



MASSACHUSETTS

Transforming Health Care in Massachusetts
*Driving Change through Payment Reform:
The Alternative Quality Contract*

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Agenda

- The Current Health Care Environment
 - Why the Need for Change and Innovation?
- Blue Cross Blue Shield of Massachusetts' (BCBSMA's) Strategic Direction
 - Performance-driven Payment Strategy
- Overview of the Alternative Quality Contract
 - Performance Incentive Model – Incentives for Quality, Safety and Patient-Centered Care
 - Financial Model – Affordability

The Current Health Care Environment

Signs of a Troubled System

Overuse, Underuse, Misuse and Errors

- 44,000 - 98,000 deaths annually from preventable errors during hospitalization

(Institute of Medicine, *To Err is Human*, 1999)



- One-quarter of the patients in four MA adult primary care practices experienced an adverse drug event, and about one in eight of those (13%) were serious.

(TK Gandhi et. al. *Adverse events in ambulatory care. New Engl J Med.* 2003, Apr 17; 348 (16): 1556-64.)

- Monetary value of diagnostic radiology procedures in US is \$100 billion, \$2-16 billion of which estimated to be unnecessary.

(*Managed Care*, 2005)

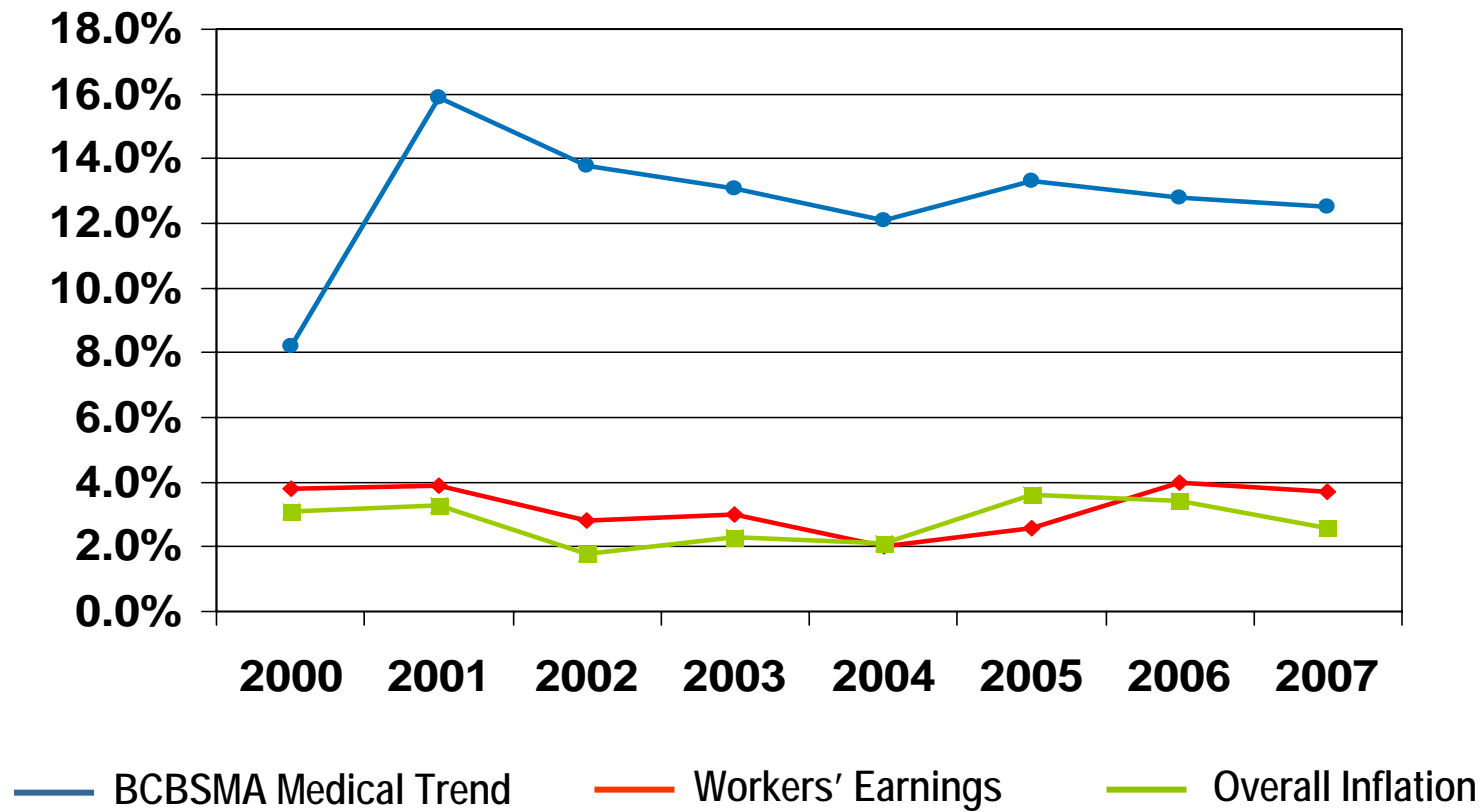


- Among older Americans with lung cancer, 76.7% of whites receive surgery, compared to 64.0% of blacks. This results in a 34.1% survival rate for whites and a 26.4% survival rate for blacks.

(National Cancer Institute, Center to Reduce Cancer Health Disparities)

Medical Trend Outpacing Inflation

BCBSMA's medical cost trend is growing four times faster than workers' earnings, and nearly five times the rate of inflation.



Sources: BCBSMA, Bureau of Labor Statistics

The Current Payment Structure

Fee-for-Service: RBRVS

- The more you do the more you get paid
- The more complex the procedure, the more you get paid
- Clinical outcomes do not influence payment
- No alignment with evidence-based care
- No payment for avoidance of unnecessary care

BCBSMA's Strategic Direction

BCBSMA's Vision

To support a health care system that delivers
safe, effective, affordable,
patient-centered care for everyone in
Massachusetts.

End-State Vision

Today

- ❑ Nationally, 30% of medical dollars are wasted
- ❑ Up to 98,000 Americans die each year due to medical errors
- ❑ Patients received only 55% of scientifically indicated care
- ❑ It is estimated that only 20% of care is evidence-based
- ❑ Wide variations exist in the delivery of health care

2016

- ❑ No unnecessary harm
- ❑ No deaths due to preventable medical errors
- ❑ All patients receive appropriate care according to EBM guidelines
- ❑ Significant elimination of variations in health care
- ❑ Engaged consumers are fully informed of treatment options

Performance-driven Payment Strategy

Payment Reform: The Vision

- Pay for:
 - Improved health
 - Clinical outcomes
 - Evidence-based care
 - Positive patient experience
 - Cognitive services
 - Population management
 - Care integration
 - Clinical teams
 - Safety
 - Quality improvement and assurance activities
- Do not pay for:
 - Volume of services
 - Inappropriate utilization
 - Errors
 - Technology/services that do not positively impact health

Overview of the Alternative Quality Contract

Cornerstones of the Alternative Quality Contract

- The Alternative Quality Contract model is composed of key components that are standard across provider entities
 - Integration across the continuum of care
 - Accountability for performance measures (ambulatory and inpatient)
 - Global payment for all medical services (health status adjusted)
 - Sustained partnerships (five-year contract)

Included in Subsequent Phases

- New products differentiating Alternative Quality Contract providers
- Member incentives to encourage healthy behaviors

Structure of the Financial Component

Financial Structure of the Alternative Quality Contract

- Financial structure based on four components:

- ❖ **Global payment**

- Based on total medical expenses
- Health status adjusted

- ❖ **Margin Retention**

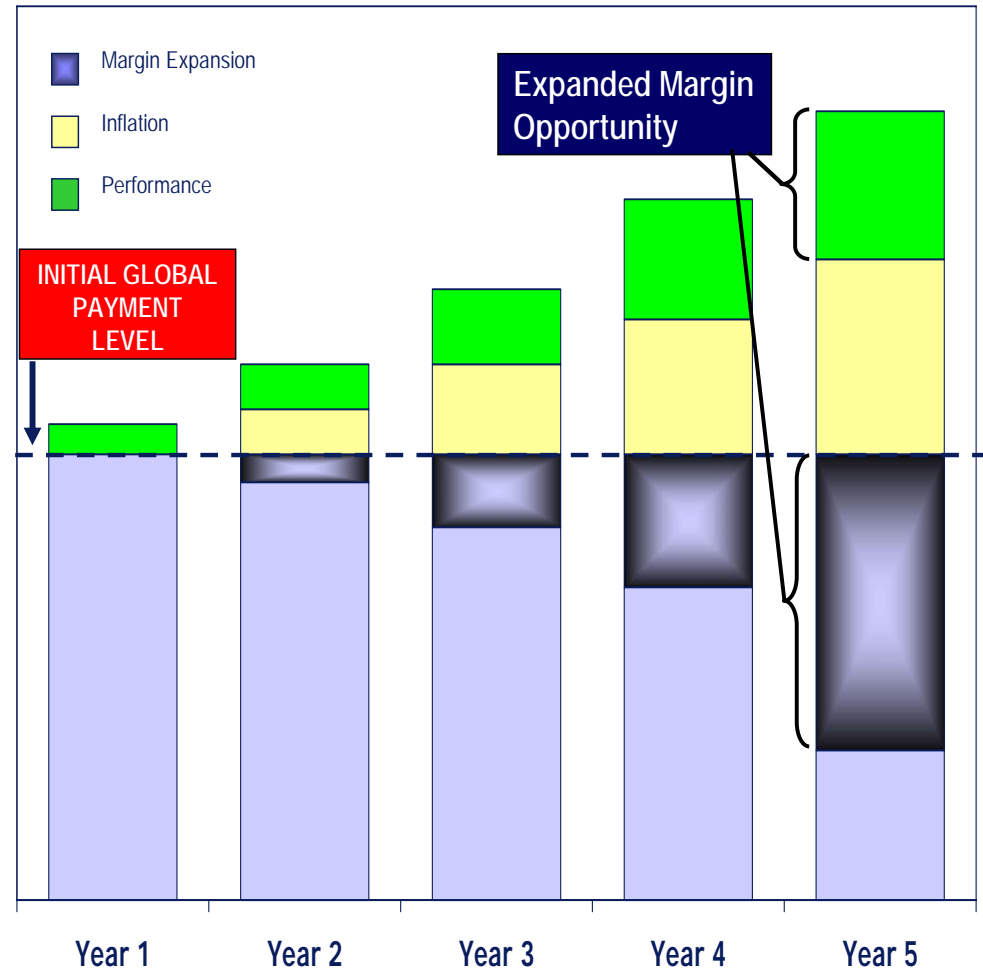
- Initial Global Payment includes inefficiencies

- ❖ **Performance Incentive**

- Up to 10% of Total Medical Expense

- ❖ **Inflation**

- Inflation factor derived from CPI



Structure of the Performance Incentives

Guiding Principles in Selecting Performance Measures

- Wherever possible, our measures should be drawn from nationally accepted standard measure sets.
- The measure must reflect something that is broadly accepted as clinically important.
- There must be empirical evidence that the measure provides stable and reliable information at the level at which it will be reported (i.e., individual, site, group, or institution) with available sample sizes and data sources.
- There must be sufficient variability on the measure across providers (or at the level at which data will be reported) to merit attention.
- There must be empirical evidence that the level of the system to be held accountable (clinician, site, group, institution) accounts for a large share of the system-level variance in the measure.
- Providers should be exposed to information about the development and validation of the measures and given the opportunity to view their own performance—ideally for one measurement cycle—before the data are used for “high stakes” purposes.

Performance Measure Set

Hospital Quality and Safety

Clinical process measures

- Acute MI
- Heart Failure care
- Pneumonia care
- Surgical care

Clinical outcomes measures

- Hospital-acquired infections
- Complications after major surgery (AMI, PE/DVT, Pneumonia)
- Obstetric trauma

Patient Care Experiences

- Communication (MD, nursing staff)
- Responsiveness
- Discharge support/planning

Ambulatory Care Quality

Clinical process measures

- Depression
- Diabetes
- Cardiovascular Disease
- Cancer Screening
- Pediatric: Appropriate Testing/Treatment
- Pediatric: Well-Child Visits

Clinical outcomes measures

- Diabetes (HbA1c in poor control, LDL-C control, blood pressure control)
- Hypertension (blood pressure control)
- Cardiovascular Disease (blood pressure control, LDL-C control)

Patient Care Experiences

- Quality of clinical interactions
- Integration of care
- Access to care

Why Is this Different from the Traditional Capitation Model?

- The global payment does not represent a reduction from current payment levels
 - Goal is not to reduce payments but to slow the rate of increase in cost to be closer to inflation
- The global payment is comprehensive and paired with quality incentives
 - Includes a significant upside potential based on a sophisticated set of measures that address quality, patient safety and patient satisfaction
- Initial global payment level is adjusted for health status
 - Global payment is set for each patient based on their age, gender and health status
- Payment is adjusted annually in line with Consumer Price Index (CPI)

Framework for Working Together in 2009 and Beyond

A health care system that provides safe, timely,
effective, affordable, patient-centered care for
everyone in Massachusetts