MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts
The Alternative QUALITY Contract

February 2008

The Genesis

Last January, Blue Cross Blue Shield of Massachusetts CEO Cleve Killingsworth challenged the company to examine how our method of paying hospitals and physicians could be transformed to better support the high quality care we all know our system is capable of delivering. Currently, Blue Cross and most other health plans base payments principally on the number of services provided, and the complexity of each service. For example, surgical and specialty care is rewarded more than primary care, and hospitals receive higher reimbursement when they perform more tests and procedures. As Karen Davis, president of the Commonwealth Fund, has written, "Fee-for-service payments create incentives to provide more and more services, even when there may be better, lower-cost ways to treat a condition…It's not realistic to tell hospitals and doctors that they must improve quality if by doing so they are likely to lose money."

What Cleve asked us to create was a system that would instead base payment on quality, outcomes, safety and efficiency – did the patient get the best result from the most appropriate treatment (e.g. based on the best medical evidence) by the right kind of provider (e.g. specialist, family doctor, nurse) at the right time (as early in the illness as possible).

A team of physicians, finance experts, and measurement scientists worked for months to develop a model that would give hospitals and physicians meaningful incentives to improve quality and safety of care while conserving health resources. We also continuously tested the concept through many conversations with key hospital and physician leaders, local and national policy experts, employers and health care purchasers.

The result: a new, innovative optional Alternative Quality Contract (AQC) that combines two forms of payment: a global or fixed payment per patient adjusted for the health of patients, and annual increases in line with inflation, and substantial performance incentives tied to the latest nationally accepted measures of quality, effectiveness, and patient experience of care.

This new contract model is an important component of BCBSMA's overall ongoing strategy to align payment reform, performance measurement, provider and member incentives, and increased transparency of cost and quality information to achieve our twin goals of improving the quality AND affordability of health care for our members, providers and employers.

The Model

Global Payment. BCBSMA will pay providers a global payment to cover all of the services and costs – inpatient, outpatient, pharmacy, behavioral health, etc - associated with each of their BCBSMA patients. The payment will be based on the average medical expense for members in the provider's geographic region, adjusted for the age, sex and health status of the provider's specific BCBSMA patients. The payment will be adjusted annually for inflation.

Providers will be expected to focus on and carefully manage both the quality and cost of services that their BCBSMA patients require, coordinating the integration of their patients' care across the full continuum of health care services.

The global payment is intended to empower physicians and hospitals to provide the care that they believe is needed to improve the health of their patients. They will be liberated from many of the constraints of traditional payment models so that they can more easily, for example, have e-mail exchanges with patients (e-visits), offer group visits for patients who share a common chronic illness, or provide follow-up home visits for patients after hospitalizations. In addition, they will be able to retain the funding associated with any efficiencies they achieve through innovations in care delivery and have the ability to re-invest those savings into continued care and system improvements.

The Alternative Quality Contract differs from capitation models of the past in several ways.

- The global payment is coupled with a sophisticated yet straightforward set of performance measures through which BCBSMA and providers can ensure that patients are receiving safe, appropriate and effective care. This coupling of payment with performance measures safeguards against undertreatment by documenting and holding providers accountable for both the delivery of appropriate services and the health outcomes associated with those services. Public reporting of physician and hospital performance, which is in development in Massachusetts, will further strengthen that level of accountability.

- One of the major criticisms of historical capitation models was that they were not funded adequately. In the Alternative Quality Contract, the global budget is based on actual regional costs and is health status adjusted so that providers are paid a rate that adequately considers the relative morbidity of their patients. The budget is also adjusted annually, in line with inflation. In addition, the contract is intended for providers with a sufficient number of BCBSMA numbers to support an adequate distribution of risk.

The Model

Global Payment, continued

- The Alternative Quality Contract includes a global payment for all services received by a BCBSMA member, including primary, specialty, and hospital care, as well as ancillary, behavioral health, and pharmacy services. Therefore when, for example, a physician spends extra time with a patient and helps that patient avoid an unnecessary hospitalization, the patient not only receives better care (as will be measured by the performance indicators), but the overall costs are less. The physicians and hospitals participating in the AQC are jointly accountable for the total quality and costs associated with each BCBSMA member covered by the contract and therefore do not have any incentives to withhold necessary care.

Performance Incentives. BCBSMA will also offer providers performance incentives on top of their global payment that have the potential of significantly increasing their total payment. These incentives are intended to support providers in achieving the highest levels of safe, affordable, effective, patient-centered care. They are linked to clinical performance measures that include process, outcome and patient care experience; and will encompass inpatient and ambulatory care (See attached list). We have chosen measures that are drawn from nationally accepted measure sets, are broadly accepted as measuring care that is recognized as clinically important, and are grounded in empirical evidence that they provide stable and reliable information at the level at which they are reported (for example, by individual physician, group practice, or institution).

The Alternative Quality Contract performance framework is based on thresholds ("gates" 1-5) with the following attributes:

- Gate 1 represents performance considered to be deserving of some additional financial recognition, typically scores at approximately the median of current statewide performance. Gate 5 is rewarded more generously as it represents the outer limit of what is possible for an institution or practice to achieve on a given measure, based on empirical analysis of local and national datasets.

- The use of gates establishes rewards for both absolute performance and for performance improvement

- The use of gates affords "transparency" to providers regarding the full scope of BCBSMA performance priorities and expectations

- The level of performance incentive payment that a provider receives is based on their aggregate performance across the full set of ambulatory and hospital performance measures. For example, if a provider had an aggregate score at the Gate 1 level, they might receive a 2% performance incentive payout; at the Gate 3 level, a 5% payout; and if their aggregate performance were at the Gate 5 level, they might receive a 10% payout.

The Benefits

We believe that there are significant benefits to this new optional Alternative Quality Contract for our members, providers, and accounts.

Members will ultimately receive safer, higher quality and more effective care. With increased transparency about health care quality and costs, members will be able to choose providers who deliver the highest quality care at cost effective rates. Through member incentives and alternative benefit plan designs, which we are currently developing, they will also become better educated health care consumers and more empowered to make the best decisions about their care.

Providers will be rewarded for their delivery of high-quality care, efficient management of services, and demonstrated improvements in patient health. We believe that this contract model will accelerate provider initiatives already underway to improve safety and performance and will liberate whole care teams to spend more time with patients and offer innovative services. We expect that the Alternative Quality Contract will give these providers a competitive advantage in the marketplace, by offering a value proposition that promotes the delivery of high quality care at efficient costs.

Employers will benefit as this new system moderates cost increases through the delivery of better care and results in more predictable and affordable premium increases, in line with the rate of inflation. We believe this new contract can cut in half the current medical cost trend, which has been rising at rates up to 12% annually. As the quality and efficiency of care is increased, we also believe that that our accounts will realize the benefits of a healthier and more productive workforce.

Current Status

Several provider organizations are about to enter the first phase of this new optional approach and, within a year, will be fully participating in the Alternative Quality Contract. There are other organizations with whom we have initiated discussions, and we anticipate that, over the next few years, at least 15-20 percent of our network will ultimately find this contract attractive and consistent with their business and organizational strategies.

We at BCBSMA are committed to working with others to achieve the kind of health care system we all want – one that provides safe, timely, effective, affordable and patient-centered care for all. We believe payment reform that shifts the focus from the volume and intensity of services delivered to the quality outcomes of those services, as does our new optional Alternative Quality Contract, is fundamental to achieving that vision.

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Clinical Process and Outcome Measures included in the Alternative Quality Contract

Ambulatory Care Measures

Clinical Process Measures
Depression
Optimal Contacts
Acute Phase Rx
Continuation Phase Rx
Diabetes
HbA1c Testing (2X)
Eye Exams
Nephropathy Screening
Cholesterol Management
Diabetes LDL-C Screening
Cardiovascular LDL-C Screening
Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Colorectal Cancer Screening
Preventive Screening/Treatment
Chlamydia Screening
Ages 16-20
Ages 21-25
Pedi: Testing/Treatment
Upper Respiratory Infection (URI)
Pharyngitis
Pedi: Well-visits
< 15 months
3-6 Years
Adolescent Well Care Visits
Clinical Outcomes Measures
Diabetes
HbA1c in Poor Control
LDL-C Control (<100mg)
Hypertension
Controlling High Blood Pressure
Cardiovascular Disease
LDL-C Control (<100mg)
Patient Experiences (C/G CAHPS/ACES) - Adult
Communication Quality
Knowledge of Patients
Integration of Care
Access to Care
Patient Experiences (C/G CAHPS/ACES) - Pediatric
Communication Quality
Knowledge of Patients
Integration of Care
Access to Care

Hospital Measures

Clinical Process Measures
AMI
ACE/ARB for LVSD
Smoking Cessation
Aspirin at arrival
Aspirin at discharge
Beta Blocker at arrival
Beta Blocker at discharge
PCI Within 90 Minutes **
Fibrinolytic Medication Within 30 Minutes **
Heart Failure
ACE LVSD
Discharge instructions
LVS function Evaluation
Smoking Cessation
Pneumonia
Antibiotic selection
Antibiotics w/in 4 hrs
Blood culture
Oxygen assessment
Flu Vaccine
Smoking Cessation
Pneumococcal Vaccination
Surgical Infection
Antibiotic received
Received Appropriate Preventive Antibiotic(s)
Antibiotic discontinued
Clinical Outcomes Measures
In-Hospital Mortality - Overall
Wound Infection
Select Infections due to Medical Care
AMI after Major Surgery
Pneumonia after Major Surgery
PE/DVT after Major Surgery
Birth Trauma - injury to neonate
Patient Experiences (HCAHPS)
Nursing communication
MD communication
Responsiveness
Discharge planning

** Reporting Only