Payment and Delivery System Reform – Lessons from Massachusetts

NIHCM Capitol Hill Briefing

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Blue Cross Blue Shield of Massachusetts
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MASSACHUSETTS HAS THE LOWEST UNINSURANCE RATE IN THE NATION

PERCENT UNINSURED, ALL AGES

NOTE: The Massachusetts specific results are from a state-funded survey — the Massachusetts Health Insurance Survey (MHIS). Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total population. Starting in 2008, the MHIS sampling methodology and survey questionnaire were enhanced. These changes may affect comparability of the 2008 and later results to prior years. The national comparison presented here utilizes a different survey methodology, the Current Population Survey, which is known to undercount Medicaid enrollment in some states.

COSTS IN MASSACHUSETTS HIGH AND RISING

NOTE: U.S. dollars are current-year values. Other currencies are converted based on purchasing power parity.

MEANWHILE AT BCBSMA.....

The Alternative Quality Contract (2009)

Global Budget
- Covers all medical services
- Health status adjusted
- Based on historical claims
- Shared risk
- Declining trend

Quality Incentives
- Ambulatory and hospital
- Significant earning potential
- Nationally accepted measures

Long-Term Contract
- 5-year agreement
- Sustained partnership
- Supports ongoing investment
AQC PHYSICIAN PARTICIPATION

PCPs

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tbody>
<tr>
<td>SCPs</td>
<td>1,373</td>
<td>1,420</td>
<td>2,303</td>
<td>4,592</td>
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<td>SCPs</td>
<td>88%</td>
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SCPs

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<td>SCPs</td>
<td>2,577</td>
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<td>SCPs</td>
<td>89%</td>
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AQC RESULTS: ACCELERATING MEDICAL COST SAVINGS

These graphs show that the AQC has accelerated progress toward optimal care since it began in 2009. The first scores are based on the delivery of evidence-based care to adults with chronic illness, including appropriate tests, services, and preventive care. The second score reflects the extent to which providers helped adults with serious chronic illness achieve optimal clinical outcomes. Linking provider payment to outcome measures has been one of the AQC’s pioneering achievements.
AND NOW...EXPANDING TO PPO

Blue Cross vastly expands quality-based payment systems
By Priyanka Dayal McCluskey
GLOBE STAFF MARCH 05, 2015
WHAT WE’VE LEARNED…

- Support is key
- Be prepared for changing payer/provider roles
- Attribution is hard but can be done well
- Models require continuous evaluation and updates
AQC SUPPORT – DATA, THE SECRET WEAPON

Sample Group Performance Indicators

1. Trend - Past 5 yrs
   Otr 2 2013
   DxCG 1.807
   Membership 39,895
   TME Spend 491.95
   Budget 516.78

2. YTD 2012 % Potentially Avoidable ED Visits
   - Asthma: 5.0%
   - Backpain: 2.9%
   - Bronchitis: 1.1%
   - Contusion: 2.7%
   - Fever: 1.4%
   * Red font indicates rate higher than network

3. Expense Category
   - Total Expense
   - Expense by Service Category
     - Anc.
     - IP Pro.
     - Pharm.
     - IP Fac.
     - OIP Fac.
     - OIP Pro.
   * Risk Adjusted

4. Condition Category Opportunities - YTD 2012
   Top Ctr.
   - Hypertension & Lipidoses
   - Back Disord & Inj
   - HA
   - HTN
   Top Ctr.
   - Op Fac. / IP Fl.
   - Op Pac.
   - Op Pac. / Anc.
   - Admits YTD 2012
   - Admits YTD 2011
   - Percent of Total Admits
   - Percent of Total Paid

5. Ambulatory Care Measure Rates

   Potential Savings moving from...
   - Hosp. A
   - Hosp. B
   - Hosp. C
   - Hosp. F
   - Hosp. G
   - Hosp. H
   - Hosp. I
   Avg. Saving $230,000

7. Med/Surg Retention

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SUPPORT BEYOND THE NUMBERS
THE DELIVERY SYSTEM IS CHANGING AND BLurring LINES BETWEEN PAYER AND PROVIDER ROLES

<table>
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<tr>
<th>PROVIDER</th>
<th>EITHER</th>
<th>PAYER</th>
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</thead>
<tbody>
<tr>
<td>Care delivery</td>
<td>Data systems and connectivity</td>
<td>Benefit design</td>
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<tr>
<td>Office and facility management</td>
<td>Care protocols and guidelines</td>
<td>Sales and marketing requirements</td>
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<tr>
<td></td>
<td>Population management systems</td>
<td>Network management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Account and customer service</td>
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A multi-stakeholder workgroup met and refined the claims-based attribution methodology.

This model has been validated by providers and members.

“Yes, those are my patients”

“Yes, that is my doctor”
MODEL UPDATES ARE VITAL TO SUSTAINED PERFORMANCE IMPROVEMENT

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

- Quality Performance Incentive
- Provider Share of Surplus (increases as quality improves)
- Provider Share of Deficit (decreases as quality improves)

Incorporating quality performance into risk sharing model

Evolving the quality measure set
KEEP ON LEARNING

INNOVATE AND LEARN AS WE GO

- Model changes
- Listening and collaboration
- Data collection and sharing
- Emerging best practices
- Evaluation