



## Changing the Way We Pay for Care: *The Move to Global Payments*

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# Agenda

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- Massachusetts healthcare market overview
- BCBSMA's response to payment reform
- AQC goals and components
- AQC model—financial and quality measures
- AQC participation and adoption
- Initial AQC results
- Looking ahead

# Massachusetts Healthcare Market



Market Attribute	Number
Population	6.6M
Total Insured	6.4M
Total Physicians	33,250
Primary Care Physicians	7,300
Acute Care Hospitals	72
Teaching Hospitals	19
Community Health Centers	52

## Massachusetts Healthcare Market, *continued*



Health Plan	Total Medical Membership
BCBSMA <ul style="list-style-type: none"><li>• 44% of the total state population</li><li>• 45% of the insured state population</li></ul>	2.9M
Harvard Pilgrim Health Care	1.1M
Tufts Health Plan	744,000
Fallon Community Health Plan	212,000

# Forces Affecting Health Plans: Economic Recovery



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- Economic recovery is slow and essentially a jobless recovery.
- Massachusetts lost 140K jobs between the start of the recession in 2008 and December of 2009. Since 2009, the state has added back 60K jobs.
- Job growth in MA is strongest in education and health services. Manufacturing and construction have declined significantly.
- Employers are buying down benefits and shifting cost share to their employees.
- Employees with higher out-of-pocket expenses are seeking fewer services.



# Forces Affecting Health Plans: Providers



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- Overall pressure to reduce costs
- Payment disparities continue to create tension within the provider community
- In MA, average wait times for new patients have increased, proportion PCPs accepting new patients has declined, and ER visits have increased
- Health plans are increasingly unwilling and unable to cross subsidize shortfalls from government programs





# Forces Affecting Health Plans: Employers



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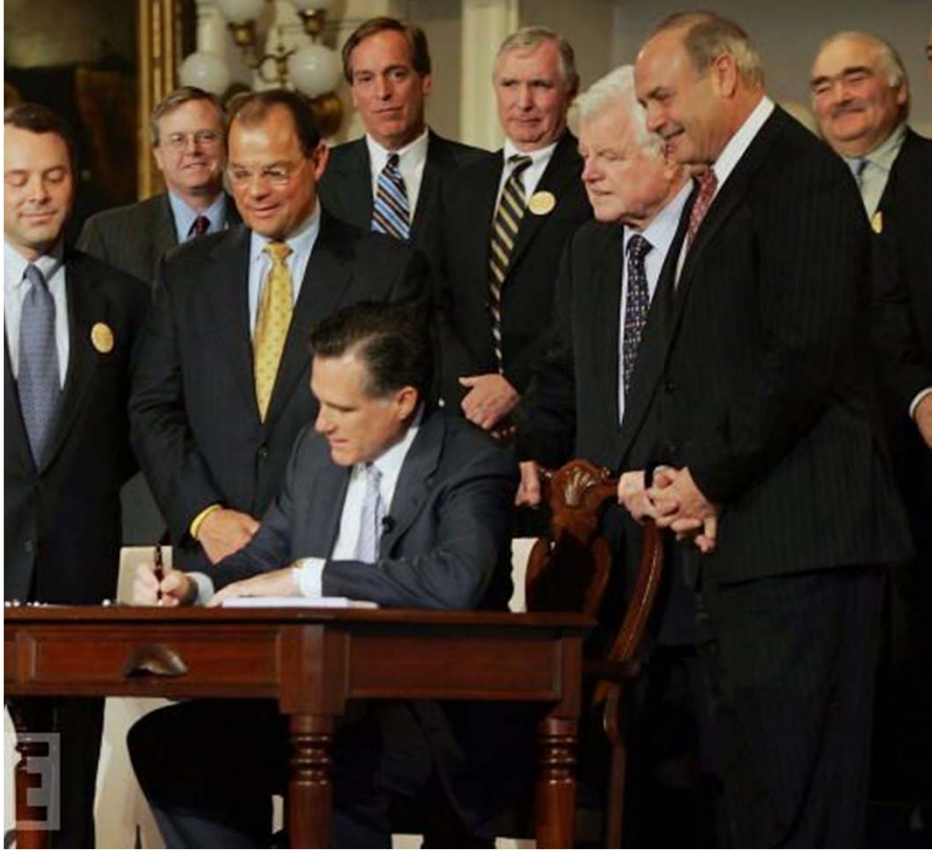
- Overall affordability of health insurance is an overriding concern of all employers
- Segments have varying sensitivity to price, brand, benefit design, networks and service levels
- Each segment has varying requirements for health plan capabilities (e.g., reporting tools, web self-service, care management services and consumer engagement tools)
- Continued interest in prevention, wellness and care management initiatives, and member engagement strategies



# Health Care Reform: A National and Local Priority



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# Making Quality Health Care Affordable



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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 that aligns financial and clinical goals.

*That's why BCBSMA developed the Alternative Quality Contract (AQC).*

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# The Goals of the AQC



- Pay providers to focus both on quality and total cost, creating the opportunity for the implementation of alternate care delivery models (email, group visits, etc.) and other innovations
- Accelerate the use of quality, outcomes-based metrics as a basis for payment
- Create a payment model which provides incentives for the integration of care delivery and patient outcomes
- Tie performance payments to achieving goals of quality, safety, efficiency and patient-centered care (eliminating misuse, overuse, underuse and medical errors)

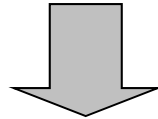
# AQC Providers are Accountable for Quality and Cost



## AQC Components

### Performance Incentives

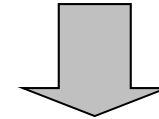
Promotes  
Quality, Safety and  
Patient-Centered Care



Providers receive upside payments for performance on a broad set of quality and patient experience measures

### Financial Structure

Promotes Affordability and  
Efficiency



Providers share risk on a health status adjusted Total Medical Expense Budget

# Financial Structure of the 2009 AQC

Financial structure based on four components:

## ■ Global Budget

- Based on total medical expenses
- Health status adjusted
- Risk Share target = 50% - 90%
- Annual Settlement to Budget

## ■ Margin Opportunity

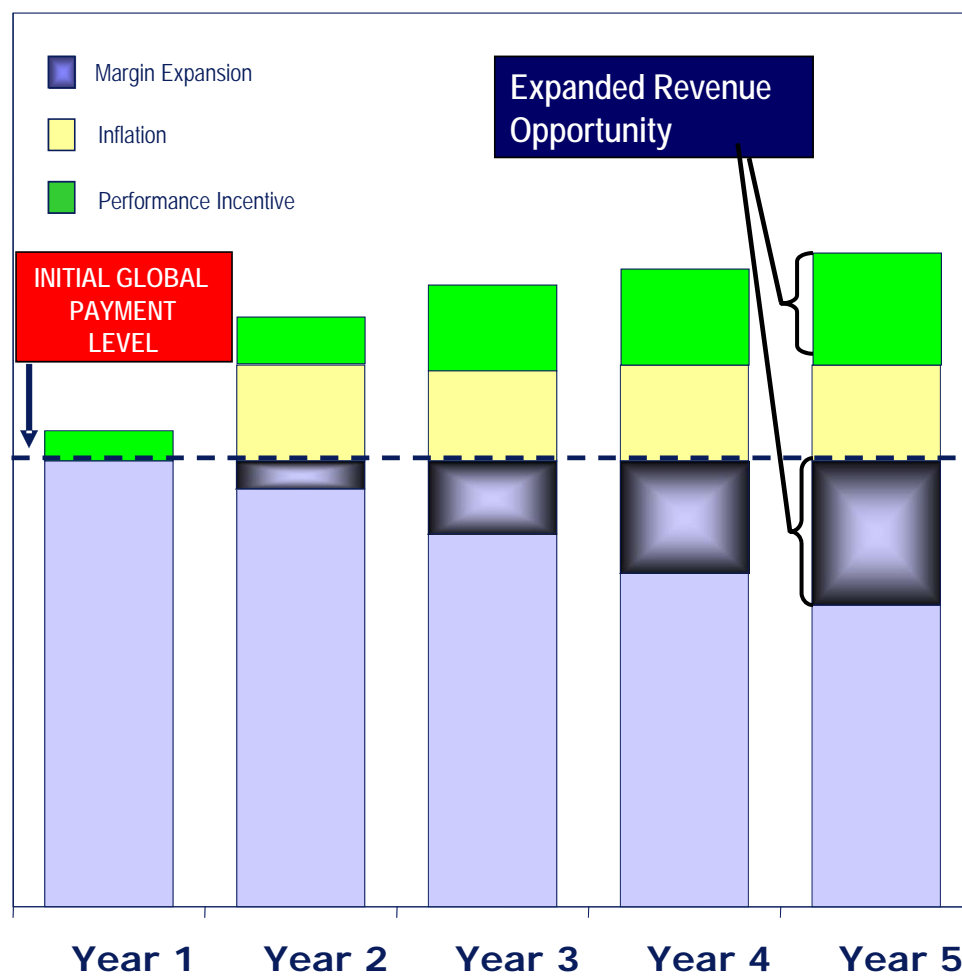
- Initial global budget includes inefficiencies

## ■ Performance Incentive

- Up to 10% of Global Budget – dependent upon degree of risk sharing

## ■ Inflation

- Goal by Year 5 is approximately 4%



# Performance Measure Set



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## Hospital Quality and Safety

- Clinical process measures
  - Acute MI
  - Heart Failure care
  - Pneumonia care
  - Surgical care
- Clinical outcome measures
  - Hospital-acquired infections
  - Complications after major surgery (AMI, PE/DVT, Pneumonia)
  - Obstetric trauma
- Patient Experience Measures
  - Communication (MD, nursing staff)
  - Responsiveness
  - Discharge support/planning

## Ambulatory Care Quality

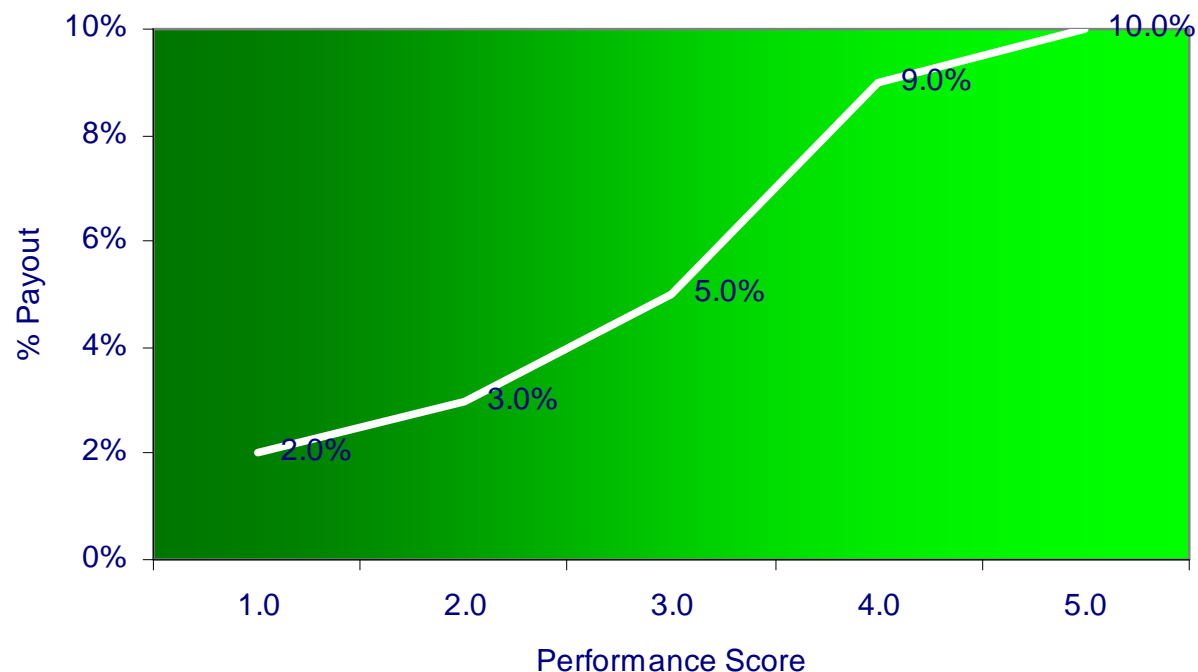
- Clinical process measures
  - Diabetes
  - Cardiovascular Disease
  - Cancer Screening
  - Pediatric: Appropriate Testing / Treatment
  - Pediatric: Well Visits
- Clinical outcome measures
  - Diabetes (HbA1c in poor control, LDL-C control, blood pressure control)
  - Hypertension (blood pressure control)
  - Cardiovascular Disease (blood pressure control, LDL-C control)
- Patient Experience Measures
  - Quality of clinical interactions
  - Integration of care
  - Access to care



# Performance Achievement Model

An aggregate performance score is calculated based on the provider's hospital and ambulatory quality performance to determine a percentage payout

## Performance Payment Model



### Example:

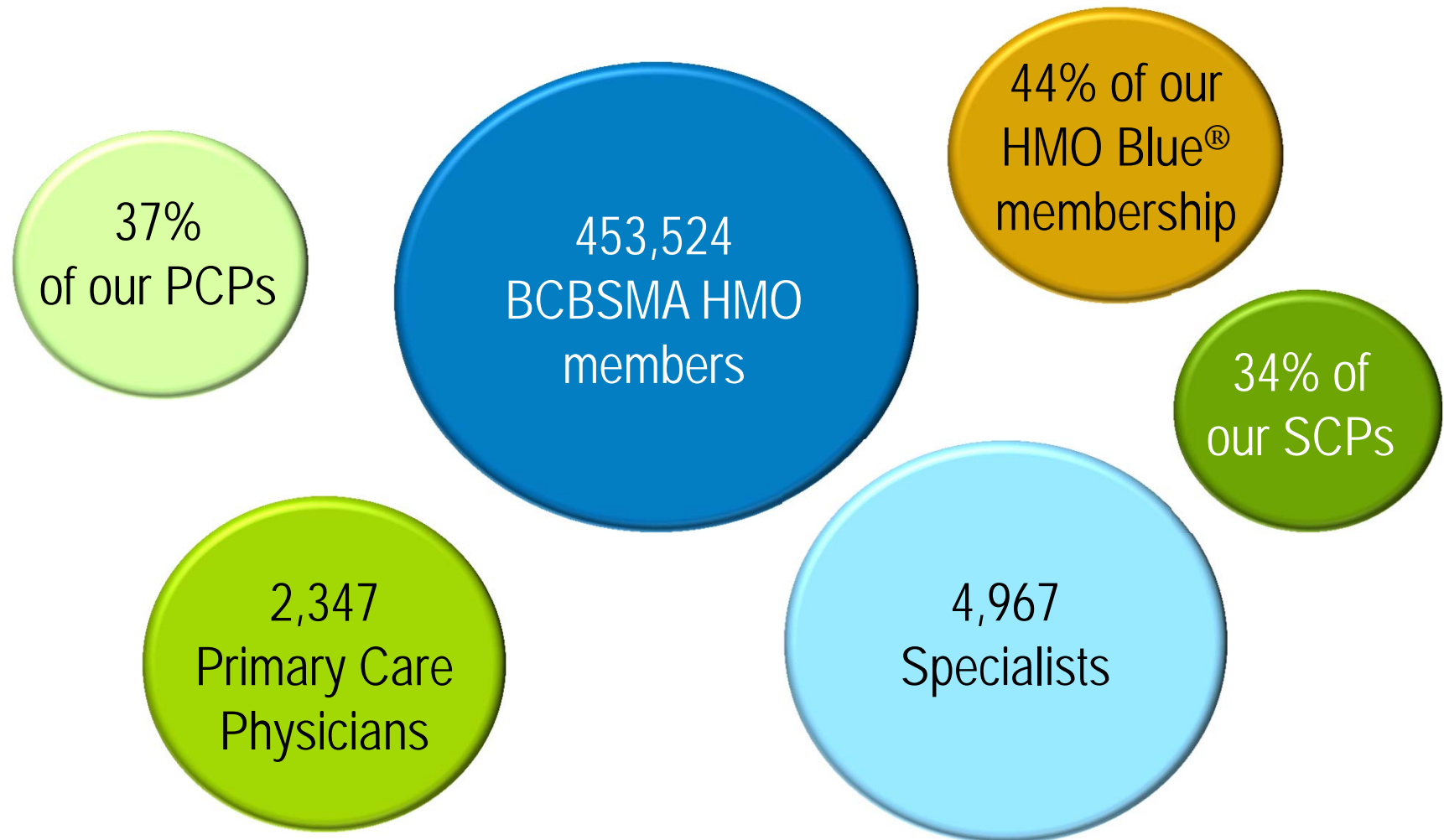
An aggregate score of 3.0 would yield a 5% payout, which if applied to a global payment of \$300 PMPM, would yield an additional \$15 PMPM for the provider.

# AQC: Adding It All Up



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Current as of March 2011



- AQC experienced more rapid adoption than originally anticipated
  - National and state health care environment
  - BCBSMA's alternative to the ACO
  - Hospital's interest in vehicle to work more closely in partnership with physicians
- AQC Outlook for Future Expansion
  - Targeting additional AQC provider organizations
- Barriers to Expansion
  - PPO plan design
  - Size of provider organizations
  - Organizational readiness: BCBSMA and provider organizations
  - Other payors: Medicare, Medicaid, and commercial



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# 2009 Results

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# First-Year Results: Cost Trend Reduction

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- **Comparison to expectations.** Year-one results show that we are on track to achieve our original goal of reducing annual health care cost trends by one-half over five years.
- **Efficiency performance.** In the first year, all AQC groups met their budgets, producing surpluses that are enabling them to invest in infrastructure and other improvements that will help them deliver care more effectively.
- **Impact on trend drivers.** There are encouraging indicators that the AQC has positively impacted two major health care cost drivers:
  - AQC groups reduced hospital readmissions, worth about \$1.8 million in avoided costs, while non-AQC groups experienced an increase in readmission rates
  - One AQC group reduced non-emergency ER visits by 22% over the past year, totaling \$300,000 in avoided ER costs



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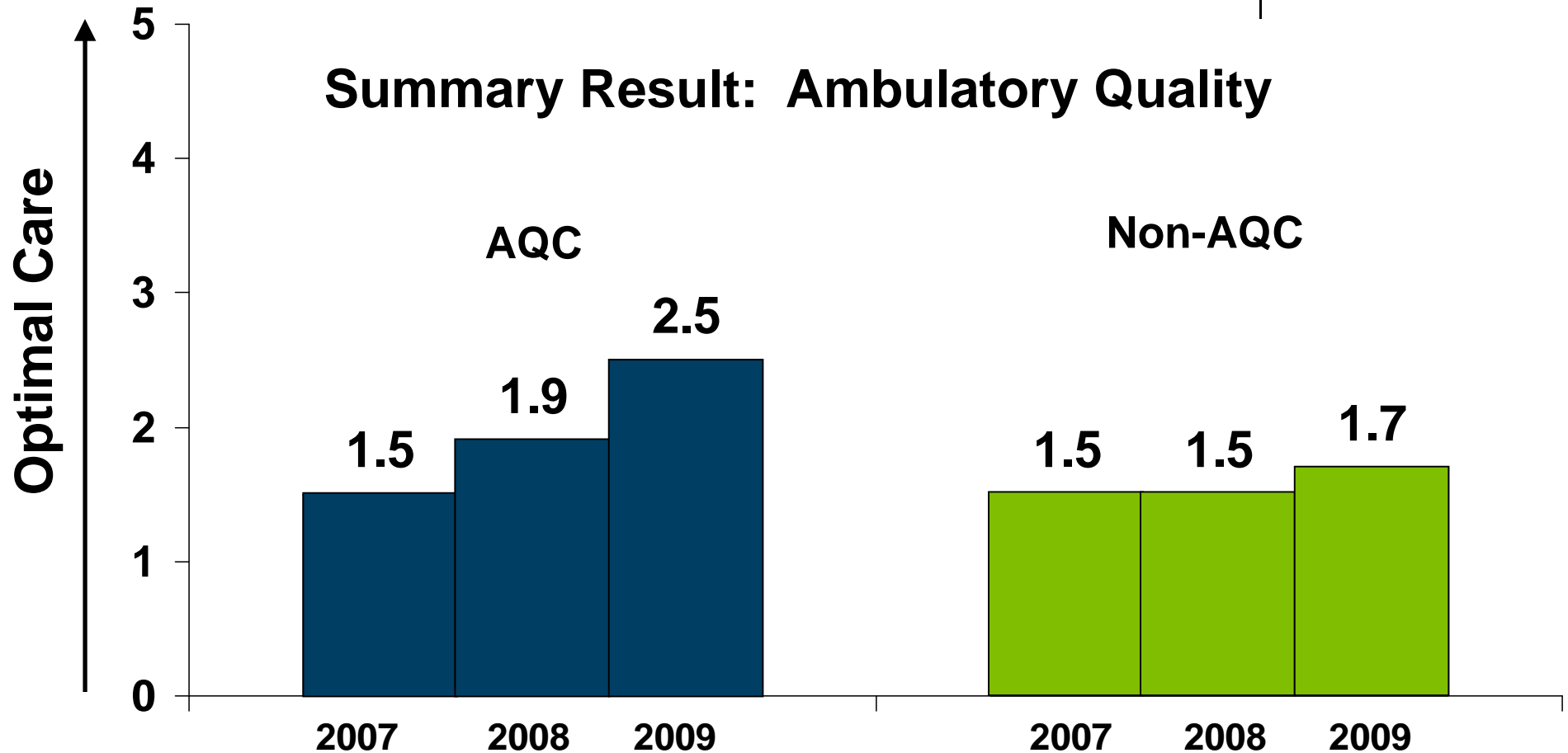
# First-Year Results: Improvements in Quality

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- **Overall improvement.** In the first year of the AQC (2009), improvements in the quality of patient care were greater than any one-year change seen previously in our provider network.
- **Clinical quality.** Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes measures.
  - **Outcome measures.** AQC groups exhibited exceptionally high performance for all clinical outcome measures with more than half approaching or meeting the maximum performance target on measures of diabetes and cardiovascular care.
- **Preventive care.** For important preventative care measures, like cancer screenings and well-child visits, as well as for important measures of chronic disease care, AQC groups' performance was three times that of non-AQC groups and more than double the AQC groups' own improvement rates before joining the AQC.
- **Patient care experience.** There were no significant changes in AQC groups' performance on patient care experience measures overall.
  - This is reassuring as it suggests some concerns expressed by critics – that patients would feel too tightly managed or access to care would be denied – have not come true.

# AQC Groups Outperform Rest of Network on Clinical Quality



\*The gate is calculated from a minimum and upper threshold for each measure. Actual performance is converted to 5-point scale between Minimum and Upper Thresholds. A score of 1.0 (Minimum Threshold) represents a score that is generally at the 50th percentile of the network distribution. A score of 5.0 (Upper Threshold) represents the “observed limits” of performance (end-state vision) or the 99th percentile of the distribution.

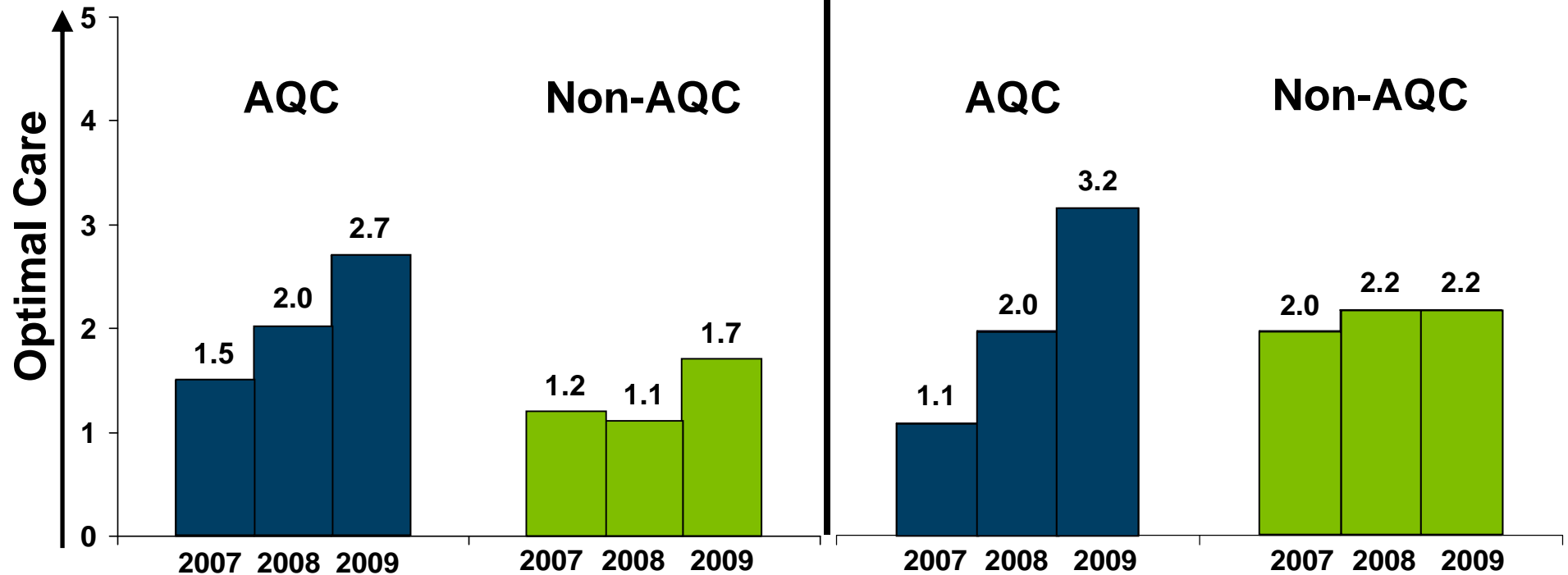
*NOTE: The measures included in the overall quality score are preventive and chronic clinical process measures.*

# AQC Groups Surpass Network on Key Preventive and Chronic Care Measures

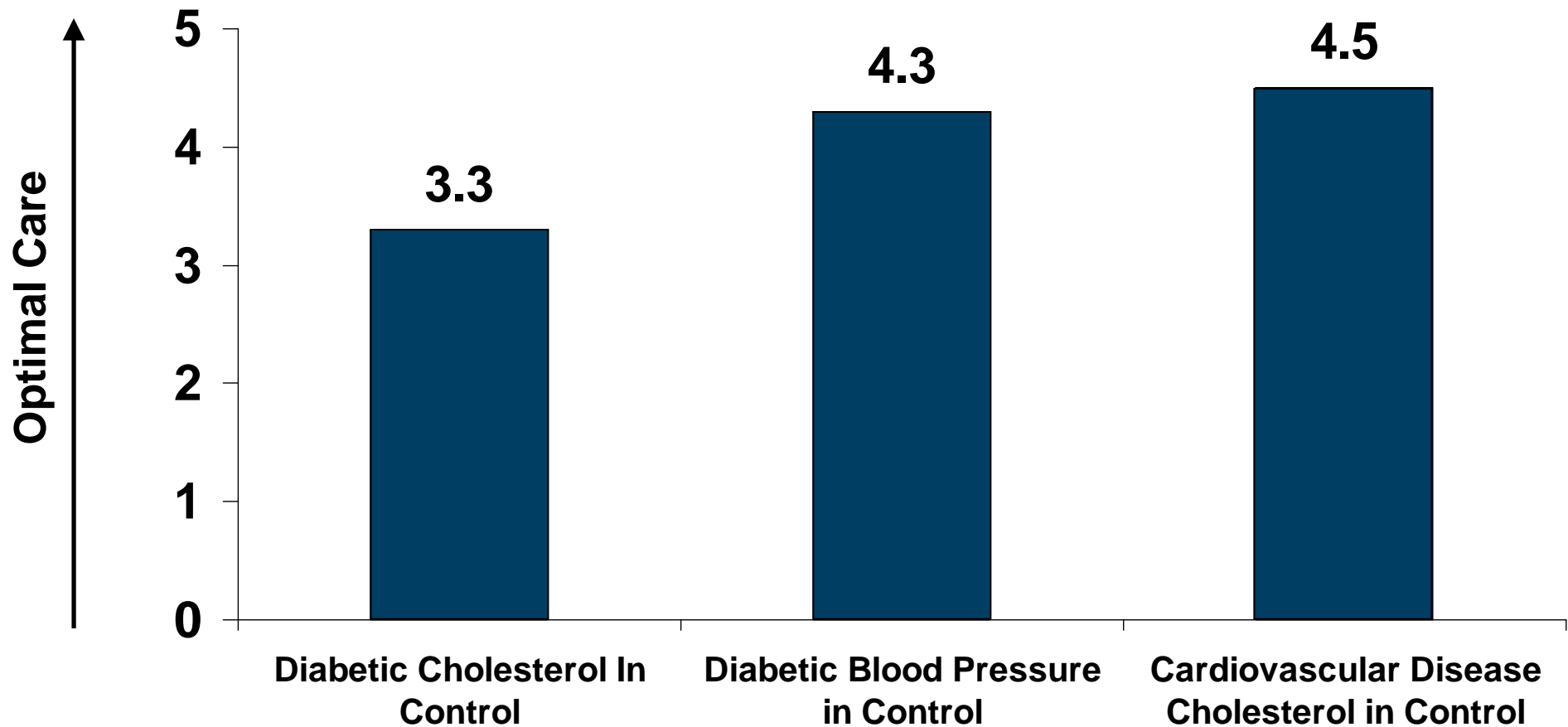


## Preventive Screenings

## Chronic Care Management



# AQC Groups Achieving Quality Outcomes for Patients with Chronic Disease<sup>1</sup>



<sup>1</sup> Results limited to AQC groups that received financial incentives for these measures in 2009.

# The AQC Drives Changes in How Care is Delivered



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## Group A

Is using Case Managers directly in the PCP practices to assist with managing the complex, high risk population. The concept is that by being more proactive, they can avoid the ER visit and the admission to the hospital.

## Group B

Is working collaboratively with their specialist community to engage specialists in the AQC contract (hosting meet-and-greet meetings for specialists and PCPs, having a radiologist on call to help PCPs determine if a high-tech radiology test is medically necessary, etc.).

## Group C

Launched aggressive screening reminder campaign and in one year saw a 6.2% improvement for preventive care measures. For diabetic eye exams, they improved by 13.6% over their 2008 results.

## Group D

Invested in and developed an innovative technology solution that links BCBSMA claims and health status data with internal practice data.



# Keys to AQC Success



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**1** The measures 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** For each measure, there is a range of performance targets representing a continuum from good care to outstanding care, so the model rewards both performance and performance improvement.

**4** Data is made available monthly, enabling the organizations to track progress and take action to manage their patient population.

**5** The groups have strong support from their leadership to implement new systems and act on the data.



Addressing ACO Regulations



Patient-Centered Medical Home



Targeted Product and Benefit Designs with  
Community Health Centers as High-Value Providers



Others?



Questions?