



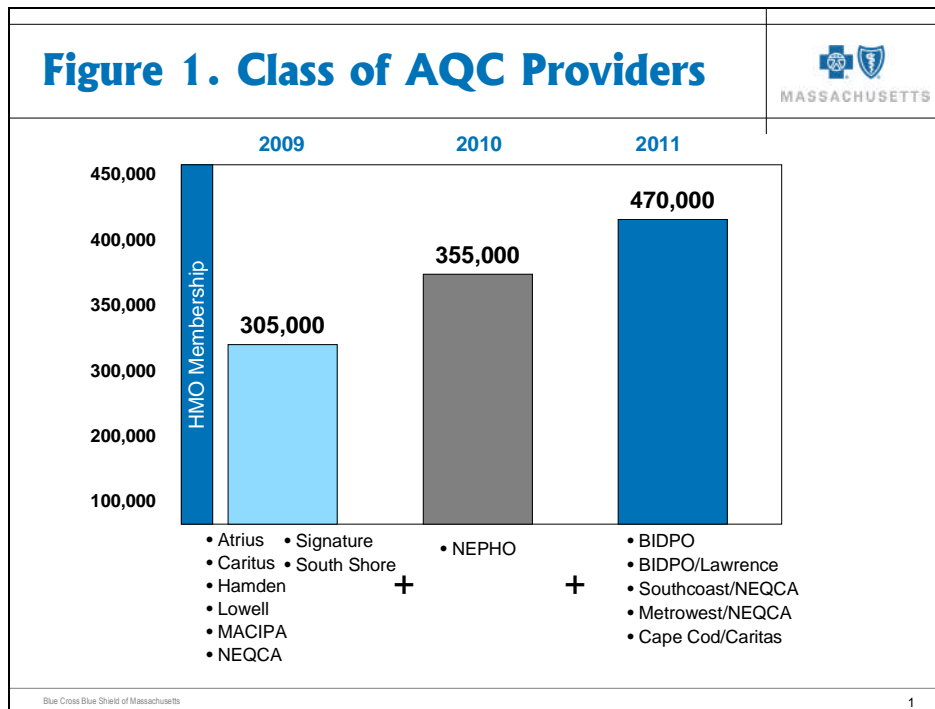
# Blue Cross Blue Shield of Massachusetts The Alternative QUALITY Contract: Year One Results

## Introduction

In an effort to moderate the unsustainable rate of increase in health care costs and improve the quality of patient care and health outcomes, Blue Cross Blue Shield of Massachusetts (BCBSMA) introduced in 2009 a new provider payment model called the *Alternative Quality Contract* (AQC). Hospitals and physicians who enter into the AQC agree to take responsibility for the full continuum of care received by their patients — including the cost and quality of care — regardless of where the care is provided. The new contract model combines a per-patient global budget with significant performance incentives based on nationally endorsed quality measures over a five year period. In speaking directly about the AQC model, Stuart Altman, a Professor of Health Policy at Brandeis’ Heller School for Social Policy and Management, and colleagues recently said, “global payment has the greatest potential for encouraging shifts in health care resource use from low-value to high-value services.”<sup>1</sup> The AQC model is premised on the belief that fundamental change in payment is required to move from a system whose incentives have been largely about increasing the *quantity* of services to a system whose incentives are focused on the *quality and value* of services provided. Over the past two years, the number of AQC groups – physicians and hospitals – has grown significantly (Figure 1). Early results of the AQC provide compelling evidence that establishing provider accountability for health care quality, outcomes and costs by changing the payment model can stimulate significant improvements in all three areas.

---

<sup>1</sup> RE Mechanic and S Altman, “Payment Reform Options: Episode Payment is a Good Place to Start,” *Health Affairs* 28, no. 2 (2009): w262–w271.



Although the AQC and its global budget has some likeness to fixed payment or capitation models of the past, the AQC specifically addresses the most important limitations of historical capitation programs. In particular, the AQC incorporates significant financial incentives that encourage physicians and hospitals to meet high standards on a broad set of quality and outcome measures. Earlier efforts at fixed payments did not include such incentives – largely because the measures did not yet exist. In addition, starting budgets for organizations in the AQC are based specifically on each organization’s historical rate of spending for its patient population and adjusted for changes in that population throughout the contract term. In contrast, previous fixed payment models set budgets based on regional norms or averages, and did not account for differences in resources required for physicians caring for sicker or needier patients. AQC contracts are generally five-year agreements in contrast to national and historical norms for one-year fixed payment arrangements. The five-year AQC time period enables physicians and hospitals to plan for use of health care services over the life of the contract. Finally, the AQC put in place several features to mitigate financial risk for the groups, including a requirement that all groups carry reinsurance for high cost cases (i.e., covers 70 to 90 percent of cost if medical expenditures exceed a threshold, such as \$100,000), flexibility in the AQC model with respect to the degree of financial risk

sharing assumed by the provider organization and a “unit cost corridor” that adjusts AQC budgets if BCBSMA negotiates significantly higher (or lower) fees with network providers than originally projected.

Another distinguishing feature of the AQC is the ongoing data and information support provided by BCBSMA to the AQC groups. The broad set of data and reports provided – some daily, others monthly, quarterly, biannually and annually – is designed to support physicians’ success at managing to both the quality and efficiency incentives of the AQC model.

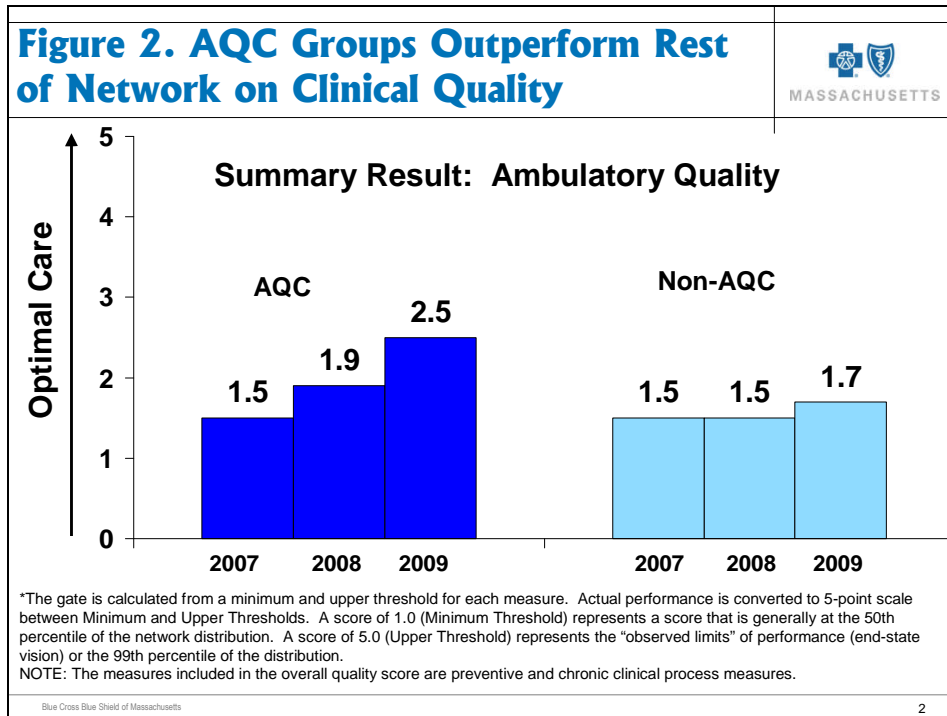
### **First Year Findings: 2009**

#### *Improving Patient Care*

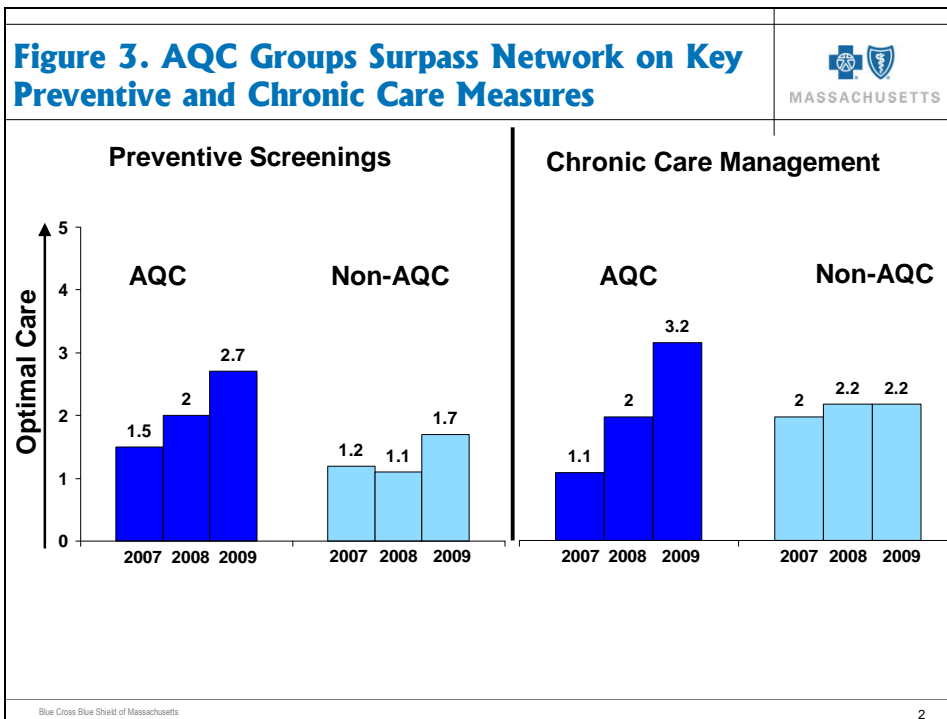
In the first year of the AQC, the improvements in the quality of patient care were greater than any one-year change seen previously in our provider network – well exceeding both the rates of improvement on quality measures that AQC groups were achieving prior to the contract, and exceeding rates of improvement among non-AQC physicians (Figure 2). The figure shows initial improvements among AQC groups in 2008 owing to the fact that early adopters of the AQC began work on the contract’s quality measures in that year, while the majority of the initial groups began in 2009.

It is important to note that despite the fact that the AQC groups vary with respect to geography, size, management structure and experience with taking on risk for patient care, each and every AQC organization was successful in managing the global budget and significantly improving quality and clinical outcomes. The range of organizational models in the AQC includes multi-specialty integrated groups, independent practice associations, and several physician-hospital organizations, in which a physician group contracts with a particular hospital. Although all AQC physicians are part of some organizational structure that contracts on their behalf, about twelve percent of participating physicians are in one- or two-physician practices. For these more distributed practices, qualitative feedback indicates that the role of the organizational leadership has been critical to their success. In fact, some of the most significant quality improvements come from the more loosely-affiliated, smaller provider organizations in the AQC.

AQC groups also made significant improvements on hospital quality in year-one, including improvements on a broad set of clinical quality and patient experience measures. All hospitals in our network participate in a program called Hospital Performance Incentive Program (HPIP), which offers hospitals financial rewards for performance on a set of measures nearly identical to those used in the AQC.



Within the BCBSMA network, physicians that are part of an AQC group performed much better than those outside of an AQC arrangement on important measures of preventive care, like cancer screenings and well-baby care, as well as measures of chronic disease care (Figure 3). Physician performance on these measures is important for patients because it means that their doctors are providing evidence-based primary care throughout the year – including the appropriate preventive care and chronic disease management.

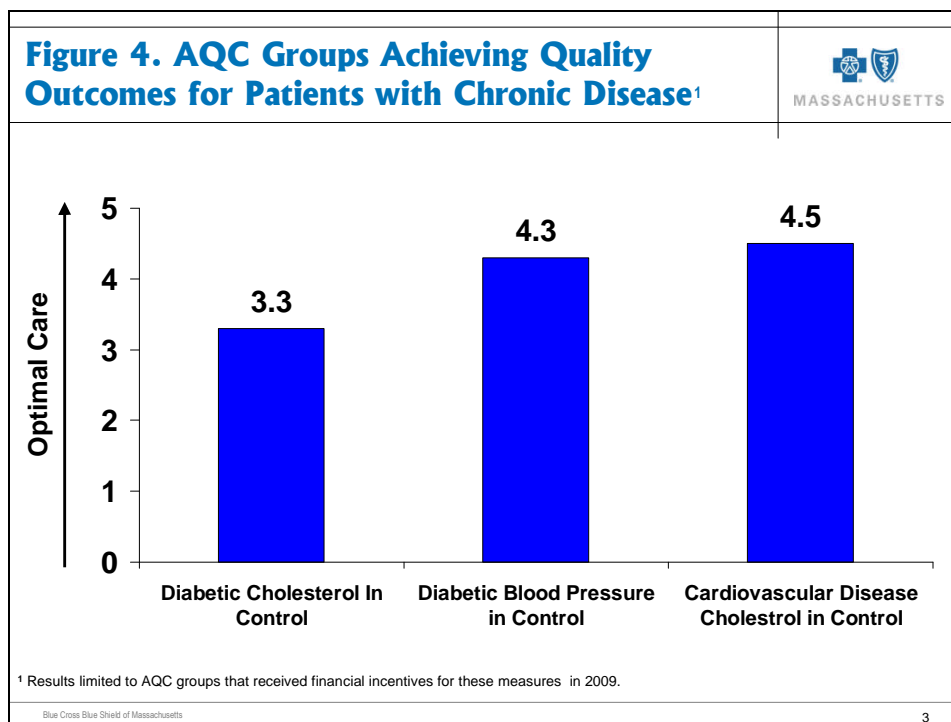


With respect to preventive care, the rate of improvement in AQC groups’ performance on certain “process measures” was *three times* that of non-AQC physicians — and more than twice the AQC groups’ own improvement rates prior to the contract. “Process measures” assess the appropriate use of tests or procedures in accordance with clinical guidelines.

For chronic diseases such as diabetes and cardiovascular disease, among the most costly and prevalent chronic care conditions, the AQC groups’ rate of improvement on screening and monitoring measures far exceeded those of physicians not in an AQC contract. In year one of the contract, AQC organizations made gains on these measures at a rate *more than four-times* what they had been accomplishing before the contract. Importantly, AQC physicians serving a large segment of socioeconomically disadvantaged patients were equally successful as those serving more advantaged groups with respect to achieving high levels of performance in both preventive and chronic care quality.

AQC groups also achieved remarkably high performance on clinical outcome measures — that is, effectively managing a patient’s chronic conditions to ensure that he or she is stable. In fact, for several of the clinical outcome measures, performance among AQC groups who worked on these measures in year one is approaching or has reached

the highest levels of quality believed to be attainable for a patient population (Figure 4). In contrast to process measures, outcome measures are clinical results, such as control of blood pressure, blood sugar, or cholesterol, which indicate that a patient’s chronic condition like diabetes or cardiovascular disease is well-managed. Achieving high performance on these measures requires physicians to engage with patients in a way that extends well beyond the bounds of the office visit. This is because success on these measures requires patients to both understand and be diligent about managing their condition on a day-to-day basis – including ongoing attention to dietary restrictions, medication use, and physical activity. Thus, to achieve high performance on clinical outcome measures, physicians must be providing truly patient-centered care – engaging patients in a way that affords the clinician detailed insight and information about a patient’s daily life, the day-to-day realities that will pose barriers, disrupt motivation, or make adherence difficult. Year one results on these clinical outcome measures demonstrate that the AQC physicians are indeed rising to the challenge of accountability for these results that occur *after* the patient leaves the office visit.



Performance on preventive and chronic care quality measures are important markers of value for all stakeholders in the health care system: patients, doctors, health plans and employers. Routine cancer screenings, such as mammograms and colonoscopies, and

preventive measures such as immunizations and well care visits are relatively low cost and have been shown in major national studies to have important implications for avoiding long-term costs to the health care system and improving patient care through early detection and treatment. In recognition of this important evidence, the Patient Protection and Accountable Care Act (PPACA) stipulates that these preventive services be provided through insurance with no out-of-pocket cost to patients. Further, substantial evidence reveals the importance of the right care for chronic diseases, such as diabetes, hypertension and cardiovascular disease, which are highly prevalent among U.S adults and for which careful management can keep conditions under good control and prevent disabling and costly complications over time. The AQC first year results offer promise that provider organizations – given the right incentives, information, data and leadership – can quickly accomplish significant improvements in patient care and outcomes while at the same time reducing the growth in health care costs.

#### *Moderating Health Care Costs*

The AQC is on track to achieve its original goal of reducing annual health care cost trends by one-half over the five years of the AQC contracts while continuously improving quality. At the same time, all AQC groups met their budgets in the first year, producing surpluses that enable them to invest in important infrastructure and other improvements, such as care managers and electronic data sharing between physicians and the hospital. Infrastructure investments will help provider organizations deliver care more effectively and efficiently. The AQC has already positively impacted two major health care cost drivers — hospital readmissions and the use of emergency rooms (ER) for non-emergent care. For example, the AQC groups improved their hospital readmission rates more than the non-AQC groups, a decrease equivalent to \$1.8 million in avoided readmission costs for the AQC groups. For the rest of the network, readmission rates increased over the past year. With regard to non-emergent ER use — one AQC group has reduced their non-emergency ER visits by 22 percent over the past year, which translates into \$300,000 in avoided ER costs.

Since the AQC's global budget is set at the outset of the agreement for a five year period and participating physicians and hospitals accept accountability for reducing the

annual rate of increase in costs, the model importantly brings both predictability and stability to annual health care cost increases, a significant benefit to the purchasers of health care, including consumers, employers and government.

### **AQC implications for State and National Reform Efforts**

The provider organizations participating in the AQC exemplify the concept of Accountable Care Organizations (ACO) and Patient Centered Medical Homes (PCMH) as envisioned by the Patient Protection and Affordable Care Act of 2010 (PPACA) and the recommendations of Massachusetts' Special Commission on Health Care Payment System in 2009. In fact, Elliott Fisher, Director of the Center for Health Policy Research at Dartmouth University, who is generally credited with developing the concept of an ACO, recently wrote that the AQC is using a set of quality measures and global budgets directly in line with his vision for ACOs.<sup>2</sup> The AQC model also embraces the concept of a PMCH in its emphasis on the primacy of the personal physician; integration of care; quality and safety; enhanced access; and payment reform. The PPACA promotes the experimentation of delivery system and payment reforms, such as ACOs and PCMHs, through Medicare demonstrations and payment reform policies, Medicaid program options for states, as well as the Center for Innovation at the Centers for Medicare and Medicaid Services (CMS). The Special Commission recommended that all health plans, both public and private, move to a global budget payment system to encourage the development of ACOs like the AQC groups.

For federal and state policymakers, the findings from the first year of the AQC hold several important lessons. Among these is evidence that improvements in both health care quality and spending are achievable through a payment model that establishes provider accountability for quality, outcomes and costs. Additionally, the demonstrated success of provider organizations that varied widely in size, scope, and composition – some with a hospital, others without; most comprised of many small and solo practices united through a common leadership – is encouraging and should inform delivery system reform efforts nationally.

---

<sup>2</sup> ED Fisher and SM Shortell, "Accountable Care Organizations: Accountable for What, to Whom and How," JAMA 2010; 304(15):1715-1716.

## **Conclusion**

The AQC was designed to address the twin goals of improving the quality and outcomes of patient care while significantly slowing the rate of growth in health care spending. In year one, significant progress was made toward achieving both goals. The AQC's success is attributable to four primary factors: 1) the quality measures contained in the contract are nationally accepted as clinically appropriate so there is wide support for improving performance on these indicators; 2) real dollars are at stake for improvement; 3) performance data is made available regularly which enables provider organizations to track progress and take action to better manage their patients' health; and 4) the participating provider groups have strong support from their leadership to implement new systems and act on the data. Based on the year one results, the AQC shows significant promise for contributing to health care delivery system reforms that will lead to long-term sustainability and improved patient care and health.