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Moving from Innovation to Business Model: BCBSMA's Alternative Quality Contract (AQC)

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

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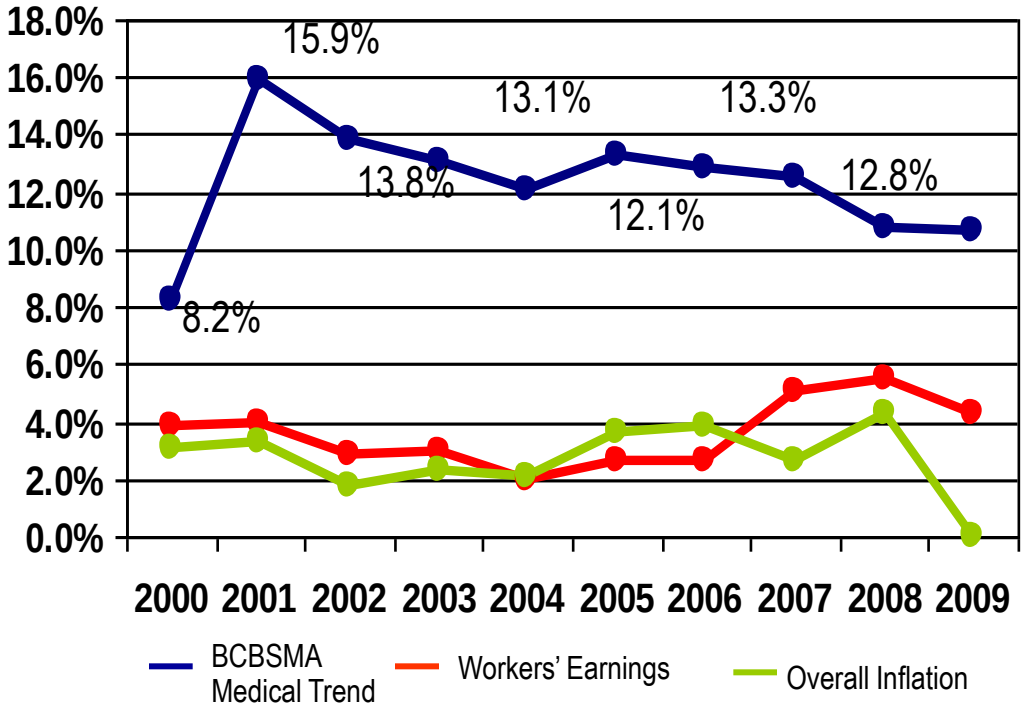
In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.

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, Bureau of Labor Statistics

Key Components of the AQC Model

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Unique contract model:

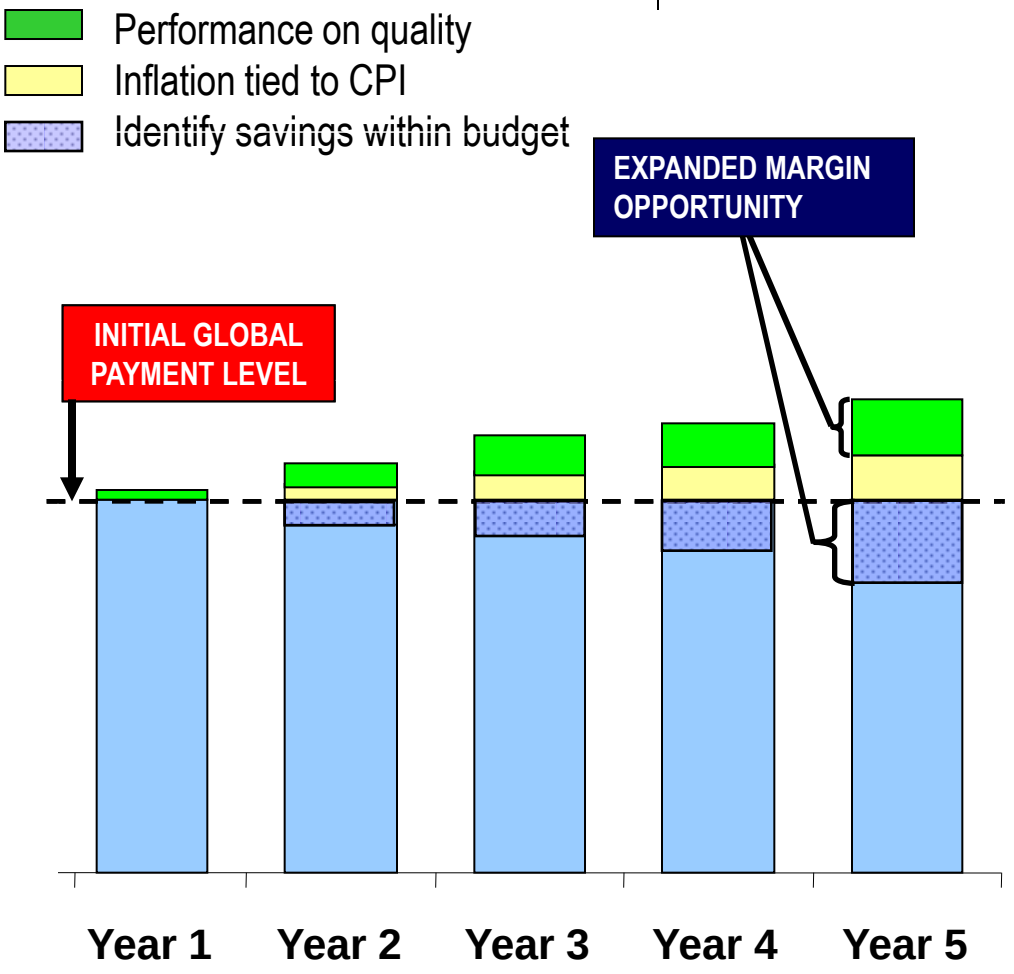
- Accountability for quality and resource use across full care continuum
- Long-term (5-years)

Controls cost growth:

- Global payment
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care ("overuse")

Improved quality, safety & outcomes:

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



Performance Payment Model: Updated (2011)

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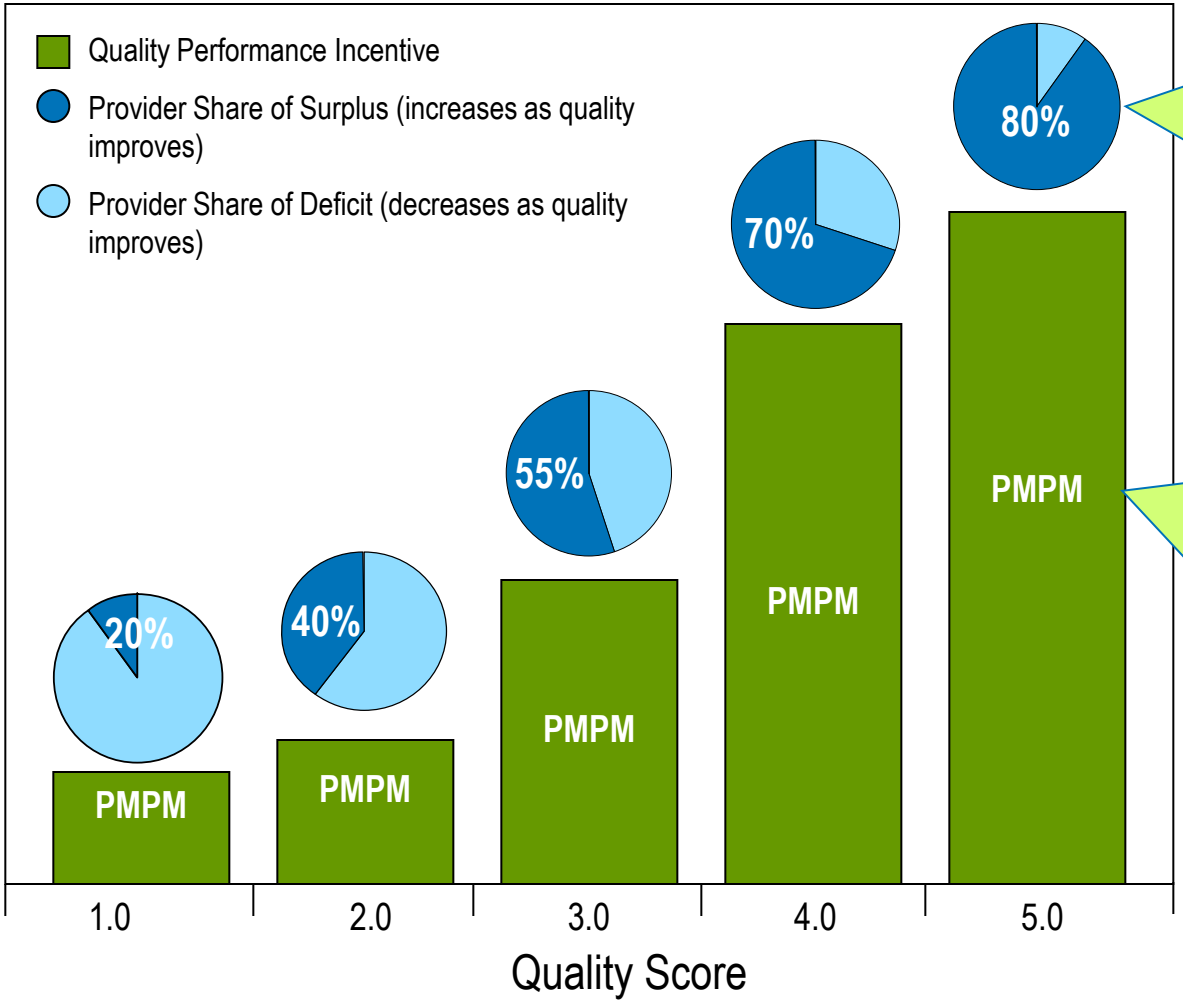
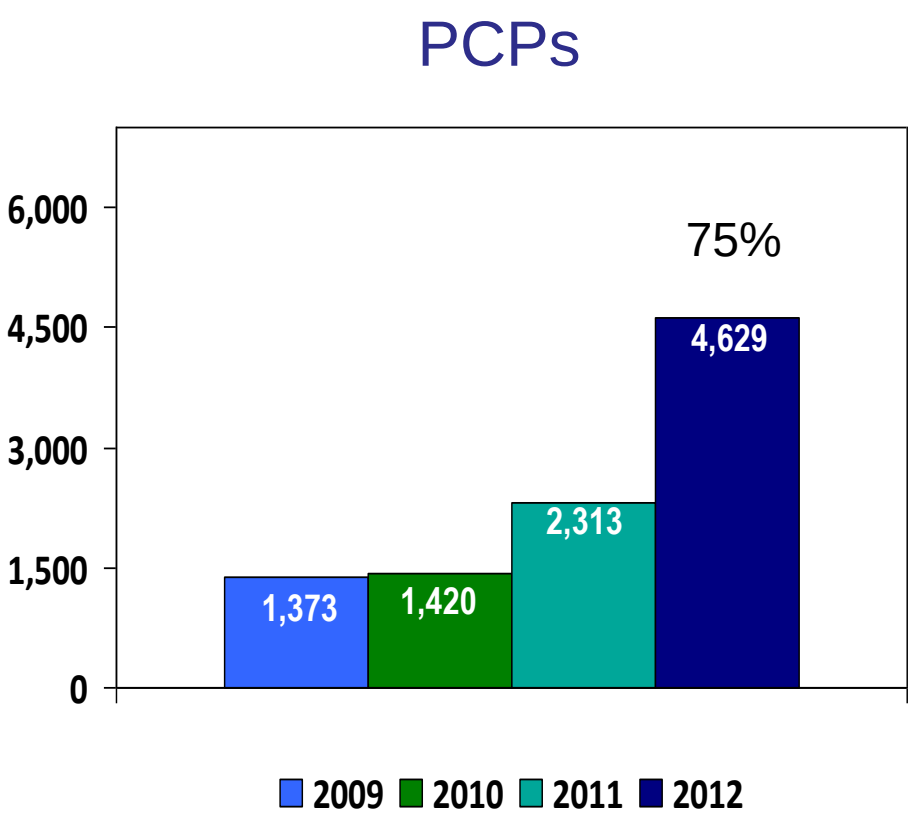
As quality improves, provider share of surplus increases/deficit decreases

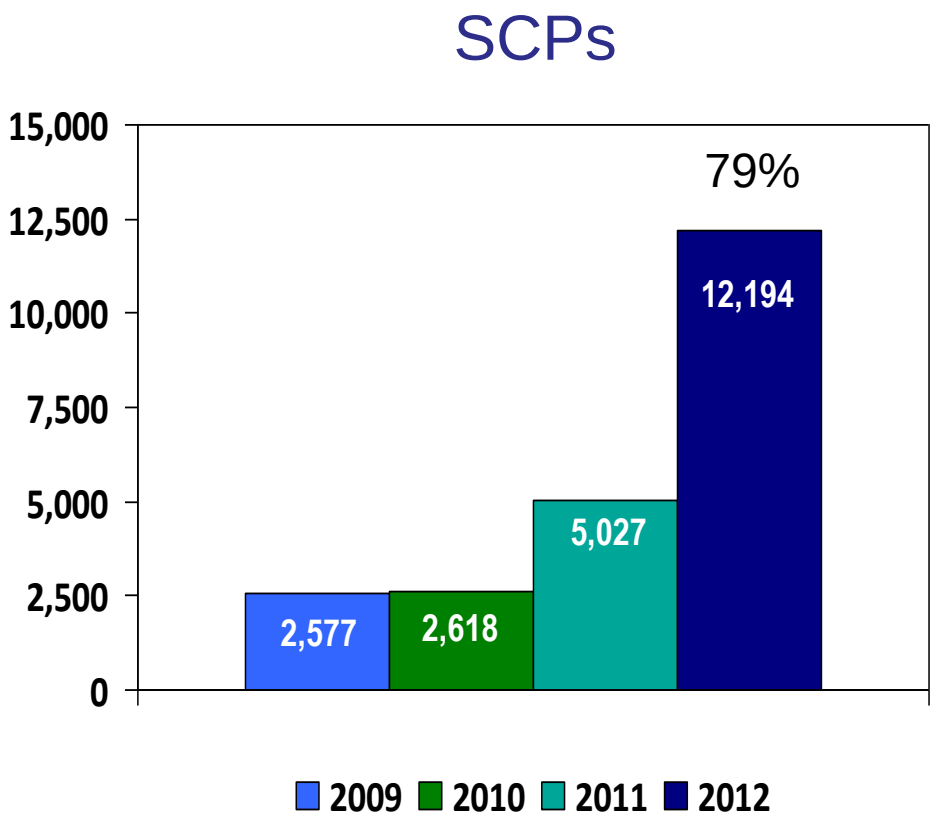


Linking Quality and Efficiency
The 2011 AQC ensures that providers have a strong incentive to focus on both objectives.

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.

AQC Physician Growth
(Current as of June 2012)





Growth has occurred through the addition of new AQC providers as well as expansion of existing AQC agreements.

Five Keys Ingredients to AQC Success

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1 **Measures** The measures are nationally accepted as clinically appropriate so there is wide support for improving performance on these indicators.

2 **Financial Incentives** Real dollars are at stake for improvement.

3 **Targets** 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 , Reports, Advice** Dynamic/actionable data and reports made available daily, monthly and quarterly, helping organizations to identify efficiency opportunities at a patient, practice and organizational level.

5 **Leadership** Each group has strong engaged leadership driving to success on integrating care, significantly improving quality and reducing costs.

Moving from Pilot Innovation to the Contracting Model of Choice

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External Factors

Unsustainable health care cost growth in the US, and MA in particular.

MA based policy reform: 2006 – access, 2012 – cost and quality

Strong political imperative to rethink payment system on both the plan and provider sides – payment reform commission, rate reviews in merged market

Internal Factors

Unsustainable premium growth for accounts and individuals as a result of health care cost growth

Strong imperative from senior leadership to “do something new” and the flexibility to move to market very quickly

Criteria

External academic evaluation by Harvard Medical School – early findings demonstrate cost growth is slowing and quality is improving

Providers responding extremely well

Again, strong public imperative to reduce costs and improve quality on tails of coverage reform