Advancing the Twin Goals of Improving Health Care Quality While Slowing Spending Growth: The Alternative Quality Contract (AQC)

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Massachusetts Spends More on Health Care than Any Other State

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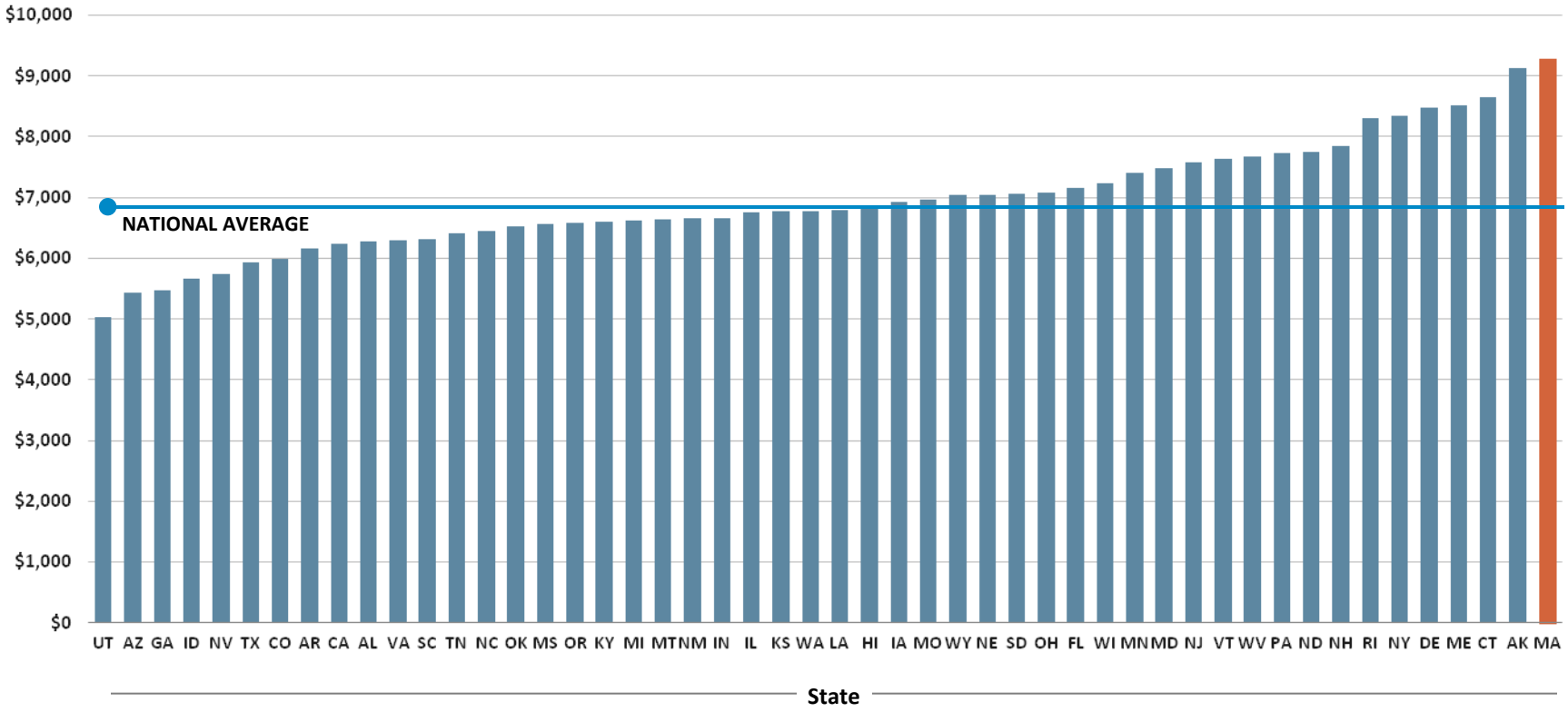
PER CAPITA PERSONAL HEALTH CARE EXPENDITURES, 2009



NOTE: District of Columbia is not included.
SOURCE: Centers for Medicare & Medicaid Services, *Health Expenditures by State of Residence*, CMS, 2011.

In MA, the Increasing Costs of Health Care Squeeze Out Other Public Spending Priorities

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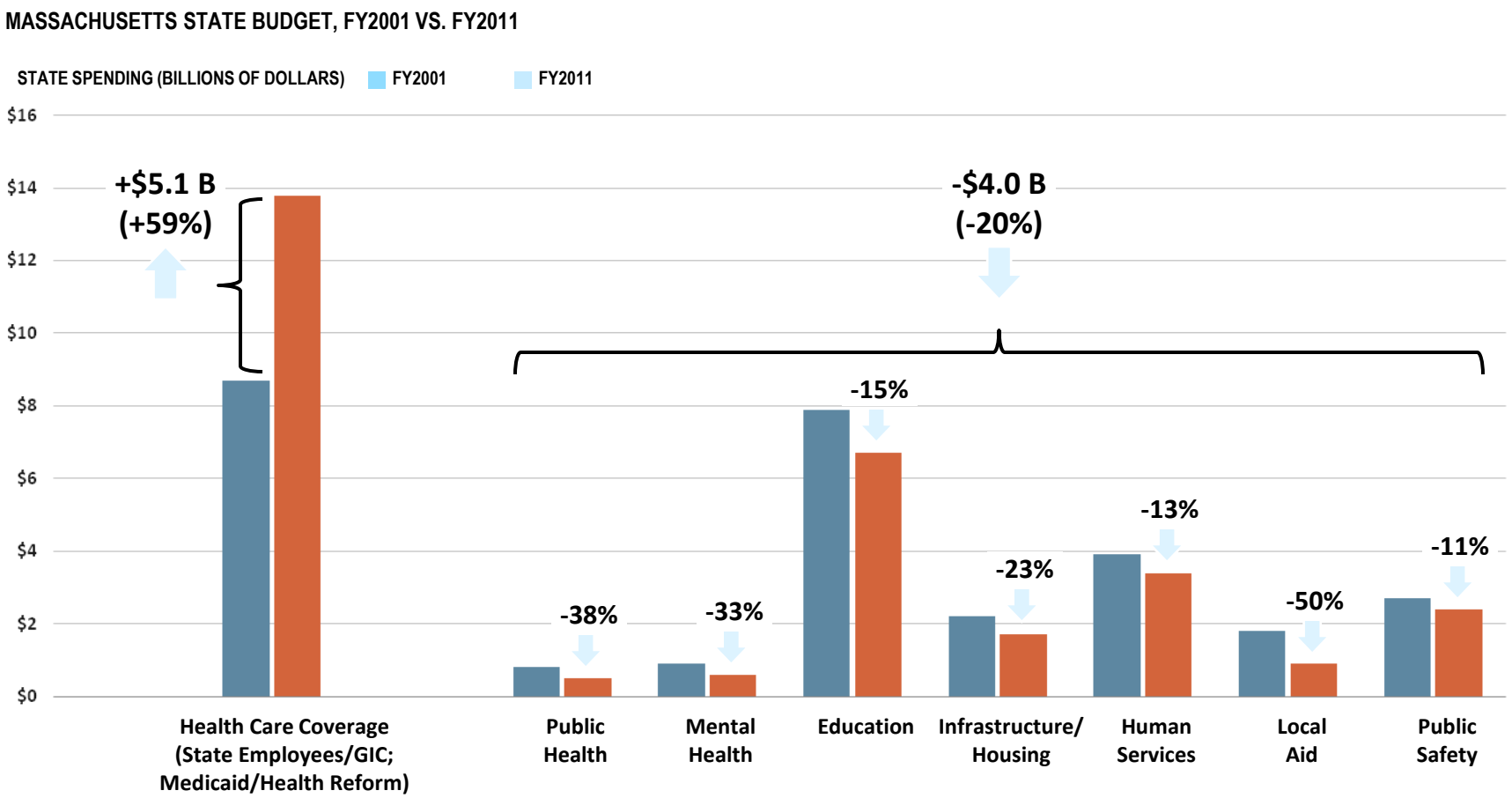

SOURCE: Massachusetts Budget and Policy Center Budget Browser.

Twin Goals of Improving Quality & Outcomes While Significantly Slowing Spending Growth

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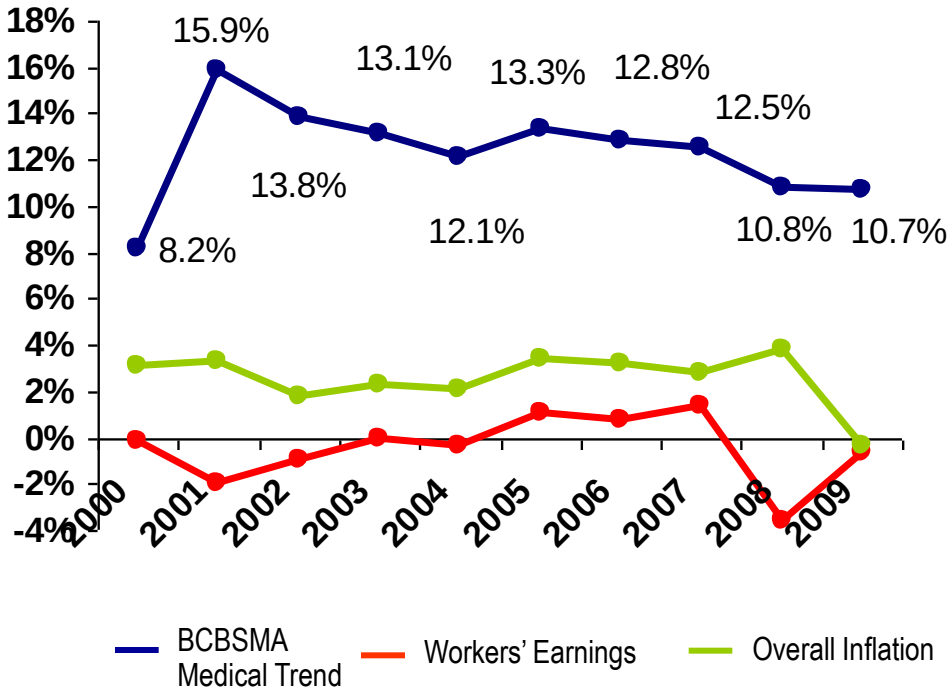
In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.

MA health reform law (2006) caused a bright light to shine on the issue of unrelenting double-digit increases in health care spending growth ("Health Care Reform II).



Sources: BCBSMA, US Census in 2010 CPI Adjusted $.,and US Bureau of Labor Statistics

Key Components of the AQC Model

Unique contract model:

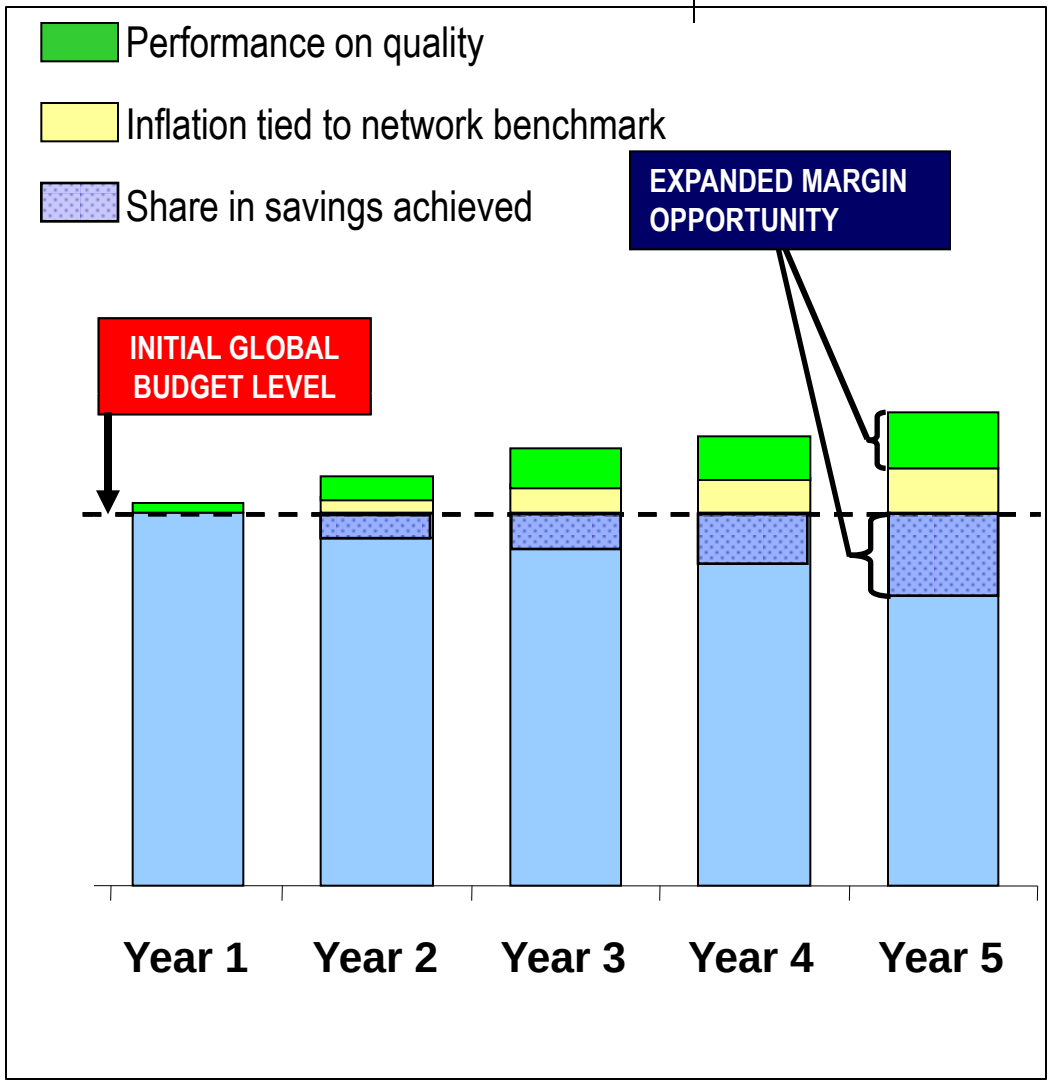
- Accountability for quality and resource use across full care continuum
- Long-term (5-years)

Controls cost growth:

- Global budget
- Incentive to eliminate clinically wasteful care ("overuse")
- Annual trend targets tied to regional benchmark
- Risk adjusted budgets address changes in population mix

Improved quality, safety & outcomes:

- Robust performance measure set creates accountability for quality, safety & outcomes across continuum
- Substantial financial incentives for high performance



AQC Measure Set for Performance Incentives

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	AMBULATORY	HOSPITAL

PROCESS	• Preventive screenings
	• Acute care management
	• Chronic care management
	  • Depression
	  • Diabetes
	  • Cardiovascular disease
		• Evidence-based care elements for:
		  • Heart attack (AMI)
		  • Heart failure (CHF)
		  • Pneumonia
		  • Surgical infection prevention

OUTCOME	• Control of chronic conditions
	  • Diabetes
	  • Cardiovascular disease
	  • Hypertension
	  • ******Triple weighted******
		• Post-operative complications
		• Hospital-acquired infections
		• Obstetrical injury
		• Mortality (condition –specific)

PATIENT EXPERIENCE	• Access, Integration • Communication, Whole-person care	• Discharge quality, Staff responsiveness • Communication (MDs, RNs)
DEVELOPMENTAL	Up to 3 measures on priority topics for which measures lacking	

Components of the AQC Support Model

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Our four-pronged support model is designed to help provider groups succeed in the AQC.

AQC Results: The First Two Years

AQC Physician Participation (Current as of July 2012)

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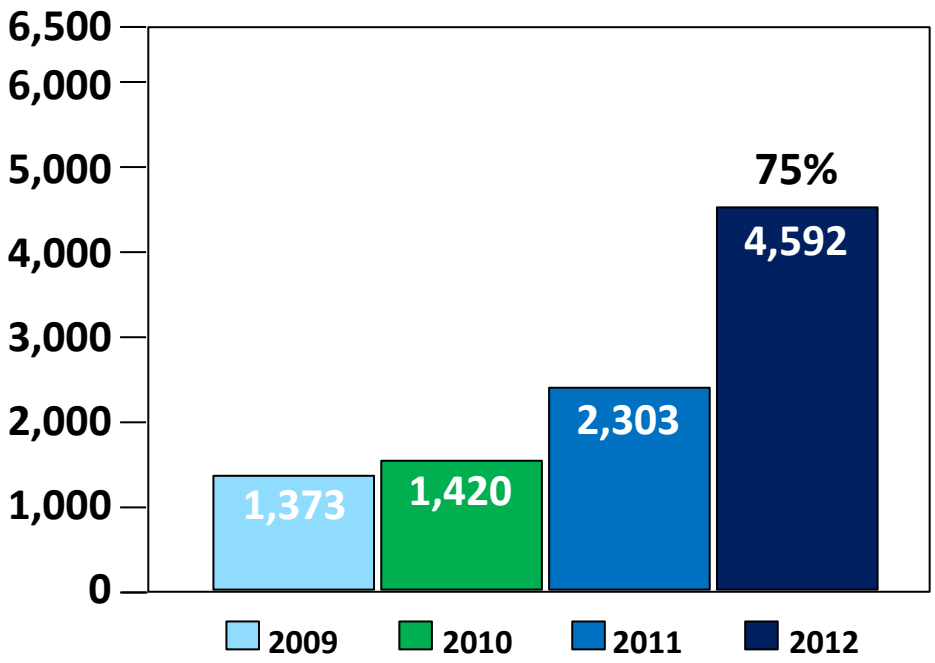
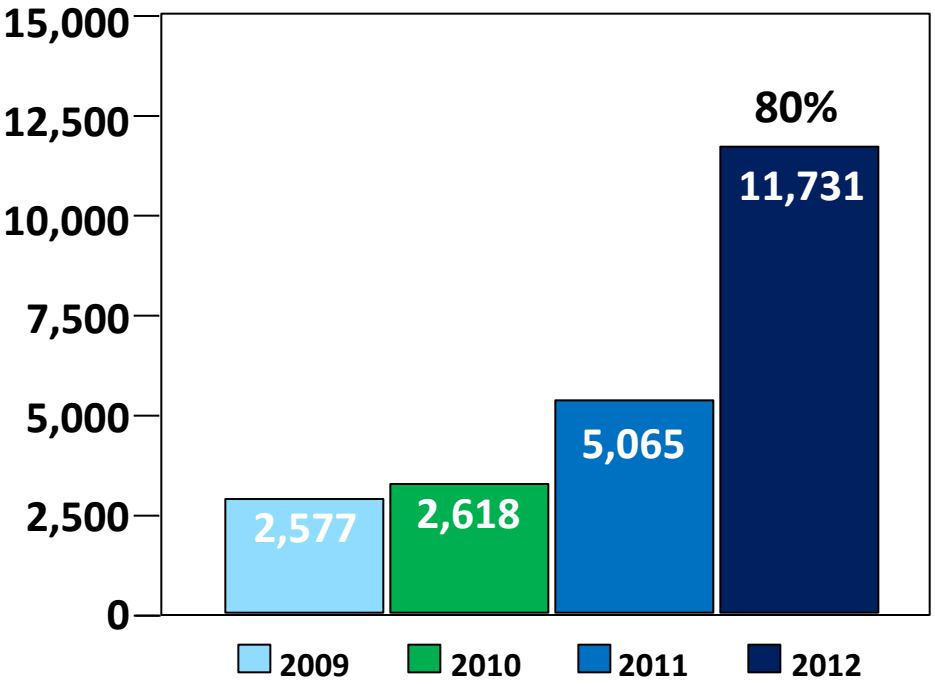
PCPs



SCPs



AQC is Significantly Improving Quality

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Year-one improvements in quality were greater than any one-year change seen previously in our provider network

- Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes 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.
- There were no significant changes in AQC groups' performance on patient care experience measures overall.

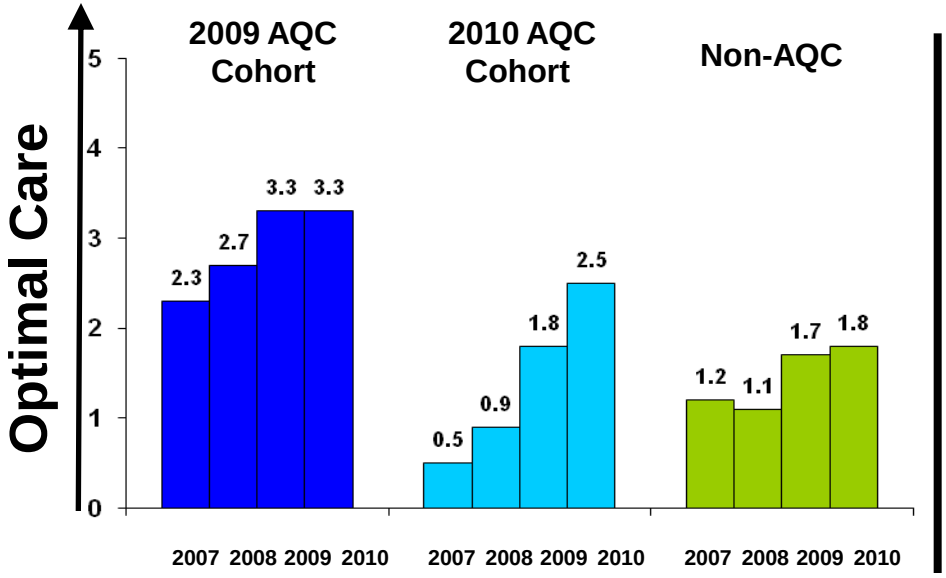
Year two showed continued significant quality improvements among AQC groups relative to others

- Some groups are nearing performance levels believed to be "best achievable" for a population.
- Significant improvements occurred in patient care experiences, including improved doctor-patient communication, access to care and integration of coordination.

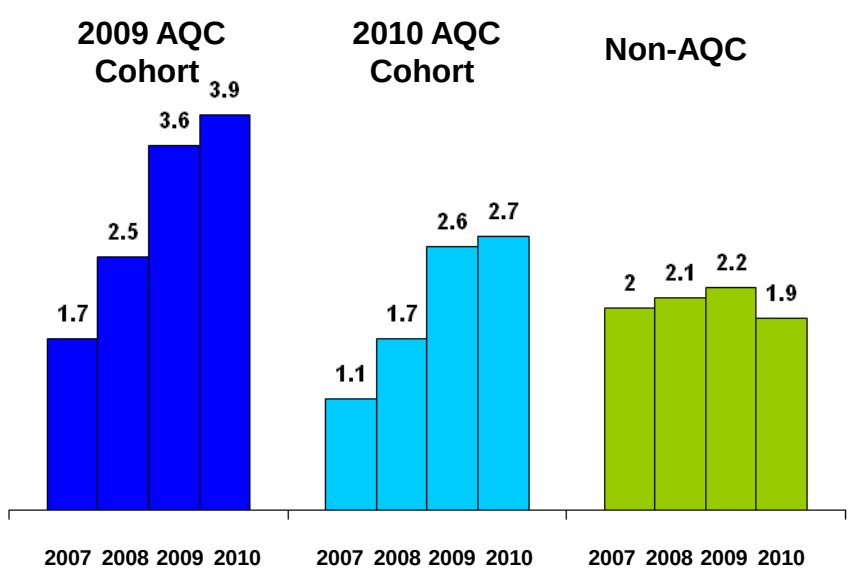
AQC Improving Preventive and Chronic Care

- The 2009 AQC cohort continues to demonstrate success improving quality—achieving benchmarks significantly higher than non-AQC peers.
- The 2010 AQC cohort made significant quality improvements in year one of their contract (2009 versus 2010).

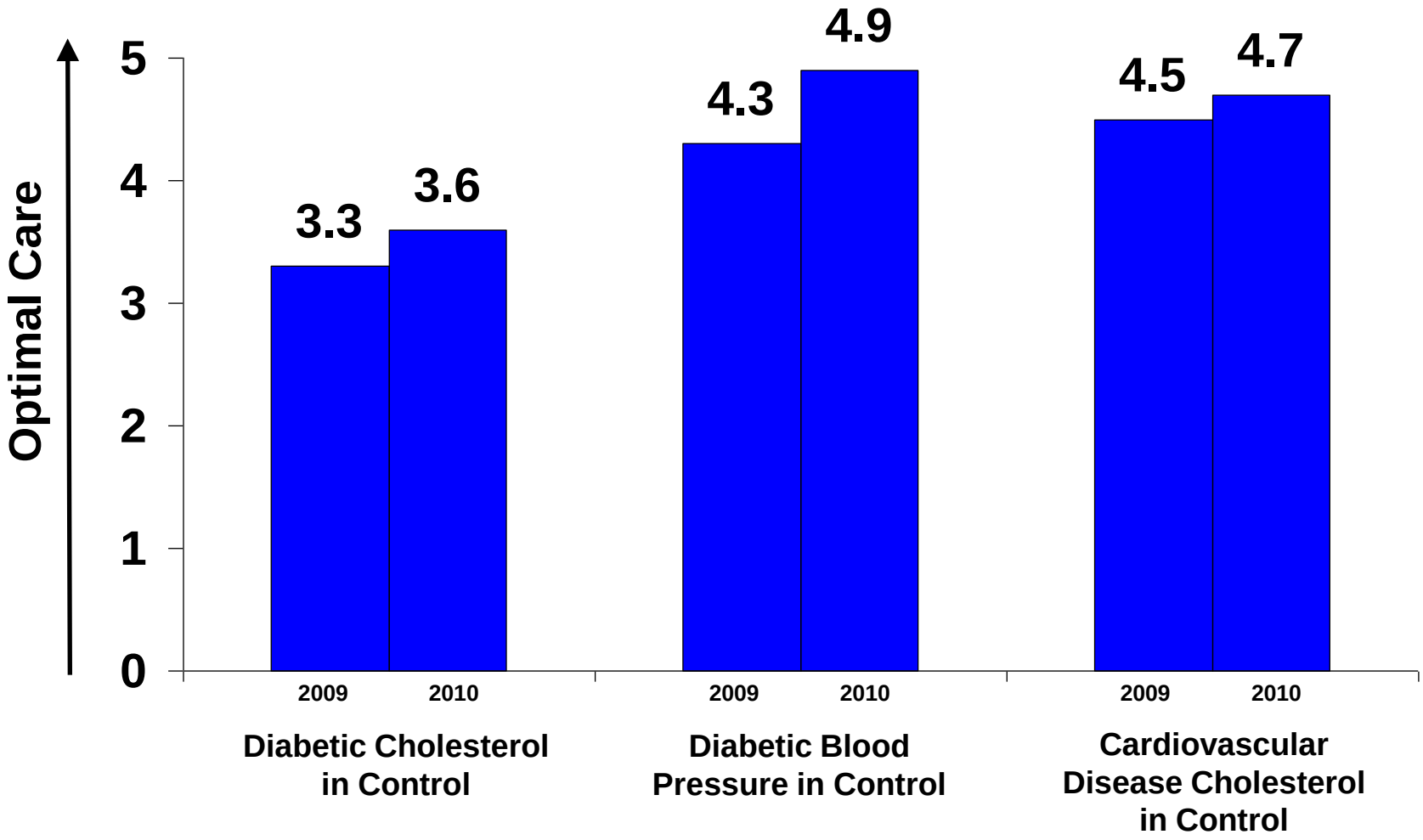
Preventive Screenings



Chronic Care Management



AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease



Results limited to AQC groups that received financial incentives for these measures in 2009.

Year-One Results: Formal Academic Evaluation

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Health Care Spending and Quality in Year 1 of the Alternative Quality Contract

Zirui Song, B.A., Dana Gelb Safran, Sc.D., Bruce E. Landon, M.D., M.A., Yulei He, Ph.D., Randall P. Ellis, Ph.D., Robert S. Mechanic, M.B.A., Matthew P. Day, F.S.A., M.A.A.A., and Michael E. Chernew, Ph.D.

"The AQC system was associated with modestly lower medical spending in the first year after implementation…a 1.9% savings relative to the control group (non-AQC)."

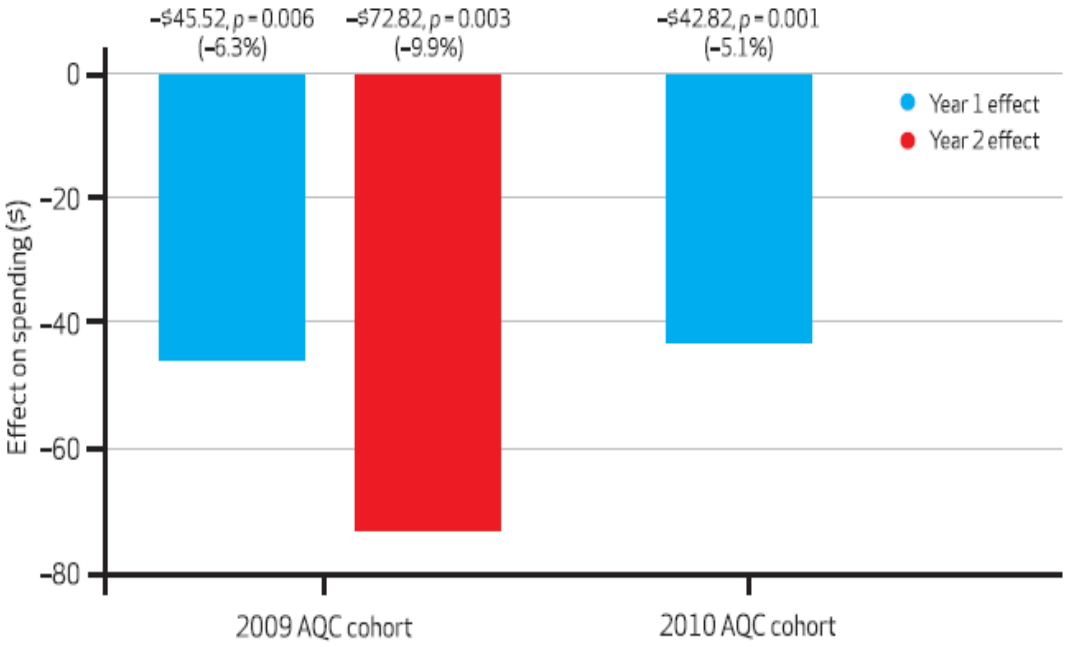
Formal Academic Evaluation : Year 2 Results

Researchers at Harvard Medical School found:

- The savings among AQC groups in year 2 was greater than in year 1 (3.3% in 2010 versus 1.9% in 2009).
- The savings were even more dramatic among AQC groups that had no prior risk/global budget experience (9.9% in 2010 vs. 6.3% in 2009).

EXHIBIT 3

Estimated Year 1 And Year 2 Effects Of The Alternative Quality Contract (AQC) On Spending In The 2009 And 2010 Cohorts' No-Prior-Risk Groups, Blue Cross Blue Shield Of Massachusetts



SOURCE Authors' analysis of 2006–10 claims data from Blue Cross Blue Shield of Massachusetts.
NOTES The figure shows difference-in-differences estimates of the separate year 1 and year 2 effects of the AQC on health care spending per member per quarter. For descriptions of the 2009 and 2010 cohorts, see the text.

Source: Song et al., *Health Affairs* August 2012; 31: 81885-81894.

Key Affordability/Cost-Related Developments in Massachusetts

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2006

- **Health reform passes (Ch. 58)**
  - Begins path to near universal coverage

2007

- Much of **Chapter 58 enacted**, e.g.:
  - MassHealth expansion
  - Commonwealth Care
  - Consumer affordability schedule
  - New health plan options for young adults
  - Employer Fair Share

2008

- **Cost Containment Part 1 (Ch. 305) passes**
  - Increased transparency about cost drivers
  - Reports on health insurer and hospital "reserves"

2009

- **Special Commission on Payment Reform**
  - Recommends move to global payment

2010

- **Government reports and hearings** on cost drivers
- **Governor rejects small group premiums**
- **Cost Containment Part 2 (Ch. 288) passes**
  - Aims to control premiums for small business, individuals

2011

- **Governor Patrick files payment reform legislation**

2012

- **Payment Reform (Ch. 224) passes**
  - Sets health care cost growth target at state GDP
  - Requires public payers (Medicaid, GIC, Connector) to transition to alternative payment models
  - Establishes ACO licensing process
  - Increased transparency of health care prices for patients

The Account View

XYZ EMPLOYER GROUP
Account Membership in AQC vs. Non-AQC
HMO/POS Only

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Measure	EMPLOYER GROUP XYZ		BCBSMA BOOK OF BUSINESS	
	PCP In AQC CY11 Score	PCP Not In AQC CY11 Score	PCP In AQC CY11 Score	PCP Not In AQC CY11 Score
UNIQUE MEMBER COUNT, %	N=2,052 (43%)	N=2,671 (57%)	N=399,845 (39%)	N=633,238 (61%)
QUALITY	%	%	%	%
Preventive Care & Screenings				
Breast Cancer Screening	77.6	78.5	82.9	79.1
Cervical Cancer Screening †	88.4	82.9	86.2	81.7
Colorectal Cancer Screening (51 - 75) †	77.7	74.1	71.8	68.4
Chlamydia Screening				
Ages 16-20 †	80.8	59.2	70.9	57.3
Ages 21-24	76.6	76.6	69.6	65.0
Chronic Care Management				
Depression				
Acute Phase Rx	66.7	61.1	69.4	68.4
Continuation Phase Rx	38.9	55.6	55.4	53.1
Cardiovascular				
LDL-C Screening	75.0	83.3	90.8	89.2
Diabetes				
HbA1c Testing (2X)	71.6	59.1	77.4	71.0
Eye Exams	58.8	61.8	66.6	59.8
Nephropathy Screening	87.3	83.6	88.9	82.4
Diabetes LDL-C Screening	87.3	83.6	90.9	86.6
Adult Respiratory Testing/Treatment				
Acute Bronchitis †	23.5	3.8	37.5	23.9
Pediatric Care				
Upper Respiratory Infection (URI)	92.1	93.8	94.5	94.1
Pharyngitis †	100.0	93.8	96.9	94.4
< 15 months Well Care Visits	90.9	81.0	92.7	87.4
3-6 Years Well Care Visits †	88.8	81.3	94.0	89.1
Adolescent Well Care Visits †	78.4	67.4	77.6	70.4

AQC Effect: Fee-for-Service (FFS) Trend

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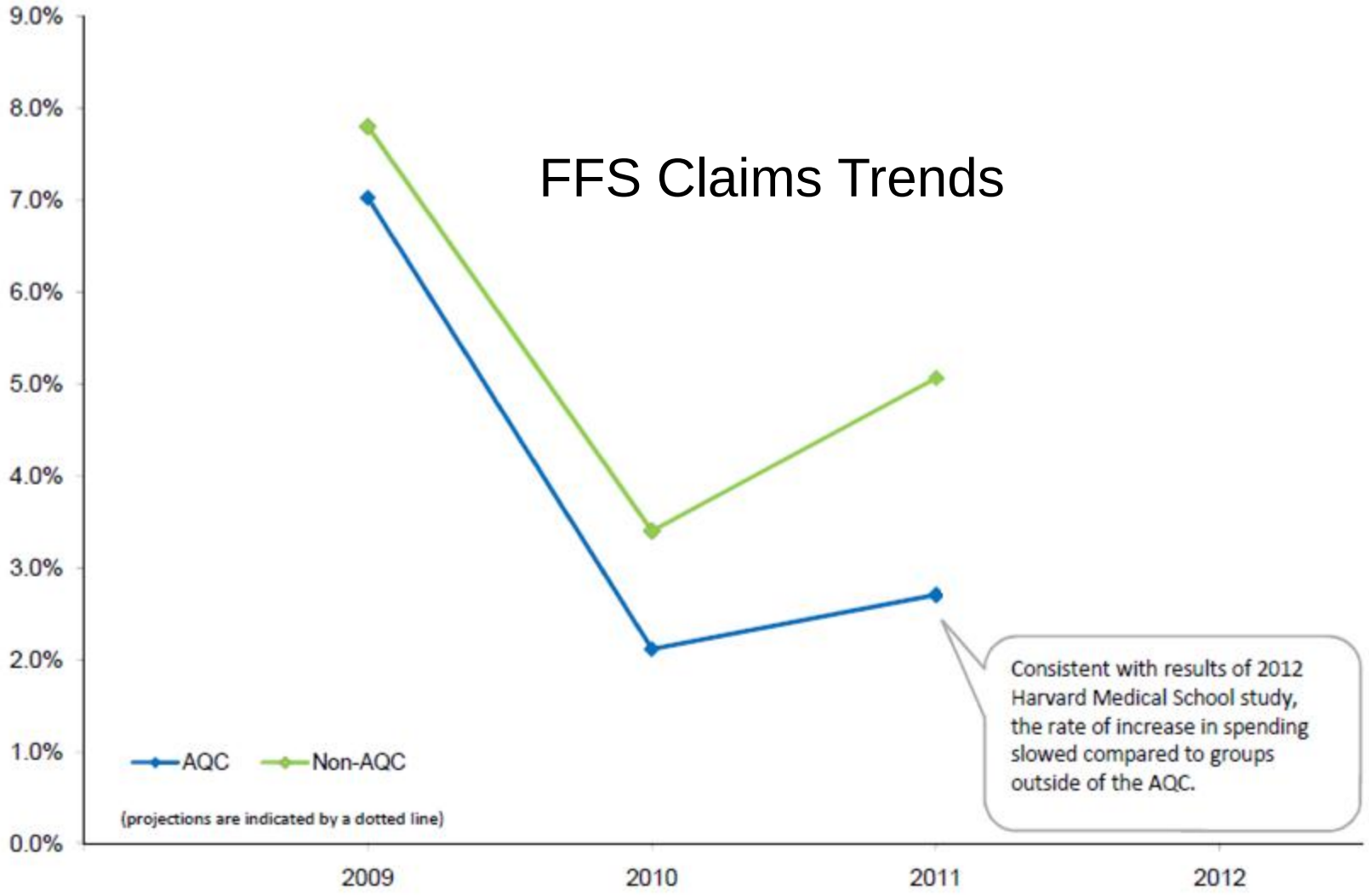

Products That Engage Members to Make Better Health Decisions

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Network Based

Select high value providers through benefit tiers, cost/quality transparency, select and preferred networks and Centers of Excellence

Value Based

Encourage appropriate medical care use and treatment compliance through evidence-based benefit designs

Consumer Driven Health Plans(CDHP) / Account Based Health Plans (ABHP)

Make cost effective health expenditures through deductibles and personal spending accounts

Healthy Engagement

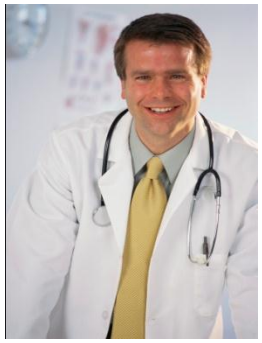
Improve compliance with healthy behaviors and treatment compliance rewarded through incentives and/or differential benefits

Shared Supports

- Personal Health Assessment
- Biometric Screenings
- Personal Health Record/Trackers
- Total Population Management
- Integrated Health Management
- Utilization Management
- Pharmacy Management
- Transparency
- Wellness Programming
- Decision-Support Tools
- Member Services
- Employee Education
- Informatics Reporting
- Ancillary Products
- Incentive Design

Integrate levers and capabilities to create differentiated, targeted engagement solutions that address opportunities to improve health decisions and lower costs

Barriers to Adherence



Cognitive

Financial

Logistical

Motivational

For More Information

Doctor and the Doll by Norman Rockwell

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