Align | Accelerate | Achieve

bright spot

cost | payment/incentives | care across settings

Organization: Alternative Quality Contract

Dana Gelb Safran, ScD, Senior Vice-President Performance Measurement and Improvement, BCBSMA
Contact later for more details: barbara.bowman@bcbsma.com, (617) 246-7606

About our organization

At Blue Cross Blue Shield of Massachusetts, we provide coverage for nearly 3 million members. BCBSMA is a not-for-profit organization founded by a group of community-minded business leaders. Our history – and future – is one of collaborating with the community to improve the health and quality of care that our members, and citizens of the Commonwealth, receive. Our provider community consists of nearly 21,000 HMO physicians; a little over 6,000 PCPs and nearly 15,000 specialists in addition to 77 acute care hospitals.

The problem we were trying to solve/the challenge(s) we faced

The rising cost of health care poses an unsustainable burden on consumers, employers and government and threatens local and national efforts at health care reform. At Blue Cross Blue Shield of Massachusetts we are acting boldly in our members' interest to make quality health care affordable. The challenge we faced was to create a voluntary payment model for doctors and hospitals in our network that would advance the twin goals of improving quality and outcomes while significantly slowing health care spending growth.

Our bright spot – the successful program, result, or process we want to share

The Alternative Quality Contract (AQC) is an innovative contract model developed by BCBSMA in 2007 and launched in 2009 to accomplish the twin goals of improving health care quality and outcomes while significantly slowing spending growth. Under the AQC, providers assume responsibility for the cost and quality of care across the full continuum of services, regardless of whether they provide that care directly.

bright spot

Alternative Quality Contract groups agree to accept a global budget to cover all health care services delivered to their patient population. Performance risk is two-sided – so groups share in budgetary savings but also are responsible for budgetary deficits. Significant earnings can be achieved through performance on a broad set of quality, outcome and patient care experience measures.

Early results of the AQC have been highly favorable and adoption has been more rapid than anticipated. As of January 2012, more than two-thirds of our physician network will be contracted under the AQC model. A formal evaluation of the AQC, being led by Dr. Michael Chernew (Harvard Medical School) recently reported year-1 results for the initial AQC cohort (2009). The study found that the AQC groups slowed medical spending growth by two percentage-points in the first year of their 5-year contract (Song Z et al, NEJM Sept 2010) – suggesting that the model is on track to achieve its goal of cutting spending growth in half over the 5-year contract term. Moreover, each and every AQC organization achieved significant quality and outcome improvements in year-1 – quickly outstripping the performance and improvement seen in the non-AQC segment of the network. All provider groups met their budget targets, producing surpluses that enabled them to invest in infrastructure and other improvements to further position them for success in managing cost, quality and patient outcomes.

The biggest hurdle

In 2007, when we began our first discussions with providers about the AQC, there was no sign of local or national payment reform on the horizon and no reason for a provider to opt into this voluntary system. Some worried that the AQC would simply be a return to the capitation payment system of the 1990s and that the quality of patient care would decline due to the withholding of treatment to maintain adequate costs. There was also fear that doctors might try to avoid sick patients and that physician access could decrease.

Aha moment or lesson learned

When the AQC was originally conceived, we imagined that the contract would need to involve a multispecialty physician group together with a hospital partner in a single deal. We presumed this would be necessary to address the model's requirement of accepting accountability for care across the continuum. As we began discussions with providers, we quickly relaxed that requirement as we realized that it was far premature to know what organizational structure would allow for success under the mode. In the end, we have every possible range of provider organizations in the AQC – some with a hospital as part of their deal and others without; some with specialty physicians included the contract and others without – and each and every one is succeeding in both managing to their budget and achieving high

levels of performance on the AQC quality measure set.

For those who want to steal shamelessly, what advice do you offer?

Payment reform does generate delivery system reform – and when payment reform establishes accountability for both total medical spending and for quality and outcomes, the natural outgrowth is the formation of true "systems" of care that integrate care across settings and manage patient care with attention to the "whole person." However, the changes in organizational and clinical relationships, process flows, attitudes and behaviors required to be successful in managing both cost and quality are substantial. They require investment, leadership, a data-rich environment and an ongoing, authentic partnership between providers, payers, purchasers and patients.