



In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

Private-Payer Innovation in Massachusetts: The “Alternative Quality Contract”

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Synopsis

In 2009, Blue Cross Blue Shield of Massachusetts began paying participating health care provider groups under the Alternative Quality Contract (AQC), an alternative to fee-for-service payment in which medical groups receive fixed payments for patient care, plus rewards based on savings generated and performance targets reached. At the end of the first year of the contract, spending in all the participating groups was below the budget targets and all earned “significant” quality bonuses.

The Alternative Quality Contract: Overview

Fee-for-service payment, the prevailing method for reimbursing health care providers, produces irrational incentives for increased use of medical services and often penalizes providers that use resources fairly and efficiently, say the authors of this Commonwealth Fund-supported study in *Health Affairs*. Seeking an alternative to fee-for-service payment, Blue Cross Blue Shield of Massachusetts launched the Alternative Quality Contract in January 2009 to improve quality of care and patient outcomes while slowing spending growth. Under the AQC, Blue Cross pays medical groups fixed amounts for patient care delivered during a defined period and awards bonuses when groups meet performance targets related to both efficiency and quality. To participate, a provider group must include primary care physicians who collectively care for at least 5,000 members of Blue Cross health maintenance organization (HMO) or point-of-service (POS) plans. The contract lasts for five years.

“Simply clinging to, or modestly rearranging, the fee-for-service payment systems of the past is not a viable option for long-term sustainability.”

By the end of 2009, eight provider groups had joined the AQC, and since then four more have joined. Although all participating physicians are members of some organization that contracts on their behalf, 12 percent are in one- or two-physician practices. The smallest AQC group has 72 physicians, and the largest group has more than 1,300.

How It Works

Budget. A medical group operating under an AQC agrees to accept a global budget to cover all health care services delivered to Blue Cross HMO and POS patients. Patients in the AQC designate a primary care physician and the physician group that employs the designated physician is accountable for the patient's clinical and economic outcomes, regardless of where care is delivered. When setting the initial budget, Blue Cross does not focus on reducing spending below current levels but rather on controlling future growth rates. To mitigate risk, Blue Cross adjusts the budget annually for changes in patients' health status. Other risk-controlling tools include allowing groups to share risk with Blue Cross (instead of the full-risk arrangement) and requiring groups to reinsure.

Incentive Payments. Groups can earn bonuses of up to 5 percent based on their performance on 32 ambulatory care measures, and up to another 5 percent for their performance on 32 measures of hospital care. The annual quality payment is based on an aggregated score. Health outcome measures, like controlling blood pressure, are given triple the weight of "process" measures, such as breast cancer screening, or patient experience measures, such as quality of physician communication.

Support. Under Blue Cross's data reporting system, provider groups receive performance reports and consultative support, and participate in sessions with other groups to share best practices. Reports emphasize unexplained variations in practice patterns that are both clinically and financially important. Variations may be condition-specific—for example, how a cardiology group differs from its peers in terms of use of particular technologies, treatments, or diagnostic tests for patients with the same underlying clinical status. Or reports may focus on potentially avoidable hospital use, including admissions that could have been averted with appropriate outpatient care, readmissions within 30 days of hospital discharge, and nonurgent emergency department use.

Early Results and Future Challenges

Blue Cross reports that in the first year of the Alternative Quality Contract, all groups met their budget targets and also achieved savings. Moreover, they all earned significant quality bonuses. Attracting more groups to participate, however, may be a challenge, the authors say. Initially, several of the largest provider groups in the state chose not to participate, citing such concerns as their ability to manage risk and the overall generosity of payments. Blue Cross has continued to have discussions with these groups, and recently one provider (Beth Israel Deaconess) signed an AQC that began January 2011.

The Bottom Line

By rewarding health care providers for quality and efficiency, rather than for volume of services delivered, Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract "exemplifies the type of experimentation with novel payment models that the Affordable Care Act encourages," the authors write.

Citation

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