

## **TOTAL COST OF CARE CONTRACTS: EARLY LESSONS**

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### **Executive Summary**

Total Cost of Care (TCOC) contracting is an ambitious payment reform effort launched in 2010 by private insurance companies and provider organizations in Massachusetts, Minnesota, and Illinois. All three markets are different in terms of their size, levels of consolidation and costs – the Massachusetts program being a statewide initiative – and the Minnesota and Illinois programs focusing on the metropolitan Minneapolis market and the western Chicago suburbs.

The TCOC experiments aim to change the payment mechanisms for care from purely fee-for-service payments based on volume to a fee-for-value payment system that links payments to the rate of growth in total cost of care provided a patient annually regardless of where the care is provided. It also provides significant incentives for providers to meet annual quality goals. Over time, TCOC aims to improve quality and value of care for beneficiaries while “bending the cost curve” to provide more predictable premium costs for beneficiaries.

The TCOC contracts share some of the characteristics of CMS’s Medicare Shared Savings Accountable Care rules which also aim to increase value while holding down costs. By measuring outcomes and costs for attributed patients over the entire year, TCOC encourages participants to coordinate services across the entire continuum of care. In addition, by assuring the most medically appropriate service is provided at the right time and in the most appropriate setting, TCOC seeks to reduce unnecessary hospital services and admissions which account for the largest portion of the health care dollar. Historically, negotiations between payers and providers have occurred every two to three years and have focused on unit price increases. TCOC contracting changes the paradigm by focusing instead on negotiating limits to the annual rates of increase over three to five year contracts. In return, providers are given the opportunity to share savings if cost growth is held below negotiated benchmark target growth rates.

BDC Advisors has reviewed the early experience of TCOC contracting with providers and payers in these leading-edge markets, with an eye toward identifying and understanding lessons learned. The primary objective of all TCOC programs is to improve quality, and during the program’s first year, all participants were able to earn significant incentive bonuses. While the books are still being reconciled for the first year’s costs, payers have indicated they expect providers enrolled in the program to have slowed cost growth below benchmarks and to earn bonuses there as well. More specifically:

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\* BDC Advisors’ observations are based on interviews with six executives employed with five different provider systems and health plans in Boston, Chicago and Minneapolis that participate in TCOC experiments.

### **Lesson One: The TCOC experiments have gained traction in advanced markets.**

TCOC experiments are well into their second year in Minneapolis and Massachusetts, with providers doing better than anticipated in terms of both quality and costs according to participating payers. The Chicago TCOC program model was launched in 2011 and is still completing the attribution of beneficiaries who will be counted in the program. Most TCOC agreements allow participants to earn bonuses (typically in the range of up to 10%) on top of their normal billings for meeting quality goals, which now cover both inpatient and outpatient care, and all participating providers in Minneapolis and Massachusetts earned quality incentives in 2010. The first checks are being cut for shared performance bonuses for 2010 in Minneapolis, while all TCOC participants in Massachusetts produced budget surpluses that have enabled them to make infrastructure investments to further improve care. Most providers indicated that while the shared savings incentives were attractive, they still constituted a relatively small portion of their total provider revenue. *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 TCOC approach appears to be gaining support of providers in Massachusetts which is a high cost market with inflation in the 7%-8% range in 2010, as well as in Minnesota which is a low-cost market with only 2% medical cost inflation in the greater Minneapolis market.*

### **Lesson Two: Early results indicate success driven more by leadership and commitment to change than organizational structure.**

To date, there is no evidence that one organizational structure is better than any other for TCOC participation. TCOC contracting appears to be agnostic vis a vis organizational structure. Contracts have been signed with a broad range of provider organizations from large multi-specialty groups, independent and employed physician practice organizations, smaller physician practices, and physician-hospital organizations. What matters most are strong leadership and commitment to change, plus effective clinical management capabilities, including experience in quality improvement programs, advanced care management procedures for chronic illnesses, a strong health IT infrastructure, appropriate market incentives, and a mission to improve value. *Physician-only organizations can work well, and payers have shown a willingness to provide grants to help them build the necessary infrastructure, providing a “watch-out” for hospital organizations that move too slowly to adapt to the market.*

### **Lesson Three: Downside financial risk doesn't appear to be essential in motivating results.**

TCOC contracts are being structured to graduate risk based on the capability of providers which have given providers enough of a comfort level to sign up for the experiment. 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. While the AQC contract in Massachusetts does require providers to share a portion of the risk if they exceed spending targets, providers have been well insulated from downside risk, and no

one has lost any money under the contracts as yet. Risk, in fact, is buffered in all cases under the AQC with withholds, mandatory reinsurance, and relatively liberal inflation assumptions. TCOC contracts focus initially on providing performance incentives to care systems for achieving measurable improvements in affordability, quality, and the efficiency of care delivery. *Providers fully expect that their risk profile will increase in future years if the experiment is sustained. Payers anticipate that the shared savings opportunities for providers will shrink in future years, with annual quality bonuses being the remaining incentive, but for now, the limited downside risks and mainly upside incentives have created a positive environment for change.*

#### **Lesson Four: You don't have to bet the farm to participate.**

Each TCOC contract is payer specific, so even in Minneapolis, which in aggregate has the broadest TCOC coverage, each TCOC contract encompasses only a small slice of any provider's total business. Because legacy hospital and physician contracts still cover the bulk of the revenues, the risks of participating are largely opportunity costs: failure to earn future incremental benefits--not loss of current business. Finally, commercial insurance companies are proving flexible partners according to program participants--by nature easier to deal with than CMS or State Medicaid programs. The commercial payers have been willing to provide grants for infrastructure and Medical Home initiatives, making it possible for providers to participate in the program while limiting major new capital investments. *Payers appear to believe they have finally developed a better mousetrap than pure fee-for-service and are looking to expand the concept. Meanwhile, providers have the opportunity to begin to finance their clinical integration efforts without betting the farm.*

#### **Lesson Five: TCOC is applicable to HMO, POS, and PPO insurance products.**

The TCOC business model appears to be applicable to both HMO and PPO populations, meaning that it could be scaled to cover the entire commercial insurance market. The Massachusetts AQC contracts focus entirely on Blue Cross Blue Shield's HMO and POS service business largely because plan members are already assigned to a primary care physician, and Blue Cross Blue Shield has the most comprehensive data repository of these patients' medical history. The Blue Cross Blue Shield of Illinois contract with Advocate Physician Partners (APP) on the other hand, focuses almost entirely on PPO patients with HMO membership to be folded in at a later date. Likewise, the Minneapolis TCOC experiments deal primarily with PPO patients. Aetna, United Healthcare, Cigna and other commercial payers are having discussions about look-alike TCOC offerings which will be modeled after the contracts currently in place. The main variables to be considered in expanding the TCOC concept are whether the providers have the data warehousing capabilities necessary to identify and attribute patients to participating providers, the timeliness and accuracy of data received from payers, and whether the providers' medical staffs are sufficiently organized clinically to accept contracts and provide comprehensive care management. It would appear that any provider who developed a robust TCOC program model, such as Advocate Physician Partners in Chicago, will be positioned to participate in CMS's Accountable Care Program assuming some changes in the proposed rule make this a viable option. *At the very least, TCOC contracts will give providers the skill sets and system needed to meet the new quality*

*and efficiency standards of CMS' Value Based Purchasing program which becomes effective in 2012. In addition, they will constitute the major portion of their commercial business which includes their most economically valuable patients.*

### **Lesson Six: Keeping patients in your network is critical to TCOC success.**

For open access networks (typical in all three markets), a reported 50% of spending for health care services typically occurs outside of a provider's network. Making sense of what the care patterns are and where the care is provided is critical to TCOC success. One AQC participant reported it expects to earn their entire shared savings bonus in the first year's contract simply by redirecting admissions from outside their network to lower cost providers within their network. Freedom of choice under PPO products also presents a challenge, since many patients self-refer to specialists or programs at tertiary medical centers which puts a premium on the ability to engage patients with a primary care physician and to have appropriate programs in place to intervene with the patient and coordinate their care.

### **Lesson Seven: Locking down the details is the key to sustainable results.**

The goal of TCOC contracting is to have a single care model across all payers, although the terms of each contract will likely be different. "All our contracts are pretty much the same," said a participant in Minneapolis which has the broadest TCOC coverage in the nation. Our interviews with payers and providers in Chicago, Minneapolis, and Boston indicate getting the details right--such as the methodology for attributing patients, the provisions for risk adjustment, and the right to have audits and transparency of records--is key to program sustainability. The IT systems need to be sufficient to compare health outcomes for patients as well as the financial efficiency and productivity of physicians. The ability to identify, track, and intervene with chronically ill patients who are the heaviest users of care, to track their adherence to treatment plans, and provide after office hours service will require a sufficient infrastructure to make sure physicians treat all of their patients using the best science on a consistent basis.

### **TCOC Overview**

While the Patient Protection and Affordable Care Act (PPACA) has been the major stimulus in the development of value based payment for health care, perhaps the most significant changes in delivery system payment reform are coming as the result of new Total Cost of Care Contracts in Massachusetts, Minnesota, and Illinois between commercial insurance companies and providers.

Blue Cross Blue Shield of Massachusetts launched their Alternative Quality Contract (AQC) in 2009 as a state-wide effort involving a variety of different providers. HealthPartners, Medica, and Blue Cross Blue Shield of Minnesota launched their Total Cost of Care Contracts in 2009 and 2010 and have focused on the four major health care systems in the metropolitan Minneapolis market. Blue Cross Blue Shield of Illinois and Advocate Physician Partners (APP) signed their agreement in January 2011 covering the western Chicago suburbs.

All of these experiments with payment reform aim to “bend the cost curve” by linking payment for health care to improved quality, safety, and efficiency for both HMO and PPO products. All of the TCOC have four common elements:

- they have a global budget covering virtually all health care expenditures for a designated population of patients regardless of the provider, including home healthcare and nursing home care;
- they provide incentive bonuses for achieving quality goals;
- they provide for financial accountability through shared savings and/or shared risks; and
- they provide technical assistance and grants for the establishment of infrastructure necessary to support initiatives such as coordinated care management, bundled payments or medical homes.

Government action—and the anticipation of government action—is an important catalyst to motivating providers to move towards clinical integration which can positively impact outcomes and patient satisfaction while reducing costs associated with waste, inefficiency, and unnecessary hospital admissions. The centerpiece of the government’s program of payment reform – the Medicare Shared Savings Program – will not be fully operational for several years. Even the recently announced Pioneer Accountable Care Program, which begins this summer, will serve only 30 or so applicants nationally.

Fortunately, while government action is highly important, it is not the sole determinant of reform. The same pressures driving government also impact private payers: unsustainable cost increases, and a growing demand from employers and consumers for improved value and quality. As a result, private insurers have begun to experiment with a variety of new payment reforms to change from fee-for-service (FFS) payments based on volume, to fee-for-value (FFV) payments. These reforms add a variety of quality incentives for both inpatient and outpatient care and afford providers the opportunity to share in the savings from better coordination of care and the elimination of waste, inefficiency, and unnecessary utilization of inpatient and outpatient services. None of the payment reforms aim to reduce current expenditure levels, but rather are designed to reduce the rates of future inflation and make premium rate increases more predictable.

In return for these financial incentives, providers are being asked to sign on for longer term contracts of up to five years forgoing annual rate negotiations, to agree to meet a set of quality and outcomes targets, and to accept responsibility for 100% of the cost of care for all patients attributed to their physicians, whether or not this care is provided by the network. There is some degree of risk in all of the contracts, but much less than in the proposed rule for the Medicare Shared Savings Program. For the most part, TCOCs rely on positive incentives designed to encourage provider participation, not to off load risk from insurers to physicians and hospitals.

Fee-for-service and fee-per-case or per diem payment contracts remain in place under the TCOC contracts. Physicians will still bill and be paid according to their fee schedules. Hospitals will be paid on a per case basis as they are now. The major change in the payment structure is that incentive payments are based on comparing the rate of growth in the total health care expenditures for attributed patients vs. the growth in the total cost of care in the market for patients that are not attributed to a network provider.

This switch to population health management has required a major change in mind set for providers who have heretofore worried primarily about their market share and top line revenue, and who have many times seen payers as being opportunistic rather than cooperative in their business relationships. The jury is still out as to whether the TCOCs will usher in a new cooperative relationship between payers and providers, but the experience to date is promising and worth examining in some detail.

**Market Profiles**

The three TCOC experiments are operating in three very different markets in terms of market consolidation and cost performance. As shown in the Exhibits below, Minneapolis is the most efficient market, followed by Boston, and then Chicago, with differences generally correlated with market consolidation. While TCOC contracts are most fully deployed in Minneapolis, the programs are sufficiently new that it would be hard to assert any relationship between contracting methodology and cost performance. Rather, it is sufficient to note that health plans and providers are working with this new contracting model in markets at different stages of development.

***Exhibit I – Market Consolidation***

<i>Region</i>	<i>Degree of Consolidation</i>	<i>Top Providers % of Market</i>	<i>Top Health Plans % of Market</i>
<b><i>Boston</i></b>	Hospitals: Moderate Physicians: Moderate Health Plans: High	Partners Healthcare 27% Steward Health Care 11% Beth Israel Deaconess MC 8%	BC/BS of Mass 42% Harvard Pilgrim 22% Tufts Health Plan 21%
<b><i>Chicago</i></b>	Hospitals: Low Physicians: Moderate Health Plans: Moderate	Advocate Health Care 13% Resurrection Health Care 7% Sisters of St. Francis 5%	Health Care Service 64% Aetna 9% WellPoint 6%
<b><i>Minneapolis</i></b>	Hospitals: Low Physicians: High Health Plans: High	Allina Hospitals & Clinics 31% Fairview Health Services 20% HealthEast Care System 10%	BC/BS of Minnesota 36% Medica 25% Health Partners 17%

Source: Boston, Chicago and Minneapolis HealthLeaders InterStudy Market Overview



**Exhibit II – Relative Health Care Costs**

<i>Region</i>	<i>Medicare IP Days per Decedent (Last 2 Years) <sup>1</sup></i>	<i>Medicare Reimbursements per Decedent (Last 6 Months) <sup>1</sup></i>	<i>Hospital Discharges per 1,000 Medicare Enrollees <sup>2</sup></i>	<i>IP Days Per Medicare Enrollee <sup>2</sup></i>	<i>Average Length of Stay <sup>3</sup></i>
Boston	19.7	\$18,142	350.8	1.79	3.5
Chicago	24.1	\$26,325	405.1	2.12	4.5
Minneapolis	14.7	\$13,260	316.9	1.36	3.2
National Avg.	18.5	\$16,349	336.2	1.76	3.7

Sources: 1 Dartmouth Atlas 2003-2007, 2 Dartmouth Atlas 2007, 3 Boston, Chicago and Minneapolis Health Leaders InterStudy Market Overviews

**Massachusetts AQC Contract**

The Massachusetts Blue Cross Blue Shield (Blue Cross) Alternate Quality Contract (AQC) was launched in 2009 and now includes some 500,000 Blue Cross HMO and POS patients, and some 13 diverse provider organizations in different areas of the state. These contracts now cover approximately 500,000 lives--approximately 50% of Blue Cross's HMO and Point of Service (POS) business in Massachusetts. The AQC contract has twin goals of improving quality and outcomes and significantly slowing spending growth.

The AQC is a "modified global capitation contract" in which payments to providers are based on an annual negotiated budget which covers the total health care services provided to Blue Cross patients, whether or not these services are provided within the provider groups' network. In fact, providers participating in the AQC provide only 35% of the total care for the HMO members within their individual networks according to Blue Cross. Pharmacy, home health, nursing home care, emergency admissions, specialist visits, and elective maternity services all can occur out of network making coordination of the continuum a major health management issue.

The Blue Cross AQC agreements last five years and include an annual spending growth limit, incentive payments for improving quality, shared savings incentives, and technical support and grants to build the infrastructure of participating providers. More specifically:

- Blue Cross has executed AQC contracts with a broad variety of providers to date, including large multi-specialty groups, academic medical centers, hospital-physician organizations, and independent practice associations representing many smaller physician practices. While AQC covers approximately 50% of Blue Cross' HMO book of business, the AQC covers a smaller portion of their

business partner's book of business which has made them willing to participate in the program and has helped to make any AQC risk palatable.

- About 2/3 of Blue Cross' business partners in Massachusetts have signed the AQC. All of the major systems in Massachusetts have now signed up except Partners Healthcare, U Mass Memorial Health Care, and the Lahey Clinic. Blue Cross reports it has had "serious" discussions with Partners about joining, and it is now considering how it could expand the AQC to include its PPO business after the contract's first year experience is evaluated.
- The AQC is an overlay to Blue Cross' fee-for-service agreements for physician services, and to the contracts it negotiates with the hospitals for inpatient care. The starting point for the negotiation is the past year's medical spending for the patients attributed to the provider's panel of primary care physicians. Blue Cross' focus has been on controlling future growth rates in the providers' contracts, not on reducing their current rates of expenditures. After the initial budgets are set, Blue Cross negotiates explicit annual rates of inflation in the budget.
- The AQC provides for an annual inflation rate tied to CPI.
- The AQC contract provides for a 10% quality incentive on top of the total per member per month payment. Groups can earn 5% of the bonus based on their performance against 32 care measures in an office based setting, and the remaining 5% based on another 32 care measures of inpatient hospital care. Shared savings incentives are paid retrospectively on top of the quality incentives, if the AQC business partner is able to beat the performance of those Blue Cross business partners who are not in the network. When 100% of the Blue Cross network of providers is covered by an AQC, business partners will need to beat the performance of the network as a whole to earn shared savings.
- Blue Cross designed the AQC on a risk-sharing as well as on a full-risk basis, but only one provider signed a full-risk agreement. Providers are generally making use of Blue Cross' in-house utilization review capabilities because of the scale opportunities.
- All providers are also required to carry reinsurance for high cost cases where spending exceeds a threshold set by Blue Cross, generally covering 70-90 percent of the cost above this limit. Finally, there is a "unit cost corridor" which either increases or decreases the global budget if Blue Cross negotiates higher or lower fees with hospitals or physicians during the course of the agreement than initially projected. Blue Cross has also included a contract provision which allows AQC budgets to be increased in the event of unforeseen future trends which have a negative impact on all HMO business.



## Discussion

According to Blue Cross, the new contract has been well received by the providers, noting that “finally, we have created a vehicle that is getting very good traction,” on the concept of population based payments. The first year learning experience on the AQC was generally positive, and the second year experience is nearly complete. Drawing on its first year experience, BCBSMA has indicated that “improvements in quality were greater than any one-year change seen previously in our provider network.”

During 2009, Blue Cross paid significant quality incentives to all AQC participants, and every contracting organization showed significant improvements in the clinical quality measurements, including several dozen different clinical and outcome indicators. During 2010, one large multi-specialty group in a risk sharing contract with Blue Cross reported their physicians were experiencing approximately a \$25 per member per month surplus on their annual contract and stood to earn an additional \$15 per member per month incentive bonus on top of that. “We’re actually doing much better than we thought we would at this point,” said a Blue Cross executive. “The cost and quality improvement under the AQC is far better than for non-AQC participants. It does look as if this payment system is a better mousetrap than fee-for-service. The global payment budget is the trick.”

“We are still in the early days of the AQC,” said one Blue Cross executive, “but the uptake on the plan is better than planned, and we now have more providers who want to join than we can accommodate.”

In 2010, all AQC business partners met or beat their budget targets, at least partly because of a liberal 7% inflation rate baked into their budgets. However, at the end of the five year AQC contract, Blue Cross anticipates that it will have slowed the growth rates for the HMO patients to approximately 3% to 4%, and that this should make premium increases for employers more predictable. The inflation rates in the AQC budget decrease annually so shared savings will get harder to earn. The AQC goal is to reduce the annual cost growth trends by at least 50%, with global budget targets trending downward toward the CPI.

For many AQC providers, the greatest opportunity for earning shared savings incentives appear to be coming from reducing “leakage” outside of their provider networks, not from cutting costs. “We’re earning our entire bonus just by reducing leakage,” said one executive. Blue Cross and providers appear to agree that the best opportunity for shared savings bonuses will come if physicians are able to establish stronger connections with patients and redirect a greater portion of their care to appropriate network settings.

Providers really don’t want to accept 100% of the risk involved in shared savings and Blue Cross doesn’t want them to have open ended risk either. “We have learned most providers don’t want full risk arrangements,” said a Blue Cross executive. “If providers accept 100% of the risk and get all of the savings, then they would come under the State Insurance regulations and would have to qualify as insurance companies. We don’t want to have any agreement which will call into question what the insurance company really is.”

Blue Cross is moving more slowly on expanding the AQC to PPO patients because of the need to develop a stable method of attributing patients to a primary care physician. Unlike the HMO, PPO members are not required to select a primary care physician. Blue Cross does not have the depth of information on PPO patients that they do on HMO patients, and therefore, it is more difficult to coordinate care and manage treatment protocols for chronic conditions. Patient attribution has not been a major issue in the AQC contract since HMO patients are already assigned a primary care physician under their plan. PPO patients are not treated any differently by their physicians than HMO patients, but there is a significant difference in the data available to physicians on PPO patients. "Physicians can't intervene as much because they don't have the same information on PPO patients as they have on HMO patients," said a Blue Cross executive. "You are able to do different things when you have the data."

Finally, the key factor for success appears to be the quality and commitment of an organization's leadership. Leadership, rather than the organizational structure, model of care delivery, information systems, or sophistication of the delivery system is what counts the most. "We are actually agnostic about the organizational structure since we have contracts with so many different types of organizations," said a Blue Cross executive. "Launching clinical integration, changing from fragmented to coordinated care systems, and establishing initiatives such as medical homes and bundled payments are highly dependent on the effectiveness of leadership."

### Minneapolis TCOC

All of the major health plans and providers in the metropolitan Minneapolis market are now involved in some form of Total Cost of Care contracts. In November 2010, Blue Cross Blue Shield of Minnesota, the state's largest insurer with 2.7 million members, signed TCOC contracts with Allina Hospitals & Clinics, Essentia Health, Fairview Health Services, and Health East, joining HealthPartners and Medica in the TCOC market. HealthPartners was an early leader in payment reform and now has TCOC agreements covering approximately 470,000 of its 800,000 members and 2/3 of its staff and affiliated physicians. The development of the Total Cost of Care contracts has been largely motivated by self-insured employers looking to improve value and quality and to have greater predictability in their rate of premium increases.

- Most TCOC contracts in Minnesota are similar and, like Massachusetts, account for 100% of the cost of care regardless of where it is provided. Physicians, hospitals, and clinics continue to get paid a basic fee-for-service or fee-for-case rate. The TCOC contract is an overlay that provides an incentive bonus for hitting quality targets, and a shared savings incentive if they are able to beat the overall cost trend in the market. However, over the length of the agreement, focus is meant to change from guaranteed rate increases to incentive payments for improvements in quality and for reductions in waste or unnecessary admissions or readmissions. The methodology for determining the TCOC targeted growth is of intense interest to providers since there will be increasing revenues at risk as any excess utilization is driven out of the system.

- With some variations, patients are attributed to providers based on the plurality of visits to primary care visits in the previous year. Medicaid, however, has a different attribution methodology, and CMS has proposed a third.
- The TCOC agreements now cover a majority of the contracted commercial revenue for the major providers, but not for Medicare and Medicaid. The total cost of care payment opportunity, according to providers, is small as a percent of the total contract revenue, but in aggregate, since most of the commercial business is covered, the contracts provide an attractive upside opportunity.
- Providers can share in savings if they beat the rate of increase in the market, generally splitting these savings with the plan or large self insured clients. Payers reported they are in the process of “cutting a check” to pay providers for 2010 performance results, and have indicated that they expect some providers to beat the trend by 2% or so which will be an accomplishment since the medical inflation rate in the Minneapolis market in 2010 was only 2.7%. At the same time, the plans will be sending checks to their self-insured and fully-insured customers who were given a pass on any risk of losses the first year so the TCOC experiment could prove it worked.
- Timeliness of data is reported to be an issue for some providers since there is up to a 12 month lag time in reconciling the books after the year has closed. Part of this is a result of complex claims processing procedures, late claims for major cases, or outsourcing portions of the acuity adjustment process to other data processors. Given the delays in data, most large providers do not have a clear idea how they did in 2010, and many have no immediate plans for how to distribute shared savings to their physicians.
- A portion of the revenue in the contract is withheld in case the providers overspend their estimated budget and they are at risk for any losses up to the amount of the withhold, but unlike Massachusetts, they would not have to pay back losses in excess of the withhold if they overspent their budget. Unlike Massachusetts, no reinsurance is required.
- The contracts primarily focus on PPO business to date, although there is interest in expanding the TCOC concept to include Medicare and Medicaid patients.
- Performance data is reviewed on a quarterly basis with risk adjustments made quarterly as well. The methodology used for projecting the inflation increase is of critical importance since the medical cost increase in the Minneapolis metropolitan area last year was 2.7% as compared to approximately 7.5% in the state as a whole. Some payers are reluctant to ink longer term agreements with the inflation rate so low. Providers are concerned that they not be locked into low

growth rates which could lag the state average as the economy starts to pick up speed.

- While there are separate agreements for hospital and physician care, in addition to the TCOC contract, contract negotiations are synchronized so that all contracts are negotiated together. In addition, payers have provided direct grants to providers over the last three to four years to help them build their medical home infrastructure.

## Discussion

The Minneapolis market is unique since the TCOC concept has been implemented more widely than in other areas of the nation also experimenting with the concept. Self-insured employers have initially pushed the concept on plans rather than having it initiate within the insurance industry as in Massachusetts and Illinois. The Minneapolis experiment has been carried out in a market where there has been generally low medical cost inflation compared to the rest of the nation and where there have been significant quality incentives paid to providers for at least 15 years.

The first Total Cost of Care contract was signed in 2009, and 2010 was the first full year experience for most providers. Given the low rate of health care inflation in the market and the long history of quality measurement, it may be more difficult to be a winner in Minneapolis than less managed markets in the nation.

Providers in the market place seem supportive of the goals of payment reform and longer term collaborative partnership with payers, but wary that the new TCOC approach may simply be the traditional annual contract negotiations in a different guise.

Both the payers and providers are on a relatively steep learning curve. Providers know that TCOC bonus dollars are in addition to their regular revenue stream. Many do not pay bonuses to their salaried physicians so all funds flow to the bottom line. Therefore, providers have tended to focus on the TCOC process rather than the dollars, which seems appropriate. The change in mindset from top line revenue to TCOC may evolve over time, but a lot will depend on the final 2010 results and whether the TCOC model is viable in such a demanding market.

The TCOC experiment in Minneapolis has been designed to have limited downside risk and mainly upside potential. Like Massachusetts, payers report that they are largely agnostic about the organizational structure of groups they contract with, and like Massachusetts, they see the quality of an organization's leadership being the key factor for success in the process.

Most providers foresee a time when they will have a greater portion of their revenue exposed to risk. "I don't think it is going to be a smooth process," said one executive. "I think it is going to be jerky--like an elevator ride going down, but the risk chasm will increase. The key question will be when you jump to capitation, but for now, we are focusing on the process and not the dollars. The payers are learning as much as we are, and we have so much to learn."

## Chicago TCOC

Advocate Physician Partners (APP) and Blue Cross Blue Shield of Illinois (Blue Cross) signed Total Cost of Care “shared incentive” contracts covering approximately 200,000 Blue Cross PPO patients in January 2011 for a three year contract term. APP’s Blue Cross HMO business will be folded into the contract in future years. APP is a non-profit physician driven organization separate from the Advocate Health System representing more than 3,900 employed and independent physicians, which serve a population of more than one million people in the Western Chicago suburbs, and which managed over \$1 billion in health care payments in 2010. APP and the Advocate Health System are the largest provider systems in Illinois, and Blue Cross is the largest health care insurance company in Illinois.

APP and Blue Cross have had a long term partnership in payment reform moving from pure fee-for-service based on volume to fee-for-value contracts which increasingly compensate based on outcomes and shared savings incentives. The TCOC contract will be an overlay on the traditional types of contracts for hospital and physician services that APP has been in for many years. Under the new contract, APP will be responsible for the Total Cost of Care per member per year with the exception of transplant services and pharmacy benefit management services not provided by Blue Cross. Out of network care accounts for 50% of the total care expenditures for the patients attributed to the TCOC contract which reflects the experience of the Minneapolis and Massachusetts experiments.

Patients will attribute to primary care physicians based on jointly agreed criteria—generally utilization patterns and a plurality of visits--developed with Blue Cross. The trend (increase) in the cost of care for members per year (risk adjusted) attributed to APP will be tracked and compared to the (risk adjusted) cost of care trend per member for the rest of the market which is not managed. To the extent that APP is able to manage its patients better than the non-managed portion of the market, Advocate has an arrangement with Blue Cross for sharing the savings. The contract also contains provisions that include both upside and downside risk protection for both parties, and a year-end reconciliation of final results.

In addition to the shared incentives agreement, APP has an agreement with Blue Cross and other providers which provides incentive payments to APP physicians for meeting certain quality targets. Blue Cross has also provided funding for APP’s IT infrastructure which allows APP to compare both health outcomes for its patients as well as the financial efficiency and productivity of its physicians. To succeed with the TCOC contracts, APP will need to be able to monitor parts of the continuum of care which they were not previously responsible for, such as skilled nursing care and care provided by specialists at downtown medical centers. APP has acquired new information systems which will allow it to identify gaps in its network, determine what the care patterns are outside the network, and where the dollars are spent. Under the Advocate Care Model supported by the contract, APP will be adding dedicated care managers to its primary care physician offices duplicating many of the features of the medical home.

## Discussion

APP is probably as well prepared as any organization to make the mindset change from top line revenue focus to a population health focus required for TCOC payment reform to succeed. They have been leaders in clinical integration and have been intellectual thought leaders on the subject for several years.

APP has proven executive leadership, strong information technology capabilities, and is well financed. Its medical staff is well organized and respected. It has a cooperative working relationship with Blue Cross, the largest payer in Illinois. In addition, APP has been successful--distributing over \$51 million to its 3,900 physicians on performance payments for meeting quality targets and for the extra work required to make clinical integration work.

APP is also in a strong market position since it has the ability to deal with its entire medical staff in the Advocate Health System--both employed physicians and independent practitioners. Provider systems in other markets frequently are only able to deal with their employed physicians and lack the comprehensive care management capabilities APP developed to meet the needs of the Chicagoland market.

APP is entering uncharted territory, however, as it tries to manage the out of network care. Approximately a third of commercial PPO business is generally in obstetrics and maternity services, and downtown Chicago medical centers are a major draw for this service, as are specialty programs in cancer and cardiology. APP may be able to earn its savings incentive simply by reducing out of network "leakage" as is the case in Massachusetts. Reduction in hospitalizations and re-hospitalizations will reduce volume in the Advocate Hospitals, so APP will also need to focus on new programs which build patient loyalty and satisfaction as well as efforts to reduce admission splitting among specialists. Payment reform is a market issue in Illinois.

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