Improving Quality While Slowing Spending Growth
The Role of Payment Reform

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16 September 2016
Average spending on health per capita ($US PPP)

Total expenditures on health as percent of GDP

Source: OECD Health Data 2011 (Nov. 2011).
The increasing cost of health care in MA compared to other public spending priorities

STATE BUDGET, FY2001 VS. FY2014 (BILLIONS OF DOLLARS)

Source: Health Policy Commission, 2013 Cost Trends Report, data from the Massachusetts Budget and Policy Center
The Alternative Quality Contract:
Twin goals of improving quality and slowing spending growth

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.


Sources: BCBSMA, 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 population-based budget
- Shared risk: 2-sided symmetrical
- Health status adjusted
- Annual inflation targets set at baseline for each year of the contract and designed to significantly moderate cost growth

Improved quality, safety & outcomes:
- Robust performance measure set creates accountability for quality, safety & outcomes across continuum
- Substantial financial incentives for high performance and for improvement
# AQC Measure Set for Performance Incentives

<table>
<thead>
<tr>
<th>AMBULATORY</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROCESS</strong></td>
<td><strong>HEALTHCARE PROVIDER QUALITY CORE MEASURES</strong></td>
</tr>
<tr>
<td>• Preventive screenings</td>
<td>• Evidence-based care elements for:</td>
</tr>
<tr>
<td>• Acute care management</td>
<td>• Heart attack (AMI)</td>
</tr>
<tr>
<td>• Chronic care management</td>
<td>• Heart failure (CHF)</td>
</tr>
<tr>
<td>• Depression</td>
<td>• Pneumonia</td>
</tr>
<tr>
<td>• Diabetes</td>
<td>• Surgical infection prevention</td>
</tr>
<tr>
<td>• Cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td><strong>OUTCOME</strong></td>
<td><strong>HEALTHCARE PROVIDER QUALITY CORE MEASURES</strong></td>
</tr>
<tr>
<td>• Control of chronic conditions</td>
<td>• Post-operative complications</td>
</tr>
<tr>
<td>• Diabetes</td>
<td>• Hospital-acquired infections</td>
</tr>
<tr>
<td>• Cardiovascular disease</td>
<td>• Obstetrical injury</td>
</tr>
<tr>
<td>• Hypertension</td>
<td>• Mortality (condition –specific)</td>
</tr>
</tbody>
</table>

**Triple weighted**

**PATIENT EXPERIENCE**

• Access, Integration
• Communication, Whole-person care

• Discharge quality, Staff responsiveness
• Communication (MDs, RNs)

**EMERGING**

Up to 3 measures on priority topics for which measures lacking
Performance Payment Model: Original

Performance Payment Model

Performance Score

% Payout

0% 2% 4% 6% 8% 10%

2.0% 3.0% 5.0% 9.0% 10.0%

1.0 2.0 3.0 4.0 5.0
As quality improves, provider share of surplus increases/deficit decreases

Linking Quality and Efficiency
The 2011 AQC ensures that providers have a strong incentive to focus on both objectives.

PMPM Quality Dollars
The 2011 AQC also allows groups to earn PMPM quality dollars regardless of their budget surplus or deficit. High quality groups earn more PMPM quality dollars.
As of January 2016, 2,247 (39%) of PCPs and 8,084 (54%) specialists (SCP) currently participating in AQC are also participating in PPO Payment Reform model. This translates into 26% of PPO members being cared for under PPO Payment Reform. Combined with the 86% of our HMO members cared for in the AQC, 52% of our commercial membership are cared for by providers who have accepted global budget quality contracts with BCBSMA.
AQC Results: Formal Evaluation Findings

Our strong provider relationships and targeted support have contributed to AQC success.

The AQC has been transformative. It has allowed us to innovate because it enables us to think like a system rather than individuals doctors.

- Leslie Sebba, MD, Medical Director
Northeast Physician Hospital Organization
Data and Actionable Reports

We distribute reports that can be used to help organizations recognize opportunities, develop goals and measure their success.

Daily
- Daily Census, Discharge, PCP Referrals and Inpatient & Outpatient Authorization Reports

Weekly
- New Member Report
- ED Utilization Report

Monthly
- AQC Member Call Tracking Grid
- Monthly Ambulatory Quality Report
- Monthly AQC Ambulatory Quality Measures Group Comparison Report
- Chronic Condition Opportunities Report
- Quality Diabetic Composite Score

Bi-Monthly
- Case Management Report

Quarterly
- Ambulatory Care Sensitive Conditions Report
- AQC Financial Dashboard
- Non-Emergent ED Report
- Top 100 Rx Report

Bi-Annually
- Practice Pattern Variation Report—Episode Treatment Groups (ETG)
- Practice Pattern Variation Report—Emergency Department Use for Specific Conditions

Annually
- Readmission Report
- AQC Ambulatory Quality Measures Score/Results
- AQC Hospital Quality Measures Score/Results

Recurring
- Cost and Use Report
- Site of Service Report
Benign Hypertension, With and Without Comorbidity
Individual Primary Care Physicians
Rate of ARB Use per 100 Episodes with ACE-I and/or ARB
2007

Rate = Episodes with ARB / Episodes with ACE-I and/or ARB

- The 12 primary care physicians in this group have rates of ARB use ranging from 13% to 55%.
- 9 physicians have rates above the network average.
Delivery System Innovation: Four Themes

There are four domains in which we see AQC Groups innovating to improve quality and outcomes while reducing overall spending.

- Staffing Models
- Approaches to Patient Engagement
- Data Systems & Health Information Technology
- Referral Relationships & Integration Across Settings
A shift in how healthcare is paid for
By Noam N. Levey
WASHINGTON BUREAU DECEMBER 12, 2012

Blue Cross vastly expands quality-based payment systems
By Priyanka Dayal McCluskey
GLOBE STAFF MARCH 05, 2015

Blue Cross extends incentives for care
By Priyanka Dayal McCluskey
GLOBE STAFF OCTOBER 6, 2015

BCBSMA WORK IN PAYMENT REFORM

To lower health costs, change the ways doctors get paid
Editorial NOVEMBER 11, 2014

The experience with Massachusetts Blue Cross suggests that global payments can help change the culture of medical practice. If this model shaves just a few percentage points off the spending growth rate, total health care expenditures in the nation could drop by tens of billions of dollars a year, saving trillions over the next two decades.”

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How Insurers Can Help
SEPTEMBER 30, 2012

The New York Times
Payment Reform in the Headlines

Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

FOR IMMEDIATE RELEASE
January 26, 2015

In a meeting with nearly two dozen leaders representing consumers, insurers, providers, and business leaders...HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018...

Leaders Forming New Health Care Transformation Task Force Commit to Putting 75% of Their Businesses in Value-based Arrangements by 2020

January 28, 2015

Several of the nation’s largest health care systems and payers, joined by purchaser and patient stakeholders, today announced a powerful new private-sector alliance dedicated to accelerating the transformation of the U.S. health care system to value-based business and clinical models aligned with improving outcomes and lowering costs. The Health Care Transformation Task Force, whose members include six of the nation’s top 15 health systems and four of the top 25 health insurers, challenged other providers and payers to join its commitment to put 75 percent of their business into value-based arrangements...

Prepared Remarks to the Massachusetts Health Policy Commission – October 5, 2015
Andrew Dreyfus, President and CEO, Blue Cross Blue Shield of Massachusetts

We are now offering a PPO model to the physicians and hospitals in our network, starting in 2016, and I am pleased to report that Lahey Health, the Mount Auburn Cambridge Independent Practice Association (MACIPA), the Partners HealthCare System and Steward Health will be among the first organizations to participate. These groups care for almost a third of our in-state PPO members...
How Accounts Experience the AQC

**FFS Costs**

Global budget contracts create incentives for providers to deliver more efficient, high quality care – lowering FFS trend

**Incentive Payments for Performance**

Global budget contracts will have higher incentive payments than traditional contract types

**Total Cost**

However, on a total cost basis, global budget contracts deliver on the goal of providing high quality care at more affordable trends

While the charges associated with incentive payments rose relative to traditional contracts, the overall medical trend declined significantly
Account View: Putting FFS and Incentive Costs in Perspective

<table>
<thead>
<tr>
<th>Allowed Claims PMPM</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed FFS</td>
<td>$445</td>
<td>$465</td>
<td>$472</td>
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<tr>
<td>Incentive Payments for Performance</td>
<td>$5</td>
<td>$10</td>
<td>$32</td>
</tr>
<tr>
<td>Total</td>
<td>$451</td>
<td>$475</td>
<td>$504</td>
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</table>

Components of Trend

<table>
<thead>
<tr>
<th></th>
<th>2010/09</th>
<th>2011/10</th>
<th>2 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed FFS</td>
<td>4.4%</td>
<td>1.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Incentive Payments for Performance</td>
<td>1.0%</td>
<td>4.7%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>5.4%</td>
<td>6.1%</td>
<td>5.8%</td>
</tr>
</tbody>
</table>
Impact of the AQC on Medicare spending and quality

“These results make it clear: There is no free lunch. There may be free chips or fruit salad, but if you want the lunch, you have to come to the table.” – Paul Grundy, MD, Director of IBM Global Healthcare Transformation
Priority Issues Ahead

Expanding Payment Reform to Include PPO

% PPO (+non/HMO) penetration by state, July 2012
- 85% - 100%
- 70% - 85%
- 50% - 70%

BCBSMA commercial provider network revenue, by product

53% PPO
47% HMO

Continued Evolution of Performance Measures

Outcomes:
- Clinical Process
- Patient Experience
- Clinical Parameters
- Patient Functional Status, Pain and Well-being

- OB/GYN
- Orthopedics
- Oncology
- Mental Health

Continued Evolution of the Delivery System

Payment Incentives to Front Line Clinicians

Blue Cross Blue Shield of MA

Provider Group A
- Predominantly RVU, plus small incentive on quality

Provider Group B
- A mix of salary and incentive (RVU, patient experience, and quality)

Provider Group C
- Salary only
**Recommendation**: To support the long-term success and sustainability of population-based payment models, future state measures must be based, as much as possible, on results that matter to patients (e.g., functional status) or the best available intermediate outcomes known to produce these results.
Outcome Measure Framework: Obstetric Care

- Controlling condition progression
- Acute complications of treatment
- Patient Reported Outcomes (e.g. functional status, pain, well-being)
Summary and Priority Issues Ahead

Summary

- Payment reform gives rise to significant delivery system reform

- Rapid and substantial performance improvements are possible in the context of:
  - Meaningful financial incentives
  - Rigorously validated measures & methods
  - Ongoing and timely data sharing and engagement
  - Committed leadership

- For payment reform, deep provider relationships and significant market share are advantageous
  - For national payers, remote provider relationships pose engagement challenges; member-facing incentives (benefit design) an attractive lever

Priority Issues Ahead

- Expanding payment reform to include PPO presents unique challenges
  - Gaining strong employer buy-in & support will be important; and this means models must offer value from day-1

- Continued evolution of performance measures to fill priority gaps
  - Focus on outcomes, including patient reported outcomes (functional status, well being)

- Continued evolution of the delivery system:
  - Evolving the role of hospitals in the delivery system
  - Building deeper engagement of specialists
  - Advancing innovations in virtual care

- Payment incentives to front line clinicians need continued attention
For More Information

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