Blue Cross Blue Shield of Massachusetts
The Alternative QUALITY Contract

Paying for a health care system that delivers safe, effective, and affordable care

At Blue Cross Blue Cross Blue Shield of Massachusetts, we believe the most promising way to slow rising health care costs is to enable the delivery system to improve the quality, safety and effectiveness of care. To address both cost and quality, we need a health care system in which financial and clinical goals are aligned. A key component is to change the way insurers reimburse doctors and hospitals for their services. BCBSMA has developed and implemented a model: the Alternative Quality Contract (AQC). The new contract model combines a per-patient global budget with significant performance incentives based on quality measures. The AQC places the focus on what matters most to all of health care's stakeholders—quality, value, and patient outcomes.

The Challenge

The rising cost of health care poses an unsustainable burden on consumers, employers and government, and threatens local and national efforts for health care reform. To do our part as a health plan to move toward solutions, BCBSMA is changing the way we pay for health care. The current fee-for-service reimbursement model has created unintended consequences, rewarding doctors and hospitals for the quantity and complexity of services provided instead of rewarding the quality and outcomes of care.

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."

In 2007, the company evaluated how our method of paying hospitals and physicians could be changed to better support the high-quality care the system is capable of delivering. The challenge before BCBSMA was to create a payment system that would align financial goals with clinical goals, linking payment to quality, outcomes and efficiency.

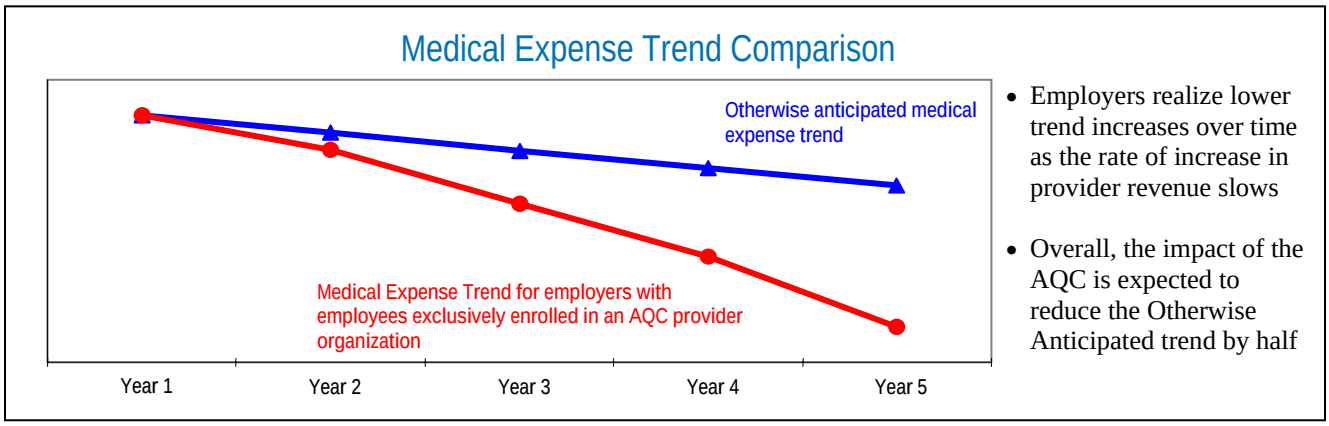
A New Model: The Alternative Quality Contract

A team of physicians, finance experts, and measurement scientists worked to develop a contract model that would give hospitals and physicians meaningful incentives to improve the quality of care while conserving health care resources. BCBSMA tested the concept with key hospital and physician leaders, local and national policy experts, employers, and other health care purchasers throughout the development process, and used that feedback and input to finalize the model.

What resulted is the *Alternative Quality Contract*, an innovative global payment model that uses a budget based methodology, which combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments (tied to the latest nationally accepted measures of quality, effectiveness, and patient experience). The goal of this restructured model is to enable the delivery system to give the patient 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 (when intervention is most appropriate), and in the most appropriate setting (e.g. hospital, physician office, independent laboratory, home).

The AQC was offered to provider organizations on an optional basis, with the first contracts effective January 2009, and is a key element of BCBSMA's overall strategy to align payment methods, performance measurement, and provider and member incentives, while increasing transparency of cost and quality information. With this new model contract in place, BCBSMA continues working toward the goals of improving the quality AND affordability of health care for members, providers, and employers.

The goal of AQC is to reduce the medical expense trend of participating organizations by half over a five-year contract term, as illustrated below.



AQC: The Cornerstones

The Alternative Quality Contract includes several key components that are dependent on each other to create the necessary alignment of incentives:

- Financial structure
- Performance measures
- Sustained partnership (five-year contract)
- Integration across continuum of care
- Savings opportunities.

Financial Structure

Global Budget. BCBSMA establishes a global budget for AQC provider organizations to cover all services and costs. The contract model is designed to include inpatient, outpatient, pharmacy, behavioral health, and other costs and services associated with each of their BCBSMA patients. The initial global budget is based on historical health care cost expenditure levels. It is adjusted each year for inflation, and the health status of the provider's specific BCBSMA patients. Providers retain the margins derived from the reduction of inefficiencies.

This arrangement empowers physicians and hospitals to provide the care they believe is needed to improve the health of their patients. They are liberated from many of the constraints of traditional payment models giving them the flexibility to, 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. This independence from many of the limitations associated with traditional payment models is the foundation of the AQC.

Performance Incentives. In addition to the global budget, BCBSMA also offers providers performance incentives with the potential to increase the total payment by up to 10 percent. It is a key feature of the AQC, designed to promote quality, safety, and patient-centered care. These incentives apply to both physician and hospital services, and are intended to support providers in achieving the highest levels of safe, affordable, effective, patient-centered care. The incentives are linked to clinical performance measures related to process, outcomes, and patient care experience, and include inpatient and ambulatory care (see attached list, page 9). Bonus payments for performance on quality measures serve as disincentive for underuse, which was a key criticism of capitation in the 1990s.

Performance Measures

Performance incentives are linked to an equally important component of the AQC—performance measures, which are meant to collectively make care safe, timely, effective, affordable, and patient-centered. These measures are:

- Drawn from nationally accepted measure sets
- Recognized as clinically important
- Grounded in empirical evidence that demonstrates the measure provides stable and reliable information at the level at which they are reported (for example, by individual physician, group practice, or institution).

The performance incentives are based on absolute performance rather than the network average to provide stable targets and reward improvement. There is also added weighting for clinical outcome measures, such as keeping blood pressure under control, reflecting the importance of improving the actual health of the patients. Performance measures are established at the beginning of the contract and do not change during its term.

An additional feature of the AQC performance incentive model is that it encourages provider organizations to work with us on what we call "developmental measures." This component of AQC represents a unique collaboration between BCBSMA and provider organizations, offering the opportunity to further develop and test new performance measures that can become important to ensuring safe and effective care.

Sustained Partnership

The AQC arrangement is a five-year agreement that encourages providers to invest in long-term, lasting improvement initiatives. It also establishes a new kind of partnership between the health plan and the organization that moves away from the sometimes adversarial relationship, which is focused on ongoing contract negotiations, and toward a more collegial partnership, which is focused on and committed to each other's success. Throughout the five years, providers are expected to focus on and carefully manage both the quality and cost of services their BCBSMA patients require, and to coordinate the integration of their patients' care across the full continuum of health care services.

Integration Across the Continuum of Care

The very essence of the AQC is the important role of the primary care physician (PCP) as the center of a patient's care. By giving PCPs significantly increased flexibility and rewarding them for improved health outcomes, the AQC underscores that principle and encourages the integration and coordination of care for both acute care episodes and for chronic conditions.

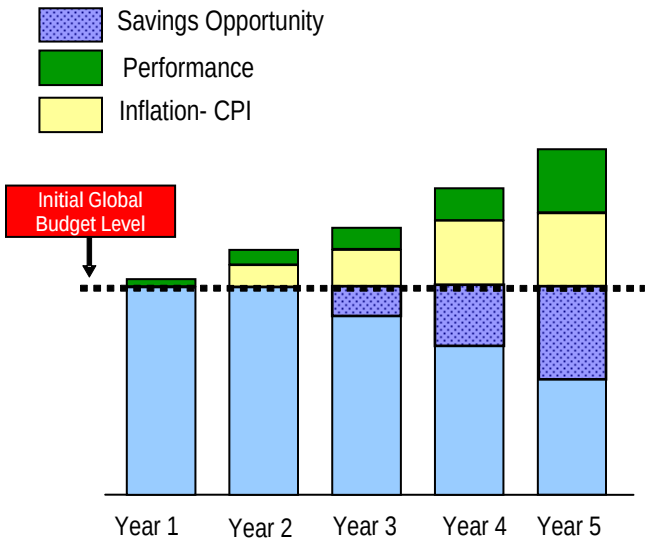
AQC Savings Opportunities

The AQC creates new incentives for providers to drive waste out of the system and focus resources on achieving the highest level of clinical outcomes for their patients by allowing providers to retain savings from the global budget to re-invest in system improvements. Opportunities to achieve savings under the AQC include reduction in duplicative services, use of more cost-effective services and providers, and the elimination of potentially preventable costly services, such as certain hospital complications and readmissions.

Provider Payment Structure

The Financial Structure

- Global budget to cover all health care services
- Performance incentives based on quality and safety metrics
  - Up to 10% above global budget
  - Protection against withholding of needed care
- Savings opportunities by addressing underuse, misuse, and overuse within global budget level
- Inflation factor derived from CPI
  - At controlled and predictable level



AQC: The Basics

Provider Criteria. BCBSMA does not require a specific organizational structure for provider organizations to participate in the AQC. Some AQC contracts are solely with physician groups (PCPs and specialists), while others are with delivery systems that include both physician and hospitals. The AQC provider organization is responsible for the cost and quality of services rendered across a member's entire continuum of care, including services provided in the hospital setting, regardless of whether or not a hospital is part of the AQC arrangement. The provider groups can retain savings if costs go down, and are responsible if costs increase, putting the focus on accountability and potential reward for improvement with the AQC group. In those instances when hospitals and physicians are collectively included in the AQC contract, hospitals and physician groups share accountability. The level of risk can vary by provider group, but within a group, the up-side risk (potential savings) is always equal to the downside risk (potential costs.)

Baseline criteria includes that the participating group must have PCPs who care for at least 5,000 to 10,000 BCBSMA HMO members, depending on the level of risk assumed by the group.

Member Criteria. 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 provider is affiliated. We are exploring ways to expand AQC membership criteria to include PPO members by applying a sound methodology for "attributing" a PCP to each member.

Payment Process. Throughout the term of the AQC, all member claims are reimbursed on a fee-for-service basis. At the end of each year, all of the services and costs, including inpatient, outpatient, pharmacy, behavioral health, and others that are associated with the AQC provider organizations' BCBSMA patients, are then charged against the AQC global budget. This determines the provider organizations' performance relative to the global budget.

Supporting Change

To maximize provider groups' success, we have dedicated BCBSMA resources to support the success of our AQC partners.

The process begins with a self-assessment that helps each group determine their readiness to be accountable for cost and quality and to manage an annual budget for all of the medical services their BCBSMA patients receive.

In addition, BCBSMA provides:

- *AQC Executive Dashboard* – a quarterly financial performance report for each group

- Extensive reporting:
  - Efficiency data
  - Quality data
  - Practice pattern variation data
  - Reports on specific areas of interest (e.g. high-tech radiology, readmissions, non-urgent emergency department visits)

- Performance improvement medical management consultative support – includes monthly meetings with BCBSMA's medical directors, analysts, and the AQC group's leadership to identify areas of opportunity and potential solutions

- Consistent member communication/messaging and collaboration with AQC groups on patient communication

- Training and support (e.g. AQC user group for data analysis)

- Collaboration and best practice sharing.

Practice Pattern Variation: *A closer look*

Practice pattern variation, or differences in treatment of a given condition that are not explained by scientific evidence, are well-documented and widely thought to be a helpful guide to finding and eliminating unnecessary care. To support AQC groups in addressing variation, BCBSMA provides groups with detailed analysis of how their own physicians vary in the treatment of specific clinical conditions. (S*elect clinical priorities in which unexplained practice variation appears are listed on page 10.*)

Example: Benign hypertension

Step 1: Examination of claims for this condition shows that within the total cost for treatment of hypertension, pharmacy costs per provider vary by more than five times as much as lab tests or office visits.

Step 2: A closer look at pharmacy costs shows that the use of ARBs results in much greater costs than the use of ACE inhibitors. At the same time, medical evidence suggests that only 10 – 15 percent of patients require the more expensive ARBs, yet they are prescribed for more than 30 percent of patients.

Step 3: BCBSMA provides physician-specific data about ARB prescription rates, so that the provider group can encourage providers and their patients to discuss and explore the feasibility of ACE inhibitors.

The result: In addition to the immediate cost savings to the health care system, members also experience lower prescription drug costs, which can lead to better levels of treatment adherence and, therefore, better long-term outcomes for the patient. [Greene R, Beckman H, Mahoney T. Beyond The Efficiency Index: Finding A Better Way To Reduce Overuse And Increase Efficiency In Physician Care. *Health Affairs*. 2008; 27(4): w250-w259.]

How is the AQC Different from Capitation?

Mindful of the criticisms of capitation, BCBSMA designed the AQC to address and incorporate the lessons learned, advancing global budgets past the pitfalls of the 1990s:

- Concern: Capitation failed to adequately fund care.
  AQC Solution. In the AQC, the global budget is based on actual historical costs for a patient and is adjusted for health status so that payments adequately reflect the relative morbidity of 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 members to support an adequate distribution of risk.

- Concern: Capitation fostered underuse of health care services.
  AQC Solution. Since the AQC includes a global budget for all services received by a BCBSMA member, and provides incentives for quality outcomes, the contract model rewards doctors for providing appropriate and efficient care.

- Concern: Capitation failed to address quality, focusing exclusively on cost of care.
  AQC Solution. The global budget is coupled with a set of nationally accepted performance measures so that BCBSMA and providers can ensure that patients are receiving safe, appropriate, and effective care. This pairing of payment with performance measures safeguards patients from 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.

- Concern: Capitation created incentives that encouraged physicians to avoid sick patients.
  AQC Solution. By adjusting the global budget for health status, the model adequately considers changes in patient morbidity, eliminating any incentive to avoid sick patients.

- Concern: Capitation shifted all risk to the provider organization rather than just utilization risks associated with providing health care.
  AQC Solution. The AQC is designed to have an appropriate level of risk sharing between BCBSMA and the provider organization. BCBSMA offers differing levels of risk sharing arrangements with AQC provider organizations, depending on the size of the group, the degree of integration, and the ability to assume risk for utilization and variations in care. In addition to risk sharing, the AQC includes tools to protect providers from unforeseen financial impact, including adjusting for health status, risk limits (typically BCBSMA is responsible for large losses on individual claims or across populations), and stop-loss (or reinsurance.)

Meeting the Challenge

BCBSMA has entered into new partnerships with nine provider groups, who represent about 25 percent of our network's primary care physicians, about 23 percent of our network's specialists, and about 31percent of our HMO membership.

BCBSMA is in the process of discussing AQC arrangements with additional provider organizations for 2010 participation, and anticipates that the number of providers who sign an AQC will continue to increase over the next several years.

There are early indications among participating AQC physician groups and hospitals that their efforts are having the desired effect, aligning the incentives of patients, physicians, hospitals, employers, and health plans to advance high-quality, high-value health care.

Validating Progress

The Commonwealth Fund has commissioned a study led by Michael Chernew, M.D., Ph.D., from Harvard Medical School, and Robert Mechanic, Senior Fellow, from the Heller School for Social Policy and Management, Brandeis University, to evaluate the AQC. The study will incorporate claims data from calendar years 2005 through 2010. By analyzing sufficient pre- and post-AQC adoption data, the study will provide a valuable lens to measure success. The study will also provide key insights for physician groups, health systems, payers, and public policy leaders about success factors and challenges associated with the AQC and will help inform future policy development related to health care payment reform.

AQC: A Part of the Solution

By restructuring the system to appropriately align financial and clinical incentives in ways that improve the quality of care, which ultimately will impact costs, the AQC will help the industry move away from the unintended consequences of the fee-for-service model. Instead of rewarding volume and complexity of service, the AQC helps foster accountability, coordination, safety, and effectiveness.

BCBSMA looks forward to continue working with our provider partners, our customers, and all industry stakeholders to shape this and other solutions to meet the challenges of health care costs and quality.

Measures Included in the Alternative Quality Contract

	Ambulatory Measures	Hospital Measures
Process	Depression 1 Acute phase Rx 2 Continuation Phase Rx Diabetes 3 HbA1c testing (2X) 4 Eye exams 5 Nephropathy screening Cholesterol Management 6 Diabetes LDL-C screening 7 Cardiovascular LDL-C screening Cancer Screening 8 Breast cancer screening 9 Cervical cancer screening 10 Colorectal cancer screening Preventive Screening/Treatment Chlamydia Screening 11 Ages 16-20 12 Ages 21-25 Adult Respiratory Testing/Treatment 13 Acute bronchitis Medication Management 14 Digoxin monitoring Pedi: Testing/Treatment 15 Upper respiratory infection (URI) 16 Pharyngitis Pedi: Well-visits 17 < 15 months 18 3-6 Years 19 Adolescent well-care visits	AMI 1 ACE/ARB for LVSD 2 Aspirin at arrival 3 Aspirin at discharge 4 Beta Blocker at arrival 5 Beta Blocker at discharge 6 Smoking cessation Heart Failure 7 ACE LVSD 8 LVS function evaluation 9 Discharge instructions 10 Smoking cessation Pneumonia 11 Flu vaccine 12 Pneumococcal vaccination 13 Antibiotics w/in 6 hrs 14 Oxygen assessment 15 Smoking cessation 16 Antibiotic selection 17 Blood culture Surgical Infection 18 Antibiotic received 19 Received appropriate preventive antibiotic(s) 20 Antibiotic discontinued
Outcomes	Diabetes 20 HbA1c in poor control 21 LDL-C control (<100mg) 22 Blood Pressure control (130/80) Hypertension 23 Controlling high blood pressure Cardiovascular Disease 24 LDL-C control (<100mg)	21 In-hospital mortality - overall 22 Wound infection 23 Select infections due to medical care 24 AMI after major surgery 25 Pneumonia after major surgery 26 Post-Operative PE/DVT 27 Birth Trauma - injury to neonate 28 Obstetrics Trauma-vaginal w/o instrument
Patient Experience	Patient Experiences (C/G CAHPS/ACES) - Adult 3 25 Communication quality 26 Knowledge of patients 27 Integration of care 28 Access to care Patient Experiences (C/G CAHPS/ACES) - Pediatric 3 29 Communication quality 30 Knowledge of patients 31 Integration of care 32 Access to care	Hospital Patient Experience (H-CAHPS) Measures 29 Communication with nurses 30 Communication with doctors 31 Responsiveness of staff 32 Discharge information

Addressing Unexplained Practice Variations: Select Clinical Priorities

Advanced Imaging

1. MRI in bursitis, tendonitis, neck and back
2. Nuclear imaging in cardiology
3. Ultrasound gynecology
4. CT in gastroenterology

Prescription Medicines

5. Unnecessary use of antibiotics for bronchitis
6. Overuse or early use of third line treatment, for example Avandia for diabetes
7. Use of brand over generic Rx for bronchitis, hyperlipidemia, hypo-functioning thyroid gland, ischemic heart disease

Orthopedic Procedures

8. Knee arthroscopy
9. Lumbar back surgery: spinal fusions

Treatment of Sinusitis

10. Allergy testing
11. Nasal steroids
12. Surgery: fiberoptic laryngoscopy and nasal endoscopy

Other

13. Cardiac procedures: catheterization and CABG
14. GI endoscopy with biopsy
15. Asthma: inhaled steroids
16. Benign neoplasm of the skin: complex removal methods used in absence of clinical need