Total Medical Expense (TME) Contracts

Harvard Medical Faculty Physicians (HMFP)/Beth Israel Deaconess Physicians Organization (BIDPO)

Value based purchasers will drive the move to TME model

- BCBSMA – Alternative Quality Contract (AQC), 2011-2014
- Tufts – 2011-2013, very similar to BCBS
- HPHC – moving to TME contract for 2012
- Medicare - Pioneer ACO application—now in Round 2
- Medicaid – Commonwealth moving toward TME contracts

Structure of TME Contracts

- Includes all medical expenses (including inpatient, drugs, DME, etc.), with shared savings if below target budget and shared losses if above target budget as per contract.
- Budget is based on actual expenses and experience from 2009 (AQC) or 2010 (Tufts), trended forward by the MA Eastern Network Trend and *adjusted for patient illness burden.*
  - *HCC (Hierarchical Condition Categories) DxCG version*
- Quality scores determine % of surplus shared
- Deficits shared
  - AQC: 50/50 BIDPO and BCBS; HMO Referral & PPO tied to AQC results
  - Tufts: 50-65% over three years; BIDMC and BIDPO share risk and surplus. Negotiated rate increases on HMO & non-HMO (POS & PPO)
  - HPHC: final negotiations in play; likely no downside risk

Document and Code to the Highest Acuity Level Appropriate for Every Encounter

- Acuity level of patient population (based on ICD-9 codes) directly influences our budget and is calculated on a calendar year basis.
- Some ICD-9 codes acuity adjust, and others do not.
- Oncology is one of highest yield specialties for acuity adjustment.
- Acuity can actually make or break our budget and, as a result, determine success or failure in the TME contracting game.
- Coding in both the outpatient *and* inpatient settings influences this.

Accountable Care Organizations

- BIDPO applied for Pioneer ACO program & selected for Round 2 consideration
- Structure of program
  - TME model
  - *Prospective* patient/member attribution
  - Three year minimum program, additional two year option
  - Upside opportunity 60-70%; then population based payment
- BIDMC and affiliates not initially part of application due to CMS requirements but may be added if BIDPO is selected to participate

Other CMS programs

- Bundled payment program: 4 models
  - Inpatient Stay Hospital , Physicians and Re-admissions
  - Inpatient Hospital Services only
  - Inpatient Stay plus post discharge/post acute services
  - Post acute/discharge services only
- Caution—different infrastructure requirements than TME and less role for PCP

Early Lessons and Take Aways

- Site of Service payment differentials come under intense attack esp. in Lab and Imaging
- Engage the PCPs as leaders
- Not equal pain—more blood is drawn from hospital (avoidable ED, I/P, Readmits, etc)
- Care Management Resources should not be embedded in PCP offices due to “mission creep” phenomenon
- Retain genuine expert advisors
- Need to cultivate health plan buy-in
- Ability to impact TME affords financial and competitive leverage
- Value Based Purchasing is here to stay—prepare to lead or become a high value vendor of choice