

Issue Date: Online, August 13, 2011

Contracting Innovations Can “total cost of care” contracts push the healthcare industry forward?

By Mark Hagland



Earlier this summer, Dudley Morris, senior advisor, and Bill Eggbeer, managing director, at the Miami-based BDC Advisors consulting firm, which specializes in clinical integration and in helping provider and payers organizations to prepare for accountable care arrangements, authored a white paper titled “Total Cost of Care Contracts: Early Lessons.” In that document, the Santa Barbara, Calif.-based Morris and the Annapolis, Md.-based Eggbeer examined the unfolding of a relatively new concept called the “total cost of care contract,” which has been evolving forward in three markets—statewide in Massachusetts; in the metropolitan Minneapolis-St. Paul healthcare market; and in the northwest suburbs of Chicago (in all three instances, Blue Cross Blue Shield plans in those markets have been the insurers involved with hospitals, medical groups and health systems there).

While total cost of care (TCOC) contracts share some of the characteristics of accountable care organizations (ACOs) as envisioned in the federal Center for Medicare and Medicaid Services (CMS) recently released preliminary rule on ACOS in its Medicare Shared Savings Program, there are also important differences. Eggbeer and Morris note that TCOC contracts are being rolled out entirely in the private sector, and that the terms of these contracts are, in their view, less bureaucratic and rigid in their terms than are the terms of CMS’s shared savings program for ACOs.

Overall, Morris and Eggbeer note in their white paper, several key points stand out about TCOC contracts, as they’ve evolved so far in the Massachusetts, Minnesota and Illinois markets:

- > “Learning to work cooperatively with insurers was seen as equally important as any financial reward, and learning new techniques for global care management was viewed as the most essential of the new skills they were developing,” the authors wrote of provider executives’ experiences to date.
- > Moreover, the authors state in their report, “Early results indicate success driven more by leadership and commitment to change than organizational structure.”
- > What’s more, they state, downside financial risk doesn’t seem to be necessary to motivate care management-driven operational changes on the part of providers. As they note, “In contrast with the proposed CMS ACO regulations, which provide significant risk-sharing for all participants after year three, the TCOC contracts rely mostly on positive incentives, not penalties for poor performance.”
- > The authors also note that the terms of the TCOC contracts that have been drafted so far largely

revolve around “opportunity costs,” allowing provider organizations to dip their collective toes into the water before making any huge plunges into the risk-taking pool; and TCOC contracts can work across a variety of products, including HMO and point-of-service insurance plans.

All that having been said, Morris and Eggbeer agree that laying the IT foundations for participation in TCOC contracts will be absolutely essential to their success, just as they will be for any provider organizations considering developing ACOs under the Medicare shared savings program. Put another way, failure to develop truly sophisticated, next-generation information systems, replete with data analytics and population health management capabilities, will doom any effort on the part of provider organizations to succeed in this new risk-taking world.

Morris and Eggbeer spoke recently with *HCI* Editor-in-Chief Mark Hagland regarding their white paper and its implications for the HCI audience. Below are excerpts from that interview.

Can you briefly introduce to our audience the “total cost of care contract” concept?

Bill Eggbeer: What we’re seeing in each of these three markets is the market’s effort to get its arms around the same issues as the federal government is, in terms of healthcare reform—and that is that the rate of growth in medical costs has become unsustainable for employers and consumers. And in these three markets, payers, providers, and consumers have come to the conclusion that the old, fee-for-service-based, volume-driven, model, is broken, and is a central contributor to the excessive rate of growth in costs—and that we need a new construct. And the new construct in each of these cases is intended to make the provider accountable in varying degrees for both the cost and quality of care for a defined population of members.

Dudley Morris: And there is a general recognition in the industry that the current fee-for-service model of payment is not sustainable in the long run; and what’s important about total cost of care contracting is that it’s a phenomenon that was initiated both by payers and providers, but mainly from the insurers, from Blue Cross plans in different states, particularly in Massachusetts, Minnesota, and Illinois. The Massachusetts program is the best-known, but the Minnesota program is more comprehensive, and involves several insurers and most of the provider organizations in the Twin Cities.

The key here is changing the payment mechanism from being totally based on volume, to one based on volume-plus-quality; and the contracts are very much designed to promote and reward quality. So in the first year or so in Massachusetts, for example, most of the providers were able to receive bonuses by achieving quality goals. So the contracts don’t try to cut expenditures. You can still have a contract for hospital care, but the total cost of care contracts will be wrapped around that; and if you beat cost expectations, you receive some shared savings. And Blue Cross is looking in the long term to cut the rate of medical inflation in Massachusetts in half. And people have been willing to participate, because each contract, while being important, is not a huge proportion of their overall revenue pie.

Another revolutionary element is that, under the contracts, people receive a global budget for the total cost for care for a population. So in Massachusetts, they have about 500,000 enrollees, or 50 percent of their business, through HMO and point-of-service plans (though not PPOs). So if you participate, you’re responsible for 100 percent of the cost of care, regardless of where it’s provided. So that means in maternity services, which cost 25-30 percent of a health plan’s budget—if you go over expected costs, you’re still responsible for your costs. And that’s where we’re inserting a burden or opportunity on the information technology, because I don’t see how this can work without having much stronger IT systems than most hospitals have. And it’s going to require adding new systems for data analytics and risk stratification.

Do you see total cost of care contracts as being different from ACO development?

Morris: The qualification of the critical success factors is similar—you have to have a degree of clinical integration so that you can do contracting for a large primary care physician base; you have to be able to track admissions and outcomes and other data; and track quality indicators. All of those are similar to what’s in ACOs. The difference I see is that the Medicare ACO regulations impose a far higher level of risk. It’s much easier for providers to participate in total cost of care contracts at a much more manageable level of risk. So you can get involved in this new value-based medicine, if you will, without having to bet the farm. I think everybody had the same reaction to the ACO regulations when they came

out, that it would just be too hard.

Eggbeer: I would just add that I think there are two key differences. One is that the ACO program really requires bilateral risk, both upside opportunity and downside risk. And there were two options—one, put off the downside risk for a couple of years, but it's still there; whereas in the total cost of care contracts, in at least two of the three markets, providers are insulated from real risk, and that's an incentive for providers to get engaged. The other critical difference is the bureaucracy involved in the ACO program, everything from the FTC [Federal Trade Commission] and Department of Justice scrutiny that providers will be subjected to, to the organizational structures that will need to be put in place, and so on, whereas the total-cost-of-care commercial programs are much more flexible.

Morris: And in the ACO regulations, they've said they would include retrospective patient identification; whereas in total-cost-of-care contracts, they're starting with prospective patient identification. That's why they started with the HMO population in Massachusetts, where they already had strong identification of patients. The challenge will be when they move into the PPO population, where that isn't yet clear.

Eggbeer: In Minnesota, they're still working with retrospective patient identification, however.

What do you see as the most encouraging wins in these three healthcare markets so far?

Eggbeer: The level of participation is one of the big wins. In Chicago, it's just a contract between Blue Cross Blue Shield of Illinois and [the Mount Prospect-based] Advocate Physician Partners. But in Minneapolis, you have virtually all the provider systems and all the payers engaged in this form of contract. In Boston, you've got Blue Cross Blue Shield of Massachusetts, which is the largest payer, but most of the larger provider systems, with the exception of Partners [HealthCare].

Morris: To me, what's exciting about this is that it's the private insurance market doing what the federal government is thinking about, but showing that it can be done faster and better. So if you want to see what a federal ACO should look like, go to Massachusetts and Minnesota now and Chicago soon, and see what those kinds of systems look like. And so far in Massachusetts, the only place where they have reliable, full-year data, people have been able to achieve changes in quality, which is good news. Now, over the next two, three, four years, it will be harder to earn shared-savings money over time. And the Blue Cross of Massachusetts people believe that over time, it will become more challenging to do so.

But this is an exciting model. The challenge from a national policy model is whether you can take a pretty limited set of examples—how much of this can be taken and rolled out in less mature or developed markets. I mean, Advocate in Chicago is an extremely sophisticated system, and the Minneapolis and Massachusetts markets are very sophisticated.

What do both of you see as the strategic IT essentials for success in this kind of contracting?

Eggbeer: In most advanced markets now, health systems are implemented electronic medical records, which is a good thing. But the focal point of an EMR is the individual patient, and the architecture and other elements are focused on providing care for individual patients. The focus in a population management program like any of these total cost of care programs, is on the population, not really on an individual. And it requires that, in order to effectively manage populations, you need to get patients into registries, and manage the organization of care around those registries, to meet the needs of patients with similar conditions, within those registries; you need to know when your patients are leaving your network for specific care; it's a quite different focus. And I would argue that even when provider organizations are relatively sophisticated in their use of IT for patient care, they still have a ways to go to manage the health of populations.

Morris: Which is why you need to develop data warehouses and other tools for predictive modeling and other activities.

Eggbeer: The good news is that there are products being developed that can sit on top of those EMR systems to provide such predictive modeling and other capabilities.

Can you cite any specific examples?

Eggbeer: In Boston, because there's just one payer involved, and because Blue Cross of Massachusetts

is trying to bring transparency of data, they're sharing data with providers that providers otherwise wouldn't have access to. In Chicago, Advocate uses a company called Intelligent Healthcare as what I call a clinical performance reporting system—it's helping them with the registries and data analysis. Morris: Actually, they run the systems for them.

Eggbeer: It's an ASP [application service provider] model. And I believe that Allina in Minnesota has recently decided to purchase the same system.

Morris: There's another firm in Boston with a predictive modeling system, called Verisk. They're being looked at in several markets.

So fundamentally, providers have to move to a higher level, beyond the individual patient level, to the level of population health management and analytics, then, correct?

Eggbeer: Yes. It certainly helps to have an EMR in place, because absent the EMR, you're really dependent on the use of claims data, which has drawbacks. But if you can pull from the EMR, you're doing better.

Still, you have to pull from that next 'meta' level, correct?

Morris: Absolutely. And the ability to get claims data promptly is essential.

Eggbeer: This is a real learning curve for a lot of provider system IT departments and c-suites, because they're in the middle of a period in which they're expending a tremendous amount of money on electronic medical record systems, with the view, understandably, that the EMR will do everything. But you really have to look at the population health level and understand that the EMR won't provide what you need next.

Morris: And if you have a designated population, you have to have a totally different mindset on this, because you really are taking the next step into population management, and that's a challenge for senior management and CIOs and physicians to get to that point where they can make that jump. It's a big step.