Introduction

In its 2013 report, Moving Beyond Fee-for-Service, the Alliance of Community Health Plans (ACHP) addressed the increasing awareness that the current physician payment system is not adequate to meet the demand for affordable cost combined with high-quality care. It recommended physician payment reform begin in primary care, with specific attention to the infrastructure needed to coordinate care and share accountability for health outcomes and total cost across a diverse patient population. As primary care practices evolve, specialty care payment reforms can be developed.

This issue brief builds on those recommendations and examines how community health plans are designing value-based alternative payment models. It highlights specific, replicable strategies that are designed to reduce the total cost of care and improve health by rewarding providers for quality and specific health outcomes, such as improved management of diabetes or high blood pressure.

These strategies for creating value-based payments come from ACHP members, community-based, non-profit, high-performing plans with extensive experience in innovative payment and delivery models. They are universal best practices and not dependent on whether a health plan is integrated with a delivery system or contracts with outside providers.

ACHP recommends these critical strategies for successful implementation of alternative payment models:

1. Introduce increasing levels of risk gradually, regularly assessing for provider and practice readiness and investing in care management capabilities.
2. Tailor measures to the performance improvement goals of physician practices.
3. Develop actionable performance data, to include patient satisfaction and clinical outcomes measures, and initiate frequent payer-provider engagement to drive improvement and share best practices.
4. Provide cost and quality information at the individual clinician level and, when possible, ensure that payment incentives go to both practices and individuals.

This brief provides examples from ACHP plans for each of the four strategies. Select case studies are included to provide detailed information on new payment models that are reducing costs while maintaining commitment to high-quality care. These strategies are critical for sustaining momentum toward value-based payment and staving off the perverse incentives of fee-for-service payment models, which reward quantity over quality.

ACHP members’ payment models show savings

» In 2014, CDPHP realized a $17.11 per-member per-month reduction in the total cost of care, resulting in an overall cost reduction of 2.9 percent, or $20.7 million. These savings were accomplished while increasing payments to primary care providers by $10 million.

» After Independent Health implemented a payment model with a large urology group in which the group took full risk for all drug spending, utilization of unnecessary testosterone drugs dropped 17 percent for commercial members and more than 15 percent for Medicare Advantage beneficiaries. The provider group is projected to earn roughly $1 million in shared savings this year, and the plan will reduce costs after spending $8 million per year on testosterone drugs prior to the program.

» Tufts Health Plan has 86 percent of its Massachusetts Commercial HMO network participating in a value-based alternative payment model and 29 percent of its network participating in full-risk capitation in which providers adopt 100 percent risk for a negotiated per-member-per-month budget amount.
STRATEGY ONE: Introduce increasing levels of risk gradually and incrementally.

In the fee-for-service model payers bear the financial risk. Providers have an incentive to render a high volume of care, and the government or health plans bear the financial weight. Alternative payment models, in contrast, ask the clinical care teams to share in the responsibility of delivering high-value health care, which in some cases involves taking on financial risk. For practices to succeed, this transition to shared risk between payer and provider must be undertaken incrementally, with significant investment in care management.

**Tufts Health Plan** in Watertown, Massachusetts, introduces risk along a spectrum and individually evaluates provider groups at each step to assess their readiness to assume more risk. The plan does not have a uniform timeline for progression, instead tailoring a path for each provider group depending on its abilities, needs and culture.

To conceptualize the transition, Tufts Health Plan developed a spectrum that envisions the transfer of risk as a step-by-step process from fee-for-service toward full provider risk. (Fig. 1)

At present, 86 percent of practices contracting with Tufts Health Plan are paid through some form of alternative payment model, with 29 percent in a full-risk, capitated arrangement. Currently these arrangements are only for commercially-insured members seen by these providers.

Depending on the practice structure, Tufts Health Plan found that it takes a practice a minimum of two to three years to move from fee-for-service to some degree of risk sharing, and at least five years to move to a full-risk, capitated payment. The process may not be linear and some return to a version of fee-for-service with shared savings, but no risk, may occur. A group’s willingness to change is essential to success and strong physician leadership that recognizes the fee-for-service status quo is no longer acceptable is often the deciding factor to accelerate change.

Understanding that no provider group or hospital will progress along the shared risk continuum in the same manner, **Group Health Cooperative** in Seattle attempts to customize the approach, meeting groups where they are in terms of readiness, clinical leadership, reporting infrastructure and total cost of care alignment. The goal is to enable success and build capacity and capability in the groups. Group Health’s general approach always starts with population-based quality of care metrics such as the

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**Figure 1: Tufts Health Plan Value-Based Global Payment Strategy**

- **Fee-for-Service Methods**
  - Providers are paid when they provide a unit of service
- **Pay-for-Performance**
  - Providers are paid by fee-for-service, with a portion of reimbursement tied to efficiency and/or quality performance
- **Shared Savings**
  - Providers are paid on a fee-for-service basis, but providers and payers shared in the gains of achieving a lower cost than target
- **Budget Risk Share**
  - Providers share upside and downside risk with the payer
- **Full-Risk / Capitation**
  - Providers adopt 100 percent risk above and below a negotiated per member-per month budget
Rewarding High Quality: Practical Models for Value-Based Physician Payment

Healthcare Effectiveness Data and Information Set (HEDIS) diabetes management bundle, the medication adherence bundle and screening tests, among others. Starting with quality gets leaders to the table and creates early and deep engagement.

The process of developing quality targets for individual performance involves evaluating current capabilities, past performance, structure, culture and market dynamics. The highest performers often have less room for immediate improvement, and Group Health recognizes and rewards incremental improvement. As the chart below illustrates, providers are ranked on a scale from A-D; rewards are paid out based on both high performance and effort. For example, providers with an ‘A’ ranking have a score (the degree to which they have met quality measures) higher than 80 percent and are therefore eligible for larger bonus payments. With lower-performing groups (such as Groups C and D in Figure 2), Group Health identifies a set of easily attainable clinical targets to generate early and immediate improvement and build momentum before moving to more complicated transformation.

To encourage physician groups to assume more risk, payers can award money to practices to provide care management services. Priority Health in Grand Rapids, Michigan, includes a care management fee as part of the pay-for-performance element of its model so practices can create a care management infrastructure.

Priority Health developed a performance payout that represents roughly 15 percent of a primary care provider’s total compensation. It is divided into three parts: bonuses based on quality performance, bonuses based on patient experience measures and payment for care management in medical homes. While the care management payment is earned by delivering care management services such as working with high-risk patients recently discharged from the hospital to prevent readmissions, providers are free to use the money as they choose, including paying for technology or other infrastructure. Care management payments also ensure the practice receives reimbursement for time spent delivering services that would not be billable under fee-for-service.

A practice can earn a small care management payment for meeting patient-centered medical home criteria, but can earn three times more if it meets criteria for care management services. In Priority Health’s program, those practices that employ and integrate care managers and use risk stratification to identify high-risk patients are supplied with a list of at-risk members. This list allows the clinical care team to easily target members who would most benefit from care management services.

Figure 2: Group Health Cooperative’s Quality Incentive Program Payment Model

<table>
<thead>
<tr>
<th>Overall Quality Rating Ranking</th>
<th>Performance Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on prior year’s year-end overall HEDIS quality rating</td>
<td>Based on % of total HEDIS care gaps closed during current measurement year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Quality Rating Ranking</th>
<th>Performance Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 0% Improvement gets no payment</td>
<td>0% to &lt; 9% Improvement gets 40% of PMPM</td>
</tr>
<tr>
<td>A – Score ≥ 80% PMPM subject to ranking multiplier of 1.1</td>
<td>= 1.5 x 40% of PMPM</td>
</tr>
<tr>
<td>B – Score ≥ 71% and ≤ 80% PMPM subject to ranking multiplier of 1.1</td>
<td>= 1.1 x 40% of PMPM</td>
</tr>
<tr>
<td>C – Score ≥ 61% and ≤ 70% PMPM not subject to ranking multiplier</td>
<td>= 0.8 x 40% of PMPM</td>
</tr>
<tr>
<td>D – Score ≤ 61% PMPM subject to ranking multiplier of 0.8</td>
<td>= 0.8 x 40% of PMPM</td>
</tr>
</tbody>
</table>

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STRATEGY TWO: Tailor measures to the performance improvement goals of physician practices.

Understanding what constitutes quality and how it is rewarded requires a set of measures that reflect desired outcomes such as fewer hospital readmissions or heart attacks. However, the volume and type of quality measures used vary from market to market.

Given the many payers in its market, Security Health Plan in Marshfield, Wisconsin, employs the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System and HEDIS measures. Using the same measure set as the federal government enables providers to more easily accept alternative payments from a variety of plans in the region, without placing an undue administrative burden on the practice.

UPMC Health Plan in Pittsburgh, Pennsylvania, took a different approach as its market has only two major payers and the plan has an affiliated delivery system. Because high numbers of health plan enrollees are cared for within the UPMC delivery system, plan leaders decided to collaborate directly with providers to develop measures reflecting the needs of payers, providers and patients and best drive value-based payment models.

During joint goal setting with the plan and provider groups, physicians expressed their preference for measures that relate to a patient’s health status, rather than measures that track whether a particular test was performed, for example. UPMC works with provider groups to customize health outcomes measures after a practice has demonstrated its ability to improve care on process measures and patient flow. For example, for one practice, the plan abandoned diabetes measures that indicated a patient received the correct exam and instead instituted measures on blood pressure outcomes and HbA1c control rates, as this more appropriately identifies true quality of care at the patient and population levels. Customized measures like this were developed over a series of meetings, with frequent communication about values and goals. This has led to increased provider satisfaction with value-based payment as clinical teams feel they helped develop the new model.

New law promotes value-based payment in Medicare

» Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 to fundamentally change how Medicare pays for physician services.

» The Centers for Medicare and Medicaid Services is transitioning to value-based alternative payment models, using the Health Care Payment Learning and Action Network to identify best practices and effective strategies.

» Physicians moving away from fee-for-service payment will be rewarded either through a Merit-Based Incentive Payment System or participation in alternative payment models.

» New regulations will guide the reformed physician payment system starting in 2019.
STRATEGY THREE: Develop actionable performance data and engage providers in understanding the data so they can improve patient care.

Data are valuable only if actionable. Performance data — which include quality, cost and patient experience — should highlight clear improvement targets and a path for achieving them. Health plans are essential in this process. Many ACHP plans hold regular meetings with physician practices to jointly review data, identify opportunities for improvement — often down to the individual physician level — and share best practices.

HealthPartners in Minneapolis, Minnesota, describes itself to physicians as a “hands-on organization” during the development and evolution of practices to value-based care. The plan meets with all members of the care team regularly as they transform to the value-based model. HealthPartners focuses on helping provider groups envision success and demonstrates in a detailed way how value-based care can be a financially viable model for providers.

Providers frequently report that while other payers offer data, it is often not shared in a usable way. HealthPartners develops quarterly reports customized to each practice. Because provider groups differ in their data analytics capabilities, HealthPartners developed a tool endorsed by the National Quality Forum to examine performance on individual patient and population-based measures such as hospital admissions and readmissions, orders for high-tech radiology and emergency department visits. The detailed reports enable clinicians to clearly identify areas for improvement.

HealthPartners holds quarterly in-person meetings with each provider group to analyze reports and help them decide on specific strategies for improvement. Leaders from the plan ensure that the conversation addresses cost, quality, patient experience and strategies for improvement. Plan leaders meet with providers in person, which also allows plan leaders to understand the differences among practices and tailor the move toward value-based payment to each practice’s culture and capabilities.

Capital District Physicians’ Health Plan (CDPHP) in Albany, New York, made infrastructure investments for transformation in order to build the capability to coach physician practices. CDPHP invested in resources such as a performance management department and additional analytics experts to support practices in the program. This support includes:

» Engagement and training to achieve a cultural shift across organizational boundaries, to create a more collaborative, patient-centered approach.

» Coaching and support of primary care practices to achieve NCQA Level 3 Patient-Centered Medical Home recognition, a critical milestone in New York for practices to receive value-based payments.

» Engagement with practices to help them identify and promote opportunities and provide assistance with the clinical integration of care management.

Experience has shown that practices, overwhelmed with day-to-day operations, often do not take the initiative to access the performance data. To address this, CDPHP proactively provides them with the reports and highlights recommendations for specific areas of focus, such as lowering number of visits to the emergency room or improving medication adherence. Together, CDPHP and the practice use the data to develop detailed goals for improvement.

UPMC Health Plan uses the expertise of its entire physician network to ensure that best practices are shared quickly. In addition to monthly reports that include financial and quality data, the plan organizes quarterly meetings with 21 physician groups in which leaders from each of the groups share specific examples of care improvements they have made, allowing innovation to spread rapidly throughout the Pittsburgh region.
STRATEGY FOUR: Target payment and quality data to individual providers in addition to practices.

It is important to strive for a system in which clinicians are rewarded at the individual rather than the practice level. If they are not, it is possible that while a large physician group or hospital may be paid under a newer value-based approach, the individual providers will still be reimbursed on a fee-for-service basis. Targeting payment to individual providers rewards the highest performers and creates a culture in which everyone in the organization is invested in delivering the highest-quality care.

Security Health Plan is working with physician practices to ensure rewards reach individuals who demonstrate improvement in care delivery. Starting in 2010, the plan implemented a Medicare Advantage pay-for-performance program designed to control the cost of care while simultaneously creating incentives for quality improvement. However, it did not achieve the hoped-for results. Part of the challenge was that money went to clinics but did not make its way to individual physicians.

Security’s redesigned model still uses quality performance, based on CMS star ratings, to determine the percentage of total savings received by providers. If a group receives a 4.5 star rating, the savings are split evenly between Security Health Plan and the providers. A 5-star group receives 60 percent of savings and a 4-star group receives 40 percent. However, the key change was in providing payment to the individual physician. The provider organization has agreed that it will distribute a greater portion of the shared savings pool to the highest performers. Care teams understand that payment is coming from Security Health Plan and is based on how they compare to peers, and that opportunities exist for individual quality improvement and financial gain. Advanced-practice nurses and other non-physician staff receive a portion of the pool savings as well, in recognition of the importance they hold in achieving quality and cost goals.
Conclusion

The growing adoption of value-based alternative payment models is a key ingredient in transformation of health care delivery. This transformation can draw on the experience of successful health plans and providers, such as those reported in this brief, to inform payment and policy decisions. For these models to be successful, ACHP has identified four core requirements:

» Incrementally introducing increased levels of risk,
» Developing customized and actionable measure sets,
» Engaging providers and developing physician leadership and
» Targeting payment to the individual level of providers as well as at the practice level.

Payment reform that truly changes the trajectory of health care costs in the U.S. depends on broad national policy that can be tailored to the unique needs and structures of local communities. We hope that the recommendations and examples provided in this brief can serve as important catalysts for change at both levels in the coming years.

Case Studies

Highlighted are detailed examples from four ACHP plans that have moved toward value-based, efficient, high-quality care. Three of the plans adopting alternative payment models (CDPHP, Tufts Health Plan and Independent Health) have a contracted network of physicians, and one (Presbyterian Health Plan) has an affiliated delivery system.
Independent Health — Full-Risk, Capitated Payment Model for Specialty Pharmaceuticals

**Key Results: Utilization of unnecessary testosterone drugs has dropped 17 percent for enrollees in commercial coverage and more than 15 percent for Medicare Advantage beneficiaries. The provider group is projected to earn roughly $1 million in shared savings this year, and Independent Health will reduce costs after spending $8 million per year on testosterone drugs prior to the program.**

To address the rising cost of pharmaceuticals, Independent Health in Buffalo, New York, developed a payment model with a large urology provider group in which the plan accepts a budget-negotiated savings upfront and the provider group is fully at-risk for all annual spending on drugs.

When examining its pharmacy costs, Independent Health's analytics team saw that the average cost of testosterone drugs was increasing 8–15 percent per year, and utilization rates were growing 10–15 percent per year, likely as a result of television advertising.

Leaders from Independent Health initiated a discussion with the urology provider group to address the issue. The two made a commitment to reduce utilization rates to clinically appropriate levels and mitigate the rising spending on these drugs, while finding a financially viable solution for both organizations.

In initial conversations, it was evident that clinicians were unaware of the high and varying costs of testosterone drugs. A study on prescribing patterns revealed that between injectable testosterone treatments that cost $1 per day and topical treatments that cost $12 per day, topical treatments accounted for 90 percent of utilization. The disproportionate and unnecessary use of topical drugs was due to doctors granting patient requests for the topical treatments.

To address these trends, in January 2015 Independent Health instituted a prior-authorization program for testosterone drugs coupled with a shared savings agreement between the plan and the provider group.

For the model, Independent Health collected data on testosterone drug utilization and costs, and made an initial 10 percent reduction based on what it determined the normal prescribing rate would be without advertising. The plan then applied what it called a "management impact adjustment" in the form of a 25 percent reduction to those calculated numbers to guarantee savings to the plan. This final number is given to the provider group as its target budget for testosterone drug spending.

Based on this reduction, Independent Health realizes its savings at the beginning of the year and then pays the provider group a capitated per-member per-month sum based on market share and risk adjustments. The provider group assumes full risk, and if it is able to stay under the target budget, it gets 100 percent of the earned savings for those members. The providers were willing to take full risk because they felt the opportunity was so significant.

For the second year of the program, Independent Health will calculate 50 percent of the savings it made in the first year of the program and use that calculation as the second year upfront savings to the plan. The remaining total will be set as the budget for the second year. The process will repeat for the third year of the agreement, after which Independent Health and the provider group will examine next steps.
The prior authorization program was created to be similar to step therapy. Prescribing physicians have to prove failure of the other two types of treatment before they can prescribe the most expensive testosterone drug. Clinicians gave significant input on the prior authorization guidelines, and it was decided that as the provider group is fully at-risk, its own clinicians should review and steer prescription requests internally.

For the second year of the program, Independent Health will calculate 50 percent of the savings it made in the first year of the program and use that calculation as the second year upfront savings to the plan.

There are also formularies in place to encourage members to seek lower-cost testosterone drugs when appropriate. The low-cost injectable testosterone therapy is typically a preferred first-tier drug that comes with small, if any, copayment, while the topical drugs are either completely off the formulary or designated as a third-tier drug with the highest copay.

Prior to the start of the program, primary care doctors — rather than urologists — were writing a large portion of the testosterone prescriptions. The prior authorization process has led to a significant decrease in inappropriate prescriptions without a corresponding increase in specialty visits.

With prior authorization, utilization of testosterone drugs has dropped 17 percent. Although the program applies only to commercial patients, Medicare Advantage utilization rates have dropped 15.2 percent due to providers’ increased awareness about efficient and appropriate prescribing patterns.

A review of performance data through August 2015 shows overall testosterone costs are now down to $2 per day. The provider group is projected to earn roughly $1 million in shared savings this year, and Independent Health will reduce spending by several million dollars after spending $8 million per year on testosterone drugs prior to the program.

Quality metrics for testosterone-related treatment are also 6 percent higher than the market average. 🌟
Presbyterian Health Plan — Medicaid Multi-Specialty Sub-Capitation Model

Key Results: Presbyterian Health Plan in Albuquerque, New Mexico, has achieved a 30 percent reduction in Medicaid outpatient pharmacy costs and significant savings from emergency department diversion.

In 2015, Presbyterian Health Plan instituted a Medicaid multi-specialty payment model for primary care and multi-specialty groups that have invested in care management infrastructure and demonstrate the ability to improve performance. The model allows both upside and downside risk and has an actuarially determined capitated medical budget.

Presbyterian Medical Services — the provider group affiliated with Presbyterian Health Plan — receives a monthly capitated payment for Medicaid members. Using 2013 and 2014 Medicaid membership and claims data, Presbyterian Health Plan developed models to measure medical costs for fee-for-service claims. This information was used to define covered services that are included in the capitated payment and the projected per-member per-month costs for those services.

The annual capitated payments are calculated from prior-year fee-for-service claims data and then reduced by a percentage so that the plan can lower its spending, on a per capita basis, in the subsequent year.

The primary performance measures examine outpatient pharmacy costs, emergency department visits and emergency department costs. Additional performance measures are in place to ensure that the payment model does not cause access and quality to deteriorate. These include value of services for members, timely submission of encounters, hospitalization rates, complaint and grievance data and emergency department visits by people with significant behavioral health needs.

The two main avenues of savings for the plan are lowering drug costs and decreasing emergency department use. To ensure savings for both the plan and providers, pharmacy costs are designated as a component of medical costs. Presbyterian Health Plan then reduces the capitated payment for outpatient pharmacy costs by 30 percent and allows providers to retain the difference between the set pharmacy budget and the actual year-end drug costs. Emergency department diversion savings are calculated against the prior year’s usage and split equally between the plan and providers.

During a provider’s first year in the program, the plan institutes risk corridors so that losses or gains are within two percent of what would have been earned under fee-for-service. This ensures that a practice’s revenue will not undergo dramatic upheaval in the early years. The level of financial risk and reward grows over a five-year process and culminates in 100 percent shared risk.
CDPHP — Enhanced Primary Care Capitation and Quality Bonus Program

Key Results: In 2014, CDPHP realized a $17.11 per-member per-month (PMPM) reduction in the total cost of care, resulting in an overall cost reduction of 2.9 percent, or $20.7 million. These savings were accomplished despite increasing payments to primary care doctors by $10 million (average of $10 per-member per-month premium over fee-for-service equivalent).

The CDPHP Enhanced Primary Care program moves primary care doctors from a fee-for-service payment model to a risk-adjusted global payment with the addition of a 20 percent bonus opportunity based on success in the goals of the Triple Aim. These two payment structures combine to give physicians the opportunity to increase their earning potential by an average of 40 percent. Now in its seventh year, the program includes 193 network practices, 836 network clinicians and more than 250,000 CDPHP members (more than 50 percent of total enrolment).

CDPHP predicts payments to primary care physicians based on diagnoses its members receive from all sites of care, including primary care, hospitals and specialists. This unique risk adjustment factor drives specific prospective monthly global payment for Commercial HMO, Commercial non-HMO, Medicaid and Medicare primary care patients. The plan continues to use fee-for-service payment for a small set of services that are outside of the capitation code list, such as immunizations and skin biopsies.

Cost or efficiency is assessed using a risk-adjusted relative utilization of health care resources in six categories: inpatient hospital, emergency room, medical imaging, pharmacy, laboratory and specialists. CDPHP uses a risk-adjusted total cost of care assessment that creates an index of practice performance compared to the other practices in the network. The practice is then assigned a rank of its efficiency performance, which creates an efficiency score.

Quality is assessed using HEDIS metrics or composites in four categories: population health and prevention, management of chronic conditions, use of antibiotics and behavioral health, as well as an experience of care composite of ten patient experience questions. CDPHP creates an aggregate quality score by creating a ratio of the sum of the numerators to the sum of the denominators in these measures. This aggregate quality score is then assigned a percentile rank, which creates an effectiveness score.

The risk-adjusted global payment for primary care services is more than 80 percent of payments that primary care practices receive, and accounts for the vast majority of codes for which CDPHP reimburses.

Figure 3 compares a traditional fee-for-service model against the current Enhanced Primary Care model, demonstrating how primary care physicians in the program can earn up to 40 percent more.

CDPHP provided primary care group practices with a year-long transformation that began with leadership and cultural assessments. Four learning collaboratives facilitated the sharing of best practices among provider groups and provided additional education. Practices undergoing transformation were each given a $20,000 stipend to support their time away from the practice. At the end of the transformation program they became eligible for the enhanced payment model.

Additionally, CDPHP provided substantial financial support for practices to acquire electronic health record systems, establish connections to the local health information exchange and achieve meaningful use designation.
Under this global model of payment the actual rate of visits for healthy members decreased as physicians found alternate ways of providing necessary care, such as telehealth or group visits. At the same time, the rate of visits went up for those with the greatest need — those covered by Medicaid and Medicare and the sickest 10 percent of the population.

Money was saved despite increasing payments to primary care teams by $10 million. Savings came largely from drug utilization management, outpatient services and the sickest members having a greater level of engagement with lower-cost primary care than more expensive specialty services.

Figure 4 demonstrates cost savings by line of business and severity of condition. The sickest 50 percent to 10 percent of patients with commercial insurance account for approximately 49 percent of the cost reduction. The sickest 10 percent with insurance through Medicaid and Medicare account for approximately 20 percent of the cost reduction. The shaded cells indicate statistical significance.
CASE STUDY

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.