



# Massachusetts Payment Reform Model: Results and Lessons

In 2009, Blue Cross Blue Shield of Massachusetts introduced a payment reform model called the Alternative Quality Contract (AQC). The AQC employs a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. The twin goals of the AQC are to significantly reduce health care spending growth while improving quality and health outcomes. The AQC is one of the largest commercial payment reform initiatives in the United States and includes over three-quarters of Blue Cross Blue Shield of Massachusetts' overall network of contracted primary care providers and specialists who care for about 665,000 HMO members as of October 2012. Results of the AQC to date, including those from a formal evaluation conducted by Harvard Medical School researchers as well as the more qualitative experiences of the health plan and its provider network, suggest several important lessons for future payment reform.

Since 2009, Blue Cross Blue Shield of Massachusetts has engaged an increasing share of the physicians and hospitals in its network in a payment reform model called the Alternative Quality Contract (AQC). The AQC model combines a global budget for a patient population with significant performance incentives based on nationally accepted quality measures (Figure 1). By linking financial incentives to clinical quality, patient outcomes, and overall resource use, the AQC is designed to decrease participating provider groups' spending and cost growth, while producing significant, measurable improvements in quality.

Hospitals and physicians that choose to adopt the AQC agree to take responsibility for the full continuum of care received by their patients—including the cost and quality of that care—regardless of where the care is provided.

The AQC is not prescriptive as to what form the provider organization takes. Some AQC agreements are with physician groups alone, while others include both physicians and hospitals. Currently, the AQC applies only to members with HMO coverage, because the HMO requirement to select a primary care provider allows us to direct payments to the AQC group with which each member's primary care physician is affiliated.

### 1. Global Budget

- Based on historical total medical expenses
- Annual inflation for each year of the five-year contract period is defined up front and designed to continually moderate spending growth

### 2. Efficiency Opportunity

- Budget constraint creates incentive to carefully steward resource use
- Provider organizations share in budget savings and share risk for budget deficits

### 3. Quality Performance Incentive

- Based on a broad set of nationally accepted, validated measures of ambulatory and hospital care
- Range of performance targets on each measure reward “good to great” performance

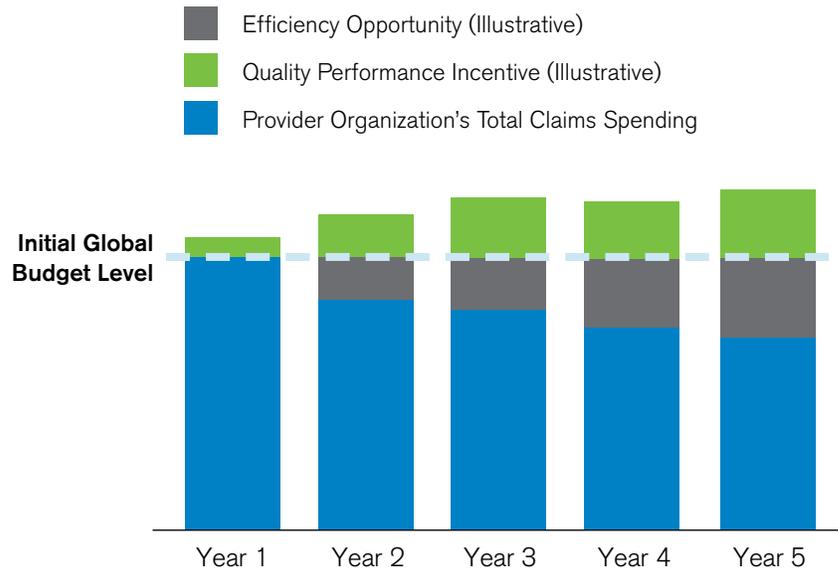


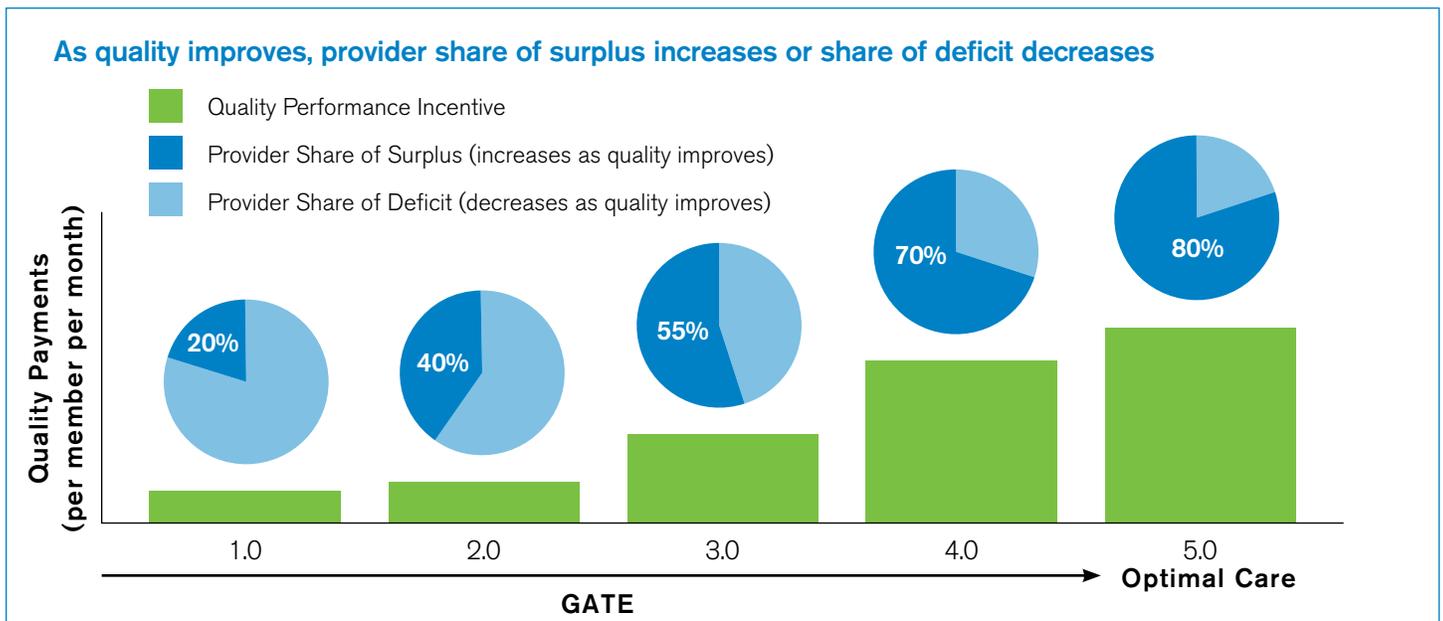
Figure 1. AQC Model

### The AQC at a glance

There are several core elements that are part of every AQC agreement:

- **A global budget:** An AQC group’s budget applies to all medical expenses for its population of HMO Blue® members, including primary care, specialty care, hospital care, ancillary services, behavioral health, and pharmacy expenses. The budget is health-status adjusted to minimize the effects of adverse selection (for example, if a group has a large percentage of chronically ill patients, its budget will reflect the higher cost of caring for this population). Annual inflation targets are established for each of the five years of the contract and are tied to the regional network average.
- **Quality performance incentives:** A group can earn substantial additional revenue based on how well it performs against a broad set of nationally accepted, validated measures of clinical quality, outcomes, and patient experience. For each measure, a range of targets signifying good to great performance creates the incentive for continuous improvement over the five-year contract period.

- **Efficiency incentives:** At the end of each contract year, the total claims expense incurred for the AQC group’s patient population is reconciled against the group’s global budget to determine its surplus or deficit. The group’s share of the surplus or deficit depends on its performance on the quality measure set (Figure 2).
- **Data, reports, and performance improvement support:** Blue Cross Blue Shield of Massachusetts provides each AQC group with a wide range of data and reports to support the group’s success in managing its budget and improving quality and outcomes. Some data are provided daily, others monthly, quarterly, or twice a year. Blue Cross Blue Shield of Massachusetts meets regularly with each group to review performance data and discuss improvement goals and strategies; it also regularly convenes groups for educational and best-practice sharing forums.



**Figure 2. Updated AQC Model Earning Potential**

*Early results show improvements in quality, coupled with a lower cost trend*

In 2009, the first year of the AQC, participating groups made unprecedented improvements in the quality of patient care—greater than any previous one-year change measured in the Blue Cross Blue Shield of Massachusetts provider network. Every AQC organization showed significant improvements in clinical quality, including several dozen process and outcomes measures. In 2010, provider groups that joined the AQC in 2009 continued to improve quality and outcomes—while groups that joined in 2010 made significant quality improvements in their first year (Figure 3). Participating groups exhibited exceptionally high performance for all clinical outcome measures, with many approaching performance levels believed to be the best achievable for chronic conditions, such as diabetes, heart disease, and hypertension.

Early results also indicate that the AQC is on track to achieve its original goal of reducing annual health care cost growth trends by half over five years.

In 2009, all of the AQC groups met their budgets, producing surpluses that enabled them to invest in infrastructure and other improvements that will help them deliver care more effectively and efficiently. Further, medical spending among AQC groups grew more slowly than in the non-AQC network.

In the second year of the contract, 2010, we saw savings deepen in key areas, such as reduced inpatient admissions, reduced use of high-tech radiology, and use of less costly settings of care.

The initial findings of a longitudinal assessment of AQC results, conducted by Michael Chernew, Ph.D. and his colleagues at Harvard Medical School and supported by the Commonwealth Fund, echo these results. Their year-one findings, published in the *New England Journal of Medicine*,<sup>1</sup> showed that the AQC was associated with significant quality improvement and two percent slower growth in medical spending in 2009.

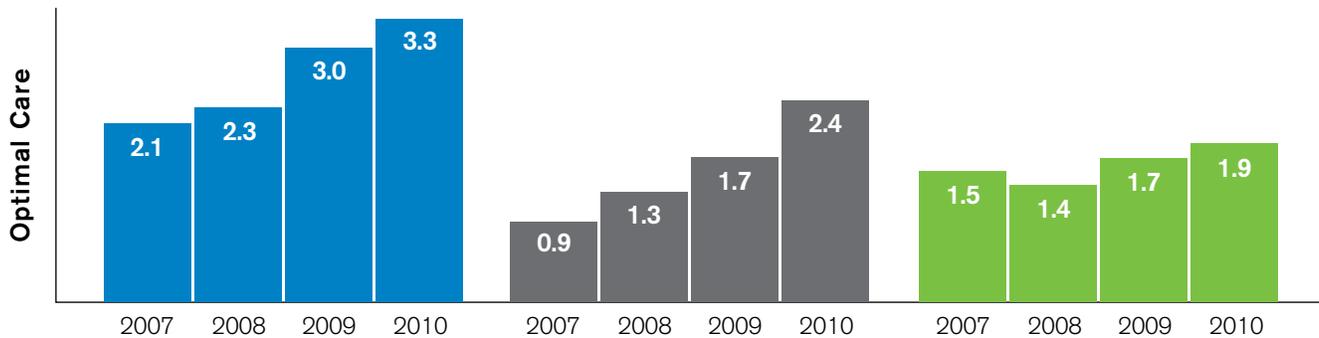
The research team’s analysis of the second year, published in the journal *Health Affairs*,<sup>2</sup> found that the savings among AQC groups in the second year was even greater—3.3 percent higher relative to the rest of the network. The savings were more dramatic among AQC groups that had been paid on a fee-for-service basis before the contract. AQC provider groups in this category achieved a first-year savings of 6.3 percent and second-year savings of almost 10 percent. For 2009 and 2010, the AQC groups were able to reduce spending largely by referring patients to lower-cost facilities for services, such as imaging and lab testing, and by reducing these areas of utilization.

Evidence from interviews of physician leaders, primary care providers, and specialists at all types of AQC groups, large and small, suggests that the global budget model enables sustainable changes in the way groups and individuals practice. Among the most common themes: 1) the AQC’s aligned quality and efficiency incentives create an environment where there is much more communication, coordination, and integration between primary care providers and specialists, and between physician groups and participating hospitals; 2) more attention is paid to quality indicators, transitions of care, preventable complications, and variations in practice

In 2010, the 2009 AQC groups continued to improve quality and outcomes—sometimes approaching “best achievable” performance.

The 2010 AQC groups made significant quality improvements in their first year.

2009 AQC's  
2010 AQC's  
Non-AQC



**Figure 3. Ambulatory Quality**

related to overuse, underuse, or misuse of tests and procedures; 3) extra resources are available to build new infrastructure and information systems; employ more nurses and medical assistants; offer patients extra preventive care, rehabilitation care, and consultation about medication use; 4) and, as one AQC physician leader put it: “Our physicians spend much more time than in the past trying to help patients get their care in the most appropriate setting, and explaining to patients what they want them to do and why.”

Further, since AQC providers are accountable for the cost of all care their patients receive, whether the care is delivered by a provider within the AQC group or not, we are seeing important changes in referral patterns. Primary care providers have an incentive to look for specialists and facilities that provide high quality at a lower cost when sending their patients for testing or a referral, so the AQC has the potential to drive value throughout the delivery system.

### 2011 updates to the AQC model

Blue Cross Blue Shield of Massachusetts is committed to monitoring the progress of the AQC and making adjustments and improvements as needed to achieve the overarching goals of the global budget. Since beginning the contracts in 2009, we have made changes both within and outside the AQC model to better support delivery-system reform.

In 2011, Blue Cross Blue Shield of Massachusetts introduced two modifications to the AQC model based on our experience in the first two years of the contract as well as input from doctors and hospitals:

- **AQC budgets linked to network trend.** The first AQC contracts, launched in 2009, were created with annual budgetary increases defined in absolute terms (a fixed percentage) and designed to grow more slowly over each year of the five-year contract with a goal of having the spending trend approximate general inflation by the fifth year. However, with trends defined in absolute percentage terms, it was necessary to build in protections for environmental factors that were largely outside of a provider group’s control, such as the potential effects of a pandemic, new government-mandated benefits, or fee-schedule increases negotiated by Blue Cross Blue Shield of Massachusetts. We discovered that applying these complex adjustments at the end of the year made it difficult for groups to accurately track how well they were doing against their budgets over the course of the year.

Starting in 2011, new AQC agreements have trend targets tied to the regional average and, in most cases, require the group to outperform the regional trend by a designated amount. Budgetary targets for the full five-year contract are set in advance. By tying the budget to the regional trend, the many environmental factors noted above are already accounted for, eliminating the need for complex year-end adjustments. We believe this new model also has the advantage of allowing groups to better monitor their progress against their budget targets using real-time monthly data provided by Blue Cross Blue Shield of Massachusetts.

- **Accountability for efficiency linked to quality performance.** Starting with the 2011 AQC agreements, a group's share of its annual global budget surplus or deficit depends on how well it performs against the AQC's quality measures (Figure 2). Higher quality scores earn a group a greater share if there is a surplus, or allow it to take on a smaller share of the deficit if one occurs. This updated approach, which links efficiency payments to quality, is designed such that, regardless of whether a group will be in surplus or deficit compared with its global budget, the incentive will drive the highest possible performance on the quality measures. In addition, quality payments are now defined in per-member-per-month terms, rather than as a percent of budget. This has the effect of equalizing the payment that groups receive for achieving a given level of quality.

### The AQC yields valuable lessons for payment reform

The following are some noteworthy lessons from the AQC that could be useful to others planning to design and implement a global budget model:

- **Start with current spending levels.** Since we are asking providers to be accountable for total medical spending, they need to be confident that the amount they are starting with is adequate. Unlike some of the capitation plans that were so soundly rejected in the past, the AQC does not force providers to operate within a reduced initial budget. Instead, we base the global budget's starting point on the amount the group spent for the same population in the prior year. We then build in a rate of increase that declines from year to year and offers substantial performance incentives. To be successful, the group has to use its budgeted dollars more effectively to produce better quality and outcomes, and to slow its rate of spending growth.
- **Data is key to supporting change.** Data and analytic results provided regularly by Blue Cross Blue Shield of Massachusetts have been important to the AQC groups' success in monitoring and improving both financial and quality performance. For example, by sharing daily hospital census information, AQC doctors are notified right away when a patient of theirs is hospitalized and are able to work closely with the hospital to plan for appropriate post-hospital care to improve patient outcomes and reduce readmission rates. Monthly data extracts from Blue Cross Blue Shield of Massachusetts to each provider allow them to have a 360-degree view

of the care their patients are receiving, regardless of where that care is provided—a critical tool for managing the quality and cost of care for their population. Data indicating the quality and practice patterns for individual clinicians within each group, together with patient-level detail about gaps in care and network-wide information for benchmarking best practices, allows for continuous quality improvement.

- **Long-term contracts encourage long-term investment.** With five-year contracts, we have time to forge ongoing partnerships with provider groups rather than returning to the negotiating table every few years, as is typical with most hospitals' and physicians' agreements. The AQC's performance measures and incentives for quality are established at the beginning of the contract and do not change during its term, which encourages providers to invest in long-term, lasting improvement initiatives.
- **Leadership is critical to success.** Successful groups have strong support from their leadership to implement new systems and act on the data. The AQC requires sweeping changes in the culture of most groups, including changes in roles and responsibilities. Physicians have to be able to work in teams with non-physicians (pharmacists, case managers, nurse practitioners, and diabetes educators) who take on increased responsibility for patient contact and clinical decision-making.
- **Payment systems are most effective when aligned with patient incentives.** We have begun to couple the AQC with new health insurance products that create strong incentives for members to choose high-value care, leading them to actively participate in discussions with their health care providers. One example is our Hospital Choice Cost Sharing feature, in which the amount members pay for certain services depends on the hospital and affiliated facilities they choose. These and similar products align member incentives with the physician incentives in the AQC to create stronger support for delivery-system change.

## Looking ahead

As we continue to sign new AQC agreements, Massachusetts providers have a new imperative to help them align their internal operations across all patients and payers. Providers are eager to broaden the set of patients for whom they assume accountability for quality and cost. We are focused on building the AQC in alignment with local and national delivery-system reforms:

- **Accountable care organization (ACO) demonstrations:** We have worked closely with officials from the Centers for Medicare and Medicaid Services (CMS) and Massachusetts' Medicaid program to encourage payment arrangements similar to the AQC. CMS has cited the AQC as a model for its ACO programs, and we encouraged our AQC providers to apply for both pilot ACO programs, Pioneer and Shared Savings. The Pioneer model, in particular, is both analogous to and synergistic with the AQC model. It is a shared-savings global budget tied to quality and patient outcomes. CMS' Center for Innovation named five provider systems in Massachusetts Pioneer ACOs; all five participate in the AQC. Participation in the Pioneer pilot from CMS and the Blue Cross Blue Shield of Massachusetts AQC will allow the provider groups to not only align operationally by having one global budget model, but also to apply strategies and best practices for coordinating care learned in the AQC to the Medicare population.

1. Song, Z., Safran, D. G., Landon, B. E., et al. "Health Care Spending and Quality in Year 1 of the Alternative Quality Contract," *New England Journal of Medicine*, published online July 13, 2011, <http://www.nejm.org/doi/full/10.1056/NEJMsa1101416>.
2. Song, Z., Safran, D. G., Landon, B. E., et al. "The Alternative Quality Contract, Based On A Global Budget, Lowered Medical Spending and Improved Quality," *Health Affairs* 31(8) 2012: 1–10.

## Conclusion

Blue Cross Blue Shield of Massachusetts' experience with the AQC offers valuable lessons for the future of payment reform, both locally and nationally, and for health plans, government, and providers alike.

The AQC offers 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. We look forward to continuing to innovate with our provider organization partners to achieve a high-performance health care system with a sustainable rate of spending growth.

For more information about the Alternative Quality Contract, please contact:

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