primary Care, LLC, had a budget risk contract with BCBSMA but no quality metrics through 2009*
- “Vanilla” physician fee schedules
- Individual PCP incentive program
- Reporting system to qualify for PCPIP was onerous
- No alignment between physicians, or between physicians and hospitals to improve quality of care and reduce cost
NEQCA’s BCBS AQC Contract

• Contract Elements:
  – Global Capitation Budget for Total Medical Expense (TME)
  – Risk share on the budget between NEQCA physicians and BCBSMA
  – Potential to earn additional dollars based on improved quality scores and patient experience survey scores
  – Tufts Medical Center’s Hospital contract aligned with quality and safety metrics and incentives
BCBSMA AQC Contract Negotiations Goals

- Increase Tufts MC and TMC PO physicians’ fees to average of Boston AMC rates
- Increase NEQCA community physician fees to be more competitive
- Weight the contract dollars heavier on the quality performance rather than greater fee-for-service rates
- Required BCBSMA to meet data requirement deliverables
- Measure NEQCA network against their own performance
BCBSMA AQC Budget

- Base rate set using 2007 and 2008 total claims utilization
- Additions to the base rate to account for market forces
- Risk-adjusted budget set using the BCBSMA DXCG methodology
- Reinsurance purchased on the open market
- On top of the medical budget, infrastructure dollars paid to NEQCA
AQC Quality Component

• BCBSMA Gate Score Method
  – 32 HEDIS measures
  – 1 point for process
  – 3 points for achieved outcomes
  – Fixed minimum and maximum thresholds
  – 20% of score based on MHQP Patient Satisfaction

• Potential to earn ~5% of the medical budget

• 2008 Quality Gate Score baseline: 1.6

• 2009 improvement goal of .3 set in order to guarantee 2010 fee increase
NEQCA 2009 Results

- Increased overall Gate Score for the network by twice the goal: from 1.6 to 2.2
- Fee increases for 2010 and 2011 guaranteed
- TME trend within contractual goal
- Budget risk began in 2010
- Higher level of physician and staff engagement
- NEQCA network growth
- Greater confidence
• Adult Primary Care at TMC—General Medical Associates
  – 32 Attendings; 5 NPs
  – 3 Chief Residents; 73 Residents

• Pediatric Practice at TMC—General Pediatrics & Adolescent Medicine
  – 6 Attendings; 2 PNPs
  – 2 Chief Residents; 32 Residents

• 6 Solo Adult Practitioners in the Boston community
• 2 Pediatricians in the Boston community
• ~500 TMC PO Specialists
Tufts Medical Center LCO Infrastructure

- Executive Director
- Medical Director
- Quality Manager
- Patient Outreach Coordinator and Quality Specialist
- Claims Analyst
• Network leader with a Gate Score of 3.19
• Interim quality payments paid in 2010
• PCPs earned 10x the quality $$ as in pre-AQC BCBSMA programs
• TME trend within contractual goal
NEQCA 2010 Utilization Strategy

• Keep local care local
• Use TMC rather than other Boston AMCs
  – Average savings per adult inpatient case: $3,000
  – Average savings compared to CHB: $6,000
• Continue to analyze claims data for patterns, leakage, overuse of high-tech imaging
• Lab steerage for NEQCA community physicians
• Continue meeting with BCBSMA Medical Management Team
NEQCA Performance 2010

• Network in surplus
• All 13 LCOs individually in surplus after reinsurance recoveries
• Quality Gate Score increased to 2.6
• 100% of withhold return to all physicians
Tufts Medical Center LCO Performance 2010

- Network leader with a Gate Score of 3.4
- TMC LCO surplus significant
- Quality Settlement rewards PCPs
- Community LCO PCPs earning more than in any other contract to date for quality and utilization management
Factors in 2010 Success

- Physician and staff engagement
- Leadership—physicians and administrators
- Partnership with BCBSMA Medical Management Team
- Patient outreach
- Focused use of HIT, including
  - Healthcare Data Services (HDS)
  - eClinicalWorks
  - GE Centricity
  - Soarian
2011 Initiatives

- Technology innovations
- Efficiency improvements
- Quality improvements
HDS Reporting Tool—Prior to 2011

- Relational database—cube structure
- Data warehouse for all risk-based claims
- Detail drill-down capability
- Financial and utilization reporting
- Population management and quality reporting
HDS Enhancements—2011

• Tufts MC awarded State Grant in August 2010
  – Purchased all 7 Ingenix Symmetry Groupers
    • ETG, ERG, PEG, PCQ Connect, PRG, EBM Connect
  – Grouper logic incorporated into data warehouse
  – Provider Dashboard and Care Manager Modules
  – Predictive modeling
  – Retrospective analysis
  – Physician peer comparisons on cost and quality
  – Physician report cards
NEQCA Efficiency Programs

• Pharmacy utilization
• Reducing Ambulatory Case-Sensitive admission
• Reducing non-emergent ED visits
• Tertiary referral incentives
• Continued evolution of reporting content and presentation
• Collaboration/review of opportunities by Quality Medical Director and analytics team

  – Important to point out what is potentially changeable vs. what is out of PCP/group control
  – Ongoing improvement of report and its structure and content based on experiences at LCO leadership meetings
2011 Tufts MC LCO Management Committee

- LCO, Tufts MC, and PO leadership, PO and Community Physicians
- Tasked to recommend a funds flow distribution method to
  - Create an alignment between reward and performance
  - Provide incentives for performance
  - Determine how distribution can best impact key groups
TMC LCO—Work on Delivering Market Value

- Physician engagement
- Access
- Decreasing leakage
- Standardizing care: care pathways
- Improving transitions of care—communication to referring physician
- Decreasing readmissions and ACS admissions
- Patient satisfaction
- Utilization management
- Pharmacy management
- Referral management
Ongoing at NEQCA and Individual LCOs

• Meetings!
  – Quality Collaborative
  – Pediatric Advisory Committee
  – Funds Flow Committee
  – Funds Flow Work Group
  – LCO Leadership
  – Performance
  – Patient Experience Collaborative
  – BCBS Medical Management Team
Lessons Learned

• Utilization Trend
  – TME due to market factors more than active referral management

• Utilization Strategy for NEQCA—Ongoing
  – Keep patients in network
  – Keep care local when possible
  – Encourage NEQCA to use Tufts MC for tertiary and quaternary care
  – Improve quality, access, and communication at Tufts MC
  – Retrospective review
  – Specialist strategy to engage more NEQCA physicians
2011 NEQCA AQC Contract Performance

- Two large multi-specialty physician IPAs added January 2011
- More focused on quality, access, communication across the network
- Expect similar 2011 results to 2010 performance for NEQCA and Tufts MC LCO
  - Average quality $$ earned per Tufts MC LCO PCP: $26K
- NEQCA working on utilization analysis by LCO to provide meaningful, actionable, and timely reports
- 2012 and beyond—in negotiations now
• “Health Care Spending and Quality in Year 1 of the Alternative Quality Contract”
  – Analyzed the seven provider groups that began contracts in 2009
  – Compared spending among these groups comparing historical claims 2006-2008 with spending in 2009.
  – Also compared performance in these groups on HEDIS process measures and management of chronic conditions in adults
  – There was a statistically significant 1.9% savings in total medical expense in the intervention group in 2009
  – Savings accrued largely from a decrease in spending on outpatient facility services without any significant change in inpatient care or physician services
  – There was no significant effect on utilization
Savings derived from a shift to lower-cost providers

The AQC was not associated with a statistically significant improvement in adult preventive care, but:

- there was an improvement in the measures of management of chronic adult conditions and in pediatric measures;
- all groups received quality bonuses;
- all groups earned on average a 3% budget surplus;
- in the first year BC paid out more than it saw in savings; and
- the design of the AQC contract is to save money over time.
• Global payments and rewards for quality can only be sustainable if there are substantive changes in utilization that eliminate inefficiencies and change utilization patterns.

• Introducing global payments introduced price competition in the market.

• Utilization will not change rapidly and hence budget updates (read decreases) and providers’ ability to practice in this new environment are key.
Future Challenges

- Negotiations will be increasingly more difficult
- Aligning all risk contracts on quality and performance metrics
- Payment reform at the state and federal level
- Defining the Tufts MC network as an Accountable Care Organization
Thank You for Your Time and Attention

• Questions?