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Transforming Healthcare in Massachusetts

Incentive Programs and Payment Reform

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- The health care industry is facing a crisis of increasing costs along with significant issues related to quality and safety of care
 - The current payment system has created unintended consequences
 - Payment system rewards volume and intensity
 - It will be a challenge for employers to continue their role in the insurance system if we can't change these dynamics
 - Providers who can demonstrate high quality, manage services efficiently, and demonstrate improved patient health will have a competitive advantage



A health care system that provides safe, timely, effective, affordable, patient-centered care for everyone in Massachusetts.

Levers of Change



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Redefining the Payment Model Through Measures and Incentives



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The Problem:

The fee-for-service system rewards overuse and duplication of services . . . without rewarding prevention of avoidable hospitalizations, control of chronic conditions, or care coordination.

The Solution:

Payment systems that reward both the quality and efficiency of care.

- *Karen Davis, President, The Commonwealth Fund (March 2007)*

Evolution of Performance-based Incentives

First Generation

- Cost-based Measures
- 5% Incentive

Second Generation

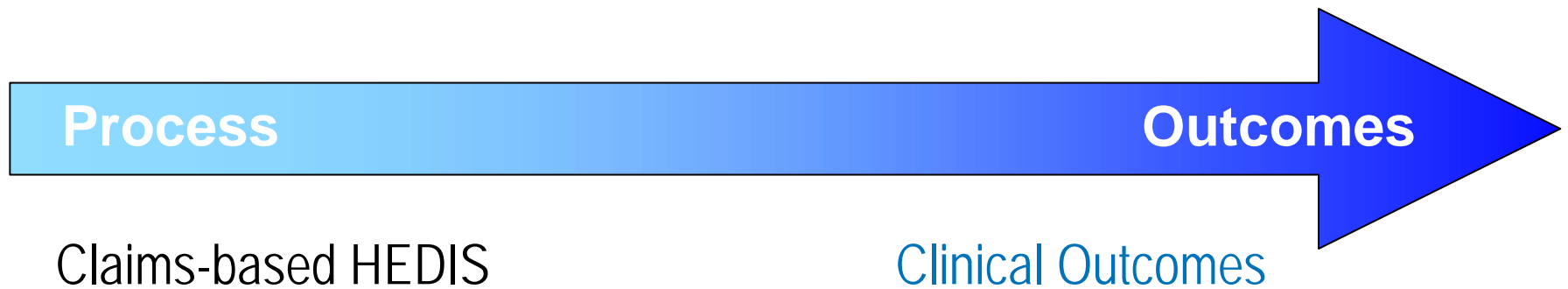
- HEDIS Measures
- 15% Incentive

Third Generation

- HEDIS/Rx/ Satisfaction
- 15% Incentive

Next Generation

- Decision Support, Technology, & Outcomes-based Measures
- 15-25% Incentive



Pay-for-Performance Goals



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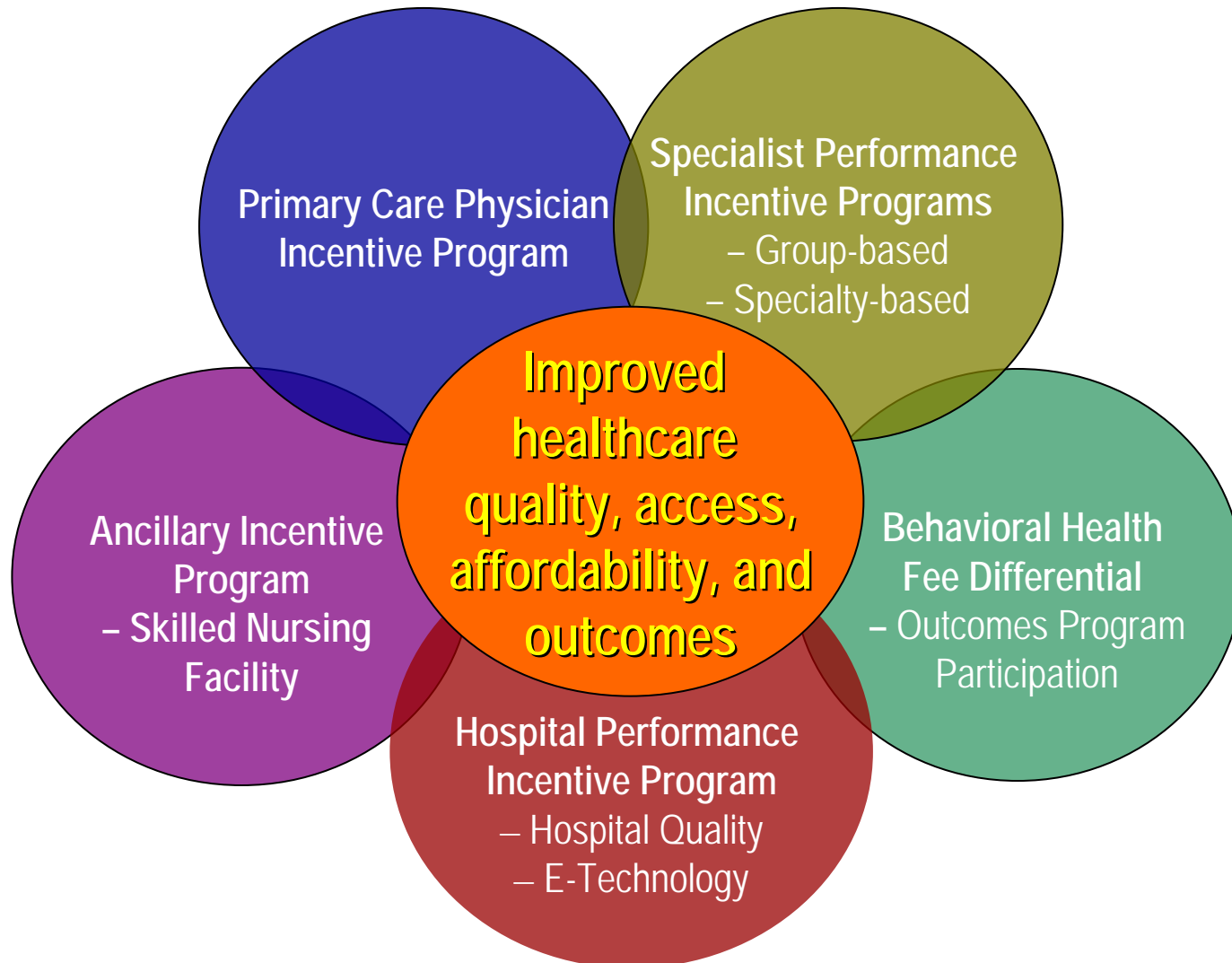
- Collaborate with our Providers to improve systems and processes that prevent medical errors and improve quality of care
- Support our Providers with data that assists them in providing more effective and efficient care
- Increase the amount of provider reimbursement that is linked to incentives (Quality/Safety, Efficiency, Technology Adoption, Reporting/Transparency)
- Evolve the payment methodology over time so that providers are paid differently for providing safe, effective, and efficient care

Pay-for-Performance Programs

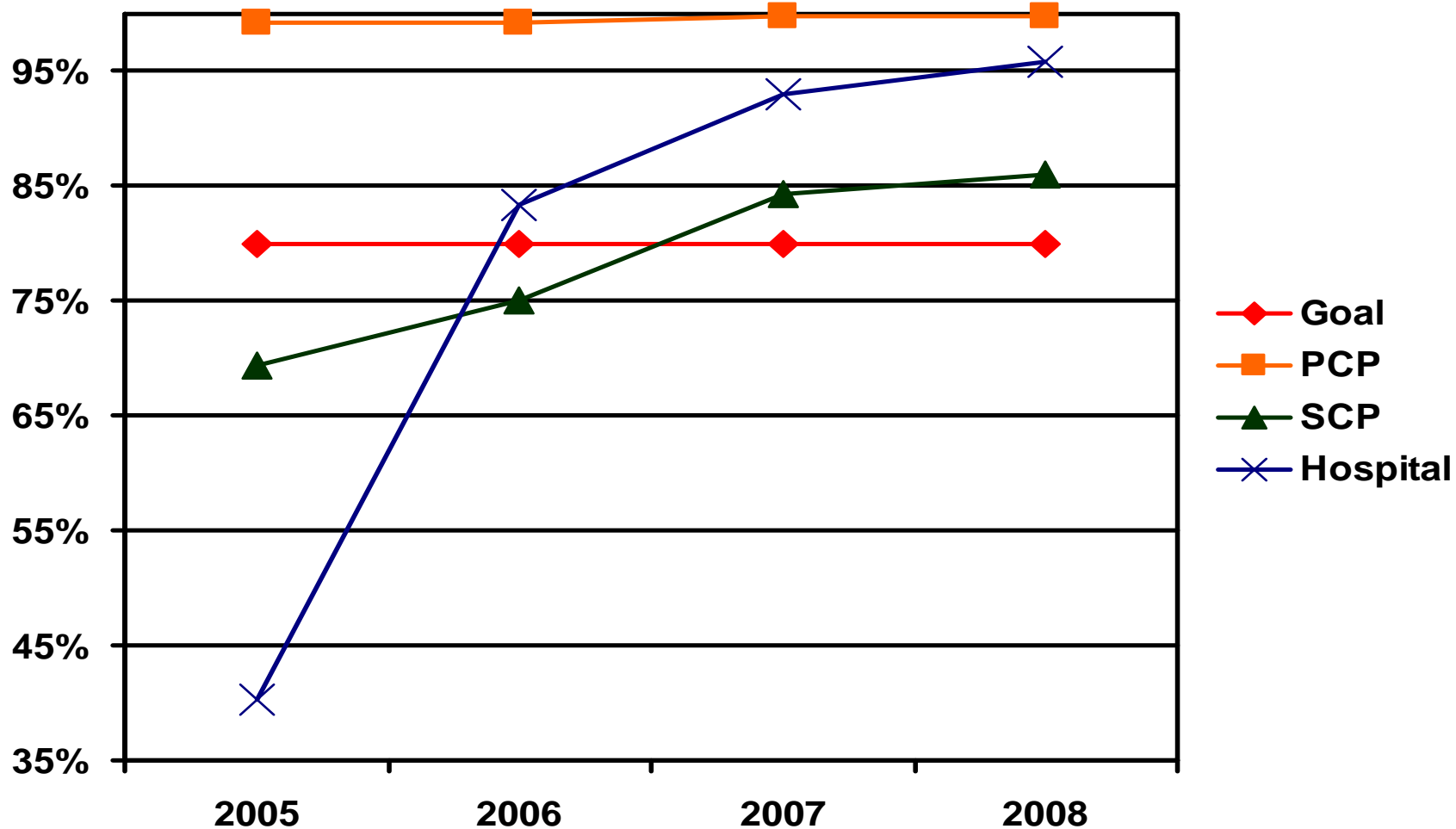
An Integrated Approach



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Network Provider Participation in Incentive-Based Reimbursement Programs

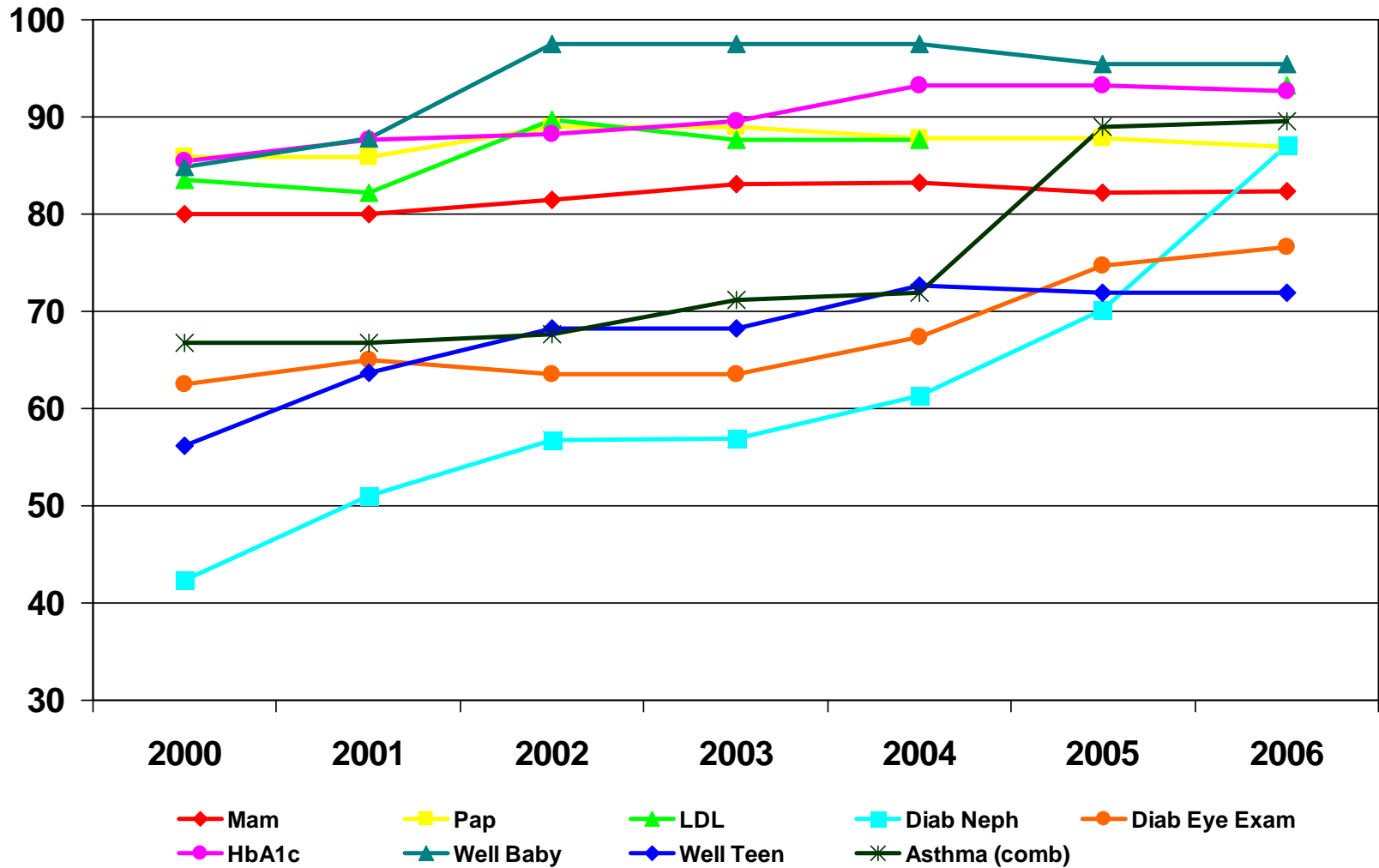


Incentive Programs' Results

- Paid out over \$27 Million in incentive payments to qualifying PCPs for their results in 2007, totaling over \$151 Million since 2000
- Payments range from \$35,000 to \$2.6 million per hospital in 2006* for those HPIP hospitals achieving performance goals; a total of \$17.6 Million
- Groups received a total payout of \$15.9 million for 2007 performance; an average payout per group of \$758,000
- Payout for initial year of SNF incentive program was \$900,000
- Results not yet available for Behavioral Health incentive programs.

All 2007 amounts include projected appeals. * Most recent available data

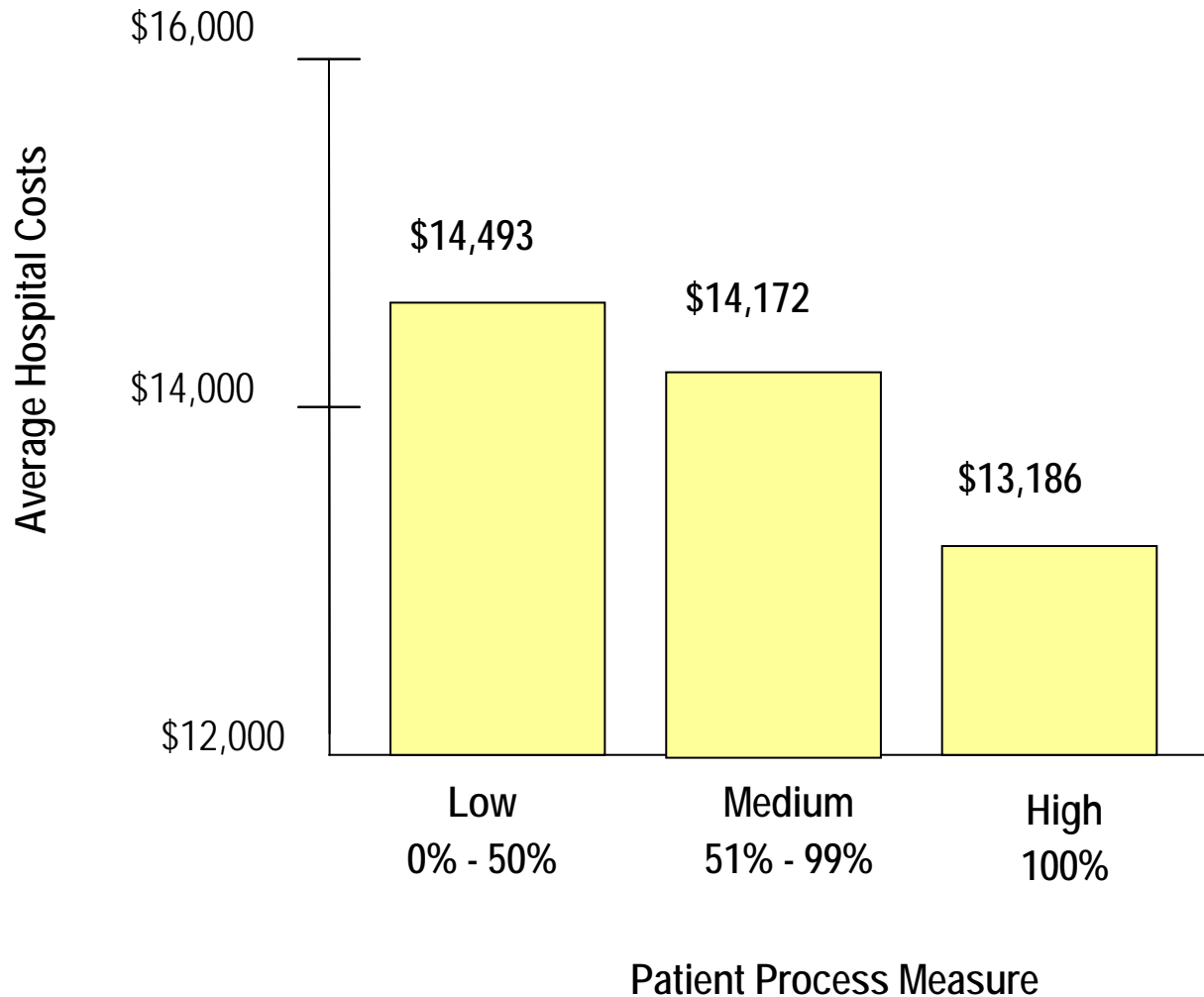
Performance Over Time on PCPIP Measures



Performance Pays: Higher Quality, Lower Costs

Premier Quality Demonstration Project

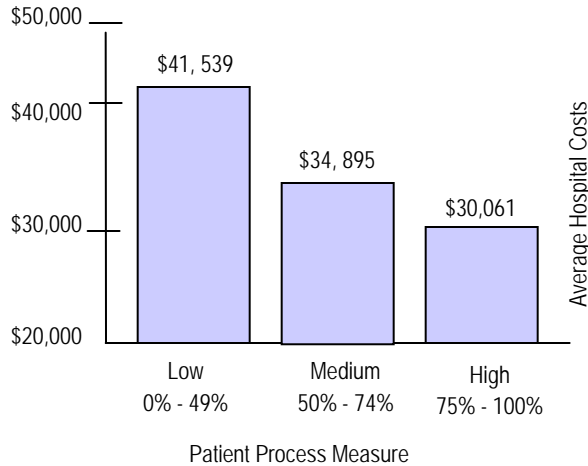
Hospital Costs for Hip Surgery Patients



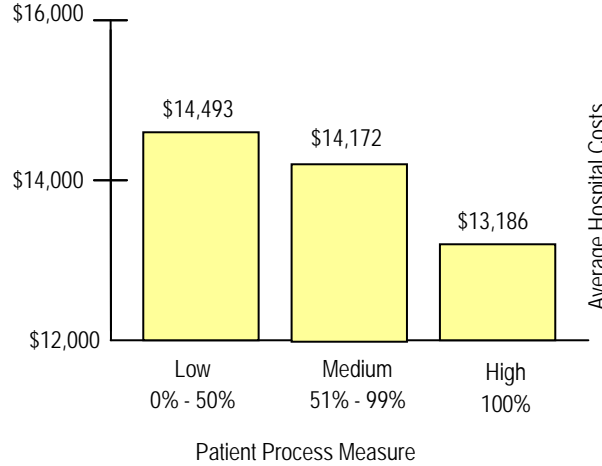
Performance Pays: Higher Quality, Lower Costs

Premier Quality Demonstration Project

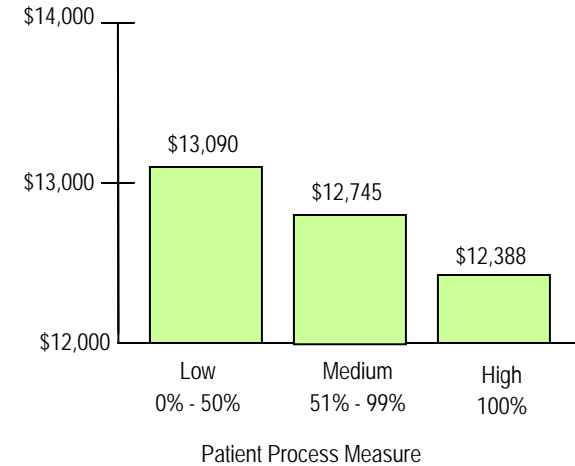
Hospital Costs for Heart Bypass Surgery



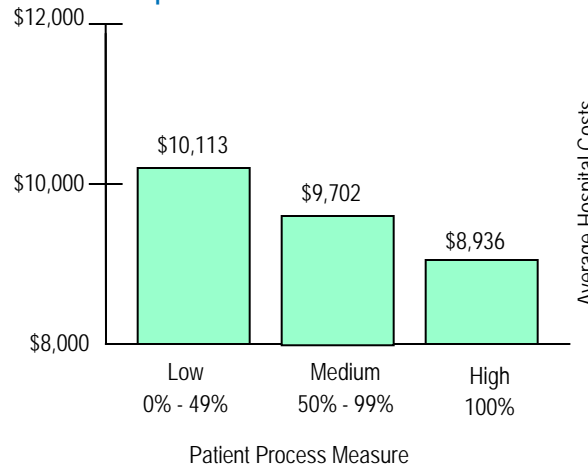
Hospital Costs for Hip Surgery Patients



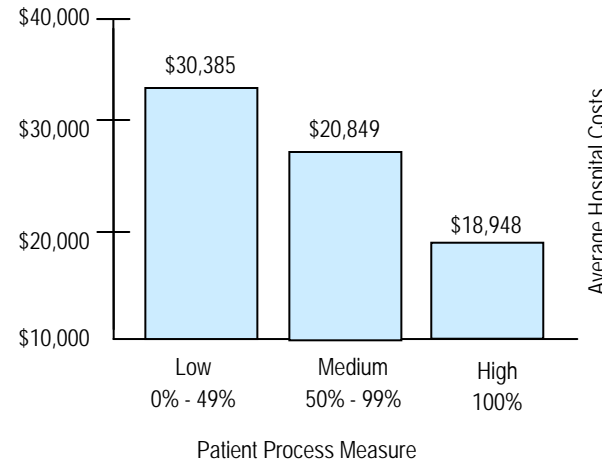
Hospital Costs for Knee Surgery Patients



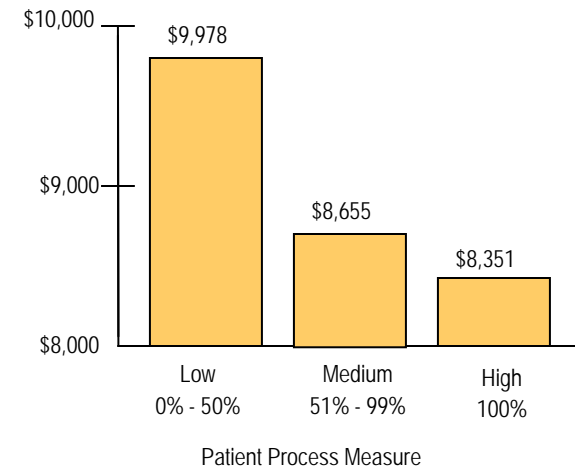
Hospital Costs for AMI Medical Patients



Hospital Costs for AMI Surgical Patients



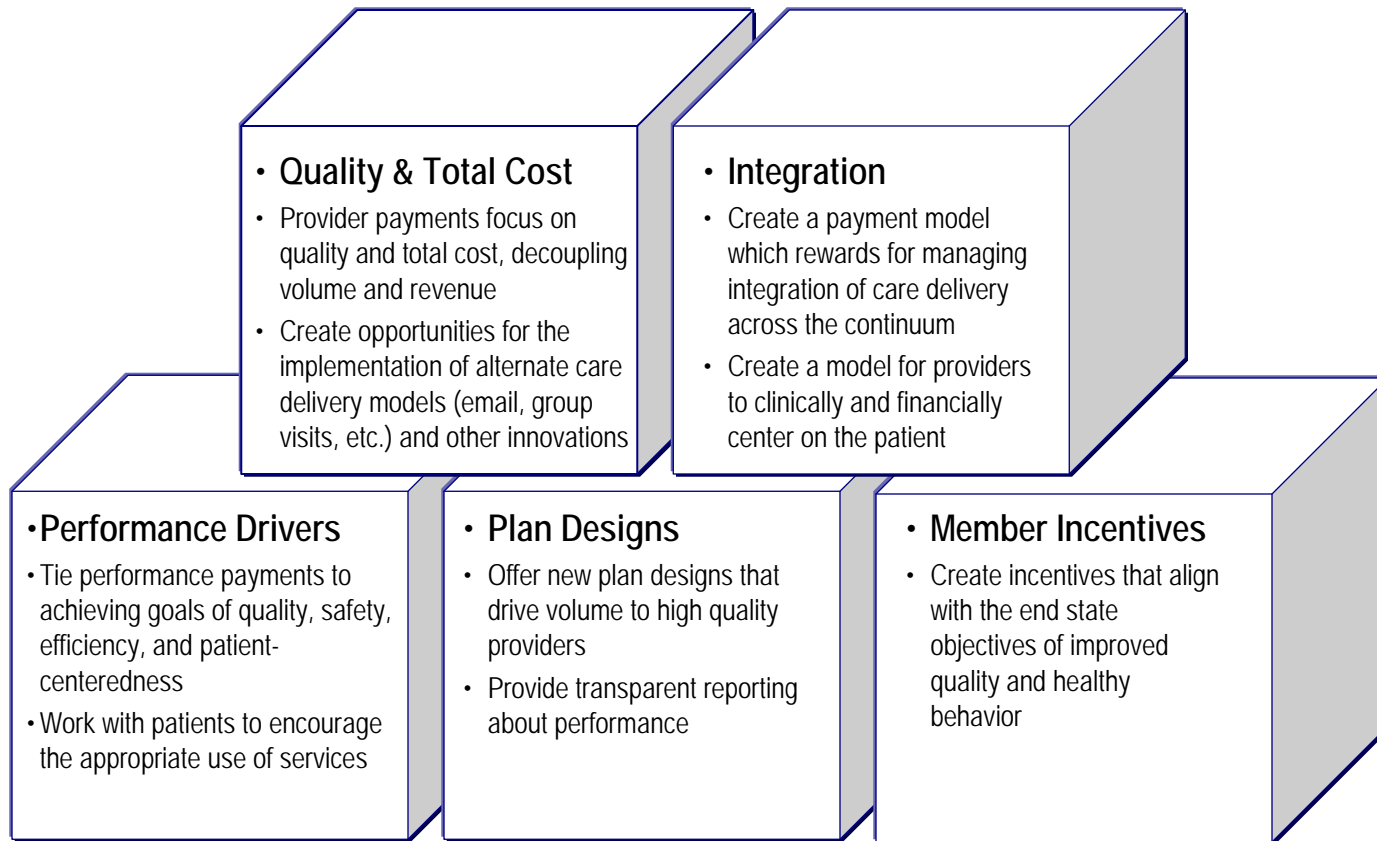
Hospital Costs for Pneumonia Patients



A New Approach – An Alternative Quality Contract



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Financial Structure of the Alternative Quality Contract

- Financial structure based on four components:

- Global payment**

- Based on total medical expenses
 - Health status adjusted

- Margin Retention**

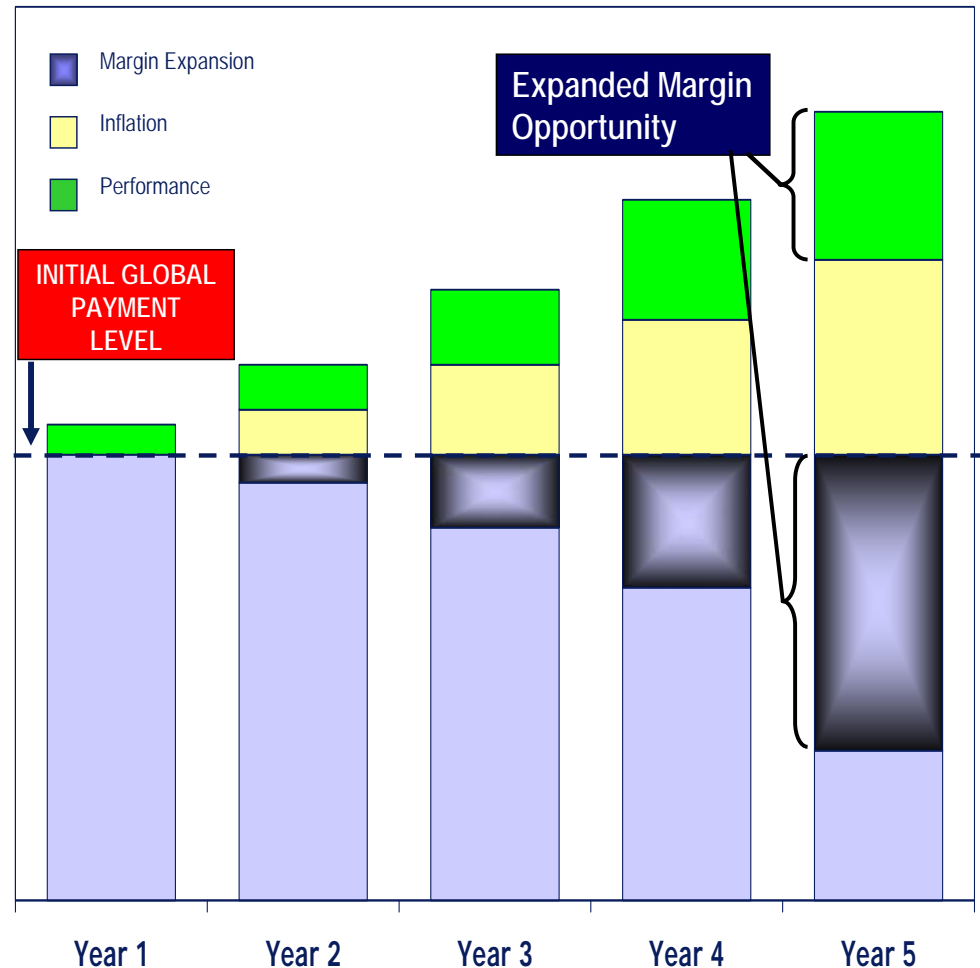
- Initial Global Payment includes inefficiencies

- Performance Incentive**

- Up to 10% of Total Medical Expense

- Inflation**

- Set at general inflation



Defining Performance Measures For The AQC



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- Goal: Measures should collectively advance safe, affordable, effective, patient-centered care
- Principles for selecting measures:
 - Nationally accepted
 - Sufficient variation among providers
 - Sufficient data on provider being measured
 - Measurement at level (individual, group, hospital, system) that can influence outcome
- Incentives based on established performance thresholds
 - Rewards for both absolute performance and for performance improvement
 - Offers transparency to providers regarding performance priorities and expectations

Hospital Quality and Safety

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

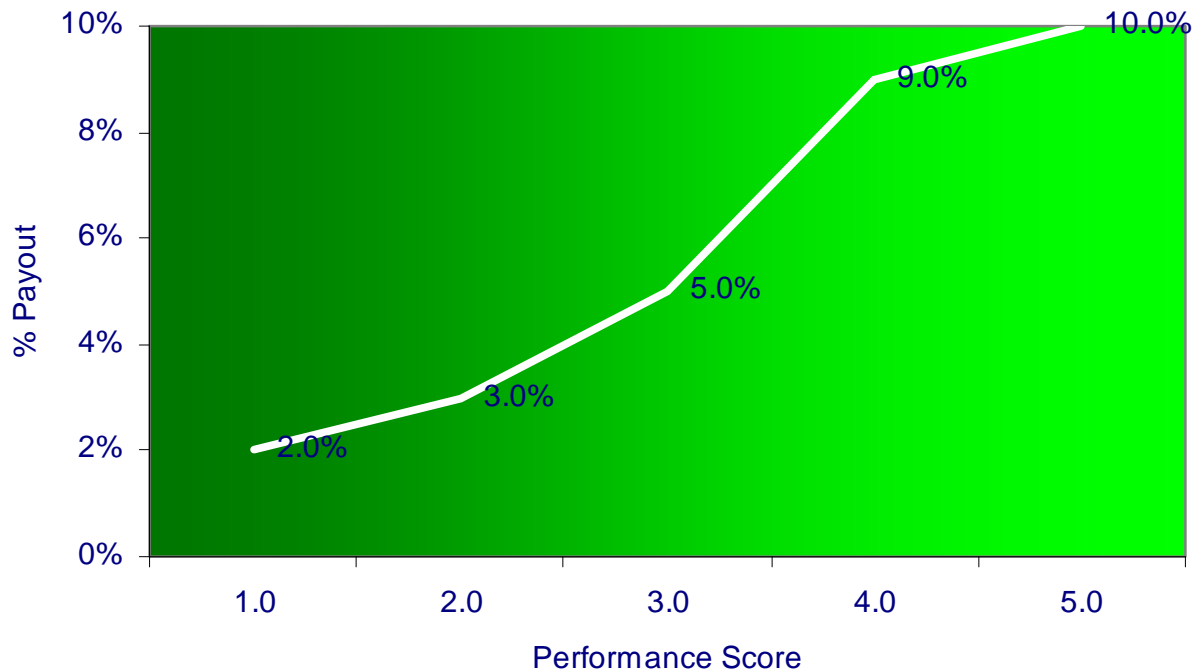
Ambulatory Care Quality

- Clinical process measures
 - Depression
 - Diabetes
 - Cardiovascular Disease
 - Cancer Screening
 - Pediatric: Appropriate Testing / Treatment
 - Pediatric: Well Child Visits
- Clinical outcomes 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 Care Experiences
 - 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 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 \$200 PMPM would yield an additional \$10 PMPM for the provider

How Is this Different from Capitation?



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- Includes a significant upside potential based on a sophisticated set of measures that address patient safety, appropriateness of care and patient satisfaction
- Global Payment for total medical expenses including primary care, ancillary, behavioral health and pharmacy
 - Global payment not reset annually
 - Providers can retain margins derived from reduction of inefficiencies
- Payment is based on actual regional cost that is health status adjusted to adequately consider relative patient morbidity
- Payment is adjusted annually in line with inflation



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Questions?



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