Tufts Health Plan — Full-Risk, Capitated Model in Commercial HMO

Key Results: The plan has 86 percent of its Massachusetts Commercial HMO network participating in an alternative payment model, and 29 percent of its network participating in full-risk capitation in which providers adopt 100 percent risk above and below a negotiated per-member per-month budget amount.

Tufts Health Plan's risk model functions as an initial fee-for-service payment that is then reconciled with an annual global budget. Tufts Health Plan works with providers to set an annual budget target based on prior claims, which is adjusted for illness severity and other relevant factors. The plan examines unit cost, case mix and utilization rates. The measures that are used include but are not limited to: cost and utilization, referral patterns, practice patterns, quality and total medical expenses.

If the annual total cost of care is less than the agreed upon annual budget target, the provider will receive a significant percentage of the surplus. If the total cost is more than the budget target, the provider will pay Tufts Health Plan a significant percentage of the deficit. For example, if a group had a budget of $400 per-member per-month (PMPM) and actually spent $405 PMPM, a 100 percent risk group would pay Tufts Health Plan $5 PMPM. A 50 percent risk group would pay Tufts Health Plan only $2.50. On the flip side, a clinical team in the 50 percent risk group would receive a smaller bonus if it achieved savings.

For its commercially insured customers, Tufts Health Plan typically has a direct relationship with a care network that includes primary care physicians, specialists and hospitals. Hospitals, specialists and primary care physicians are viewed in aggregate when negotiating the contract with the delivery group. While the contracted group is typically an organized integrated delivery network that includes hospitals and primary care and specialty physicians, the physicians may or may not be employed by the network. Some contracted groups consist only of physicians without a hospital. The contracted risk arrangement with Tufts Health Plan is held by the integrated delivery network, and it is up to that network to decide how to allocate risk among its members although Tufts Health Plan provides some guidelines.

Throughout the year, Tufts Health Plan identifies those specific measures with which provider groups struggle and uses resources to help them improve. The plan aims to pay for improvement, not just continued performance. It writes contracts so that more money is put into improving operations rather than simply protecting against maintaining status quo.

Early results indicate lower total medical expense trend for physician groups paid under this model than the fee-for-service model. Under these contract arrangements, providers are more engaged in reporting and analytics related to managing overall cost and quality of care.

Tufts Health Plan has seen positive change in provider referral patterns for contracts with alternative payment models, including moving care to lower-cost settings.

As a result of its work, the plan has 86 percent of its Massachusetts Commercial HMO network participating in an alternative payment model and 29 percent of its network participating in full-risk capitation in which providers adopt 100 percent risk above and below a negotiated per-member per-month budget amount.