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Senate Finance Committee
Medicare Physician Payment Policy: Lessons from the Private Sector

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Thank you Chairman Baucus, Ranking Member Hatch and Members of the Committee for holding this roundtable. I am Dana Gelb Safran, Senior Vice President for Performance Measurement and Improvement at Blue Cross Blue Cross Blue Shield of Massachusetts ("BCBSMA"). I appreciate the opportunity to discuss the payment reform model that BCBSMA has been implementing in our provider network since 2009. The model I will discuss today, known as the Alternative Quality Contract (AQC), employs a population-based global budget together with significant financial incentives for performance on a broad set of quality and outcome measures. The model establishes provider accountability for clinical quality, patient health outcomes, and overall medical spending and cost growth. It is now our predominant payment model – in place with more than three-quarters of our provider network.

BCBSMA is one of 39 locally based, community operated Blue Cross and Blue Shield Plans that collectively provide health benefits to nearly 98 million Americans and contract with hospitals and physicians in every U.S. zip code.

At BCBSMA, our highest priority is to make quality health care affordable for individuals, families and employers who have made us the health plan of choice in Massachusetts. Our promise and vision guide our efforts to create greater value for our members and employers. Founded in 1937 by a group of community-minded business leaders, BCBSMA is the leading private health plan in the Commonwealth—a not-for-profit company with a proud history of community and health care leadership.

We applaud the Committee's bipartisan efforts to reform payment policy at the federal level. As the largest provider and payer of health care in the nation, the federal government is in a unique position to influence the delivery of safe, effective, affordable and patient-centered health care.

As the Committee considers the important issue of physician payment, and specifically, the Medicare Sustainable Growth Rate, I am pleased to have this opportunity to share a model that is flourishing in Massachusetts. The payment reform efforts of BCBSMA suggest that it may indeed be necessary to think beyond physician payment to overall

system payment in order to realize the goal of "sustainable growth." This holistic view of payment may also be necessary to reduce the fragmentation of care that we all recognize as a key failing of our current system. This fragmentation is a byproduct of payment models that contemplate physician payment and institutional payment separately. We are hopeful that the Pioneer Accountable Care Organizations and the deliberate move away from volume-based incentives will provide a source of insight and motivation for change for the federal government. We have been working closely with the five "Pioneers" in Massachusetts, who are also AQC providers, to capitalize on the synergies of the payment models to promote real delivery system reforms.

In Massachusetts, as in the rest of the nation, the rise of health care spending imposes an unsustainable burden on the economy and on individual consumers. In 2007, BCBSMA recognized that fundamental changes to provider payments and incentives would be required to address medical cost trends. With an annual medical spend of approximately $13 billion in claims, we sought to develop a model that would achieve the following twin goals: significantly improve the quality, safety and outcomes of care, while at the same time, significantly slow the rate of medical spending growth.

AQC: The Cornerstones

Developed in 2007 and launched in 2009, BCBSMA's AQC was our effort to address these twin goals. In general, the AQC model combines a global budget with significant quality incentives in a 5-year contract to establish provider accountability for overall medical spending and spending growth, quality and health outcomes for a defined patient population. As of June 2012, over three-quarters of our statewide network of contracted primary care providers (PCPs) and specialist physicians have opted into this contract model. The AQC is providing evidence that significant, rapid improvements in health care quality and spending are achievable through a payment model that establishes provider accountability for quality, outcomes and resource use across the full continuum of health care services.

The AQC includes several key components that distinguish it from our traditional contracts and that are designed to enable the provider organizations to succeed at significantly improving quality and outcomes while moderating costs and spending growth.

Integration Across Continuum of Care

A provider organization that enters an AQC contract agrees to accept accountability for the full continuum of care provided to their patients – from prenatal care to end-of-life care, and everything in between. This does not mean that the provider organization itself must be capable of providing every aspect of care, but they must agree to be accountable for both the cost and quality of care provided to their patients, regardless of where it is provided. The only stipulation related to organizational structure in the AQC is that the provider organization must include sufficient primary care physicians to account for at least 5,000 of our HMO or POS enrollees.

The very essence of the AQC is the important role of the primary care physician (PCP) as the center of a patient's care. The decision to forego a prescriptive approach to AQC organizational structure was made as we recognized that it was premature to know which structure or organizational features were truly required to be successful under a model requiring accountability for cost and quality. As it has unfolded, the range of organizational structures among AQC groups is extremely varied – including, at one end

of the continuum, an AQC organization with only primary care physicians and at the other end of the continuum, a large multispecialty physician group with a history and roots as a staff-model HMO (that is, as much like Kaiser Permanente as anything we have in Massachusetts). In between are several physician organizations of varying size and scope, some including a broad range of specialist physicians or a hospital as part of their contract, while others do not.. Almost all include a very large number of practices that are small or solo physicians tied together through an infrastructure and leadership that work to enable their success under the AQC model.

Regardless of the organizational structure and scope, each and every organization is accountable for the full continuum of care and for the total cost and quality of care received by their patient population. They do this through relationships that expand well beyond the confines of the providers that are party to their AQC contract. Importantly, as I will detail later, every one of these organizations is achieving substantial success – both on quality and on managing overall medical spending. This proves an important lesson of a payment reform model serving as the impetus for delivery system reform, and the importance of allowing those delivery system reforms to take shape in response to the new payment incentives. Further, the early results of the contract provide evidence that global budget models can work within different demographic areas, for different patient populations and with different provider organizational structures.

Sustained Partnership (Five-Year Agreement)

The AQC arrangement is a five-year agreement that encourages providers to invest in long-term, lasting improvement initiatives. It also establishes a new kind of partnership between the health plan and the organization that moves away from the sometimes adversarial relationship, which is focused on ongoing contract negotiations, and toward a more collegial partnership, which is focused on and committed to each other's success. These five-year contracts are significantly longer than BCBSMA traditional contracts, which are typically three years for a hospital and one to three years for physicians. We value the five-year arrangement because we recognized that success under this model would require provider organizations to make significant changes in care processes, staffing and infrastructure, and we did not want either the provider or Blue Cross to be concerned by a looming contract negotiation in six or twelve months .

Global Budget Financial Structure with Performance Incentives and Savings Opportunities

Each AQC contract establishes a population-based global budget for the provider organization, covering all services and costs for its defined patient population. Organizations that adopt the AQC accept responsibility for the full continuum of care received by their patients – including the cost and quality of that care – regardless of where the care is provided. The contract budgets encompass inpatient, outpatient, pharmacy, behavioral health and other costs and services associated with each of their BCBSMA patients. Budgets are adjusted annually over the 5-year contract period to account for health status changes in the organization's patient population. The initial global budget is based on historical health care cost expenditure levels specific to that provider organization's patient population. In this way, providers are assured that their starting budgets contain sufficient funds to care for their defined population – but importantly, the organization now has important incentives to consider how best to use those funds in service of the best quality and highest value care for each and every patient. If the AQC organization achieves savings on its budget, the organization shares

in those savings. If the organization outspends its budget, the organization is responsible for a share of that deficit. The model incorporates numerous protections to guard against excessive or inappropriate transfer of financial risk to providers, while creating a very real set of incentives for provider organizations to be careful stewards of health care dollars.

Beginning 2011, new AQC contracts have trend targets tied to the regional network average, generally requiring groups to outperform the regional trend by a designated amount. By tying the budget to the regional trend, environmental factors that are outside of the provider's control (such as an epidemic, mandated benefits or BCBSMA-negotiated rates with our network) are accounted for, thereby obviating the need for complex year-end adjustments. Since the budget and annual inflation targets are set at the outset of the agreement for a five year period, the model brings predictability and stability to annual health care cost increases, a significant benefit to the purchasers of health care, including consumers, employers and government.

Performance Measures

Central to the AQC model is a set of significant financial incentives tied to performance on a broad portfolio of quality, outcome and patient experience measures. As described elsewhere,[1] the model includes 64 nationally accepted, clinically important measures of hospital and ambulatory quality that collectively support the vision of safe, affordable, effective and patient-centered care. The accountability for performance on this broad set of quality and outcome measures, and the significant financial incentives associated with this, serve as an extremely important backstop against any impulse toward "underuse" or stinting that might otherwise be a concern under a global budget model.

BCBSMA evaluates AQC groups' performance on the quality measures in terms of performance targets ("gates") ranging from 1 to 5. For each measure, Gate 1 is set at a score that represents the beginning of performance considered to be good enough to merit some financial reward. Gate 5 is an empirically-derived score for each measure that represents the best that can be reliably achieved in a patient population. By presenting a range of targets that represent "good to great" performance, the AQC model incentivizes both performance excellence and continuous performance improvement. And through use of absolute performance targets that are fixed over the course of the contract and identical for every provider that enters the contract in that year, the model enables organizations to plan their resources in a way that will allow for continuous improvement toward Gate 5 performance over the course of the contract.

One of the most important aspects of the measure set is that it includes significant accountability for health outcomes – not just for health care processes. To our knowledge, the AQC is the first contract requiring providers to assume responsibility for the outcomes achieved through their care – not solely for the care delivered in the four walls of the care setting. The importance of this feature cannot be overstated.

Data Support

In order to succeed under the AQC model, BCBSMA understands that physicians need both clinical and financial data to help them identify opportunities for quality improvement and cost savings. Thus, with the launch of the AQC in 2009, BCBSMA established a

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[1] M. E. Chernew, R. E. Mechanic, B. E. Landon and D.G. Safran., "Private-Payer Innovation in Massachusetts: The 'Alternative Quality Contract," Health Affairs, Jan. 2011 30(1):51–61.

multidisciplinary team dedicated to supporting AQC groups' success in managing to the contract's incentives related to improved quality, health outcomes, and resource use. The AQC Support Program is extended to all AQC organizations and includes a series of regular data and performance reports, ongoing consultative support from a team of clinicians and quality improvement advisors, and regular organized sessions where the groups meet together to address performance improvement issues and share best practices. Some information is provided to AQC groups daily, including information on hospitalized patients, to allow the AQC group or provider to coordinate closely with the hospital and plan for the care that will be required when the patient is discharged. Performance information is provided monthly or quarterly through a series of reports that allow groups to monitor their performance on the quality bonus measures, monitor spending relative to their budget and to evaluate opportunities for savings.

One unique set of reports that BCBSMA provides to assist AQC organizations with managing their use of overall resources is information on clinically-specific, unexplained practice pattern variations. The approach is rooted in the seminal work and compelling observations of Jack Wennberg and the Dartmouth Atlas – but importantly, moves the observations of practice pattern variation off of maps and into a framework that is clinically actionable for practicing physicians. The set of practice pattern variation analyses (PPVA) reports that BCBSMA provides includes: (1) condition-specific variations in treatment provided in a given medical or surgical specialty; and (2) potentially avoidable use of hospital resources (e.g., 30-day readmissions, non-urgent emergency department use, admissions for ambulatory-sensitive conditions).

The condition-specific PPVA reports demonstrate how physicians within a given specialty (e.g., cardiology) differ from their peers in their use of particular treatments, tests or procedures for patients with the same underlying clinical status. The AQC groups receive analyses related to conditions such as: treatment of knee, back and hip pain; use of brand-name medications rather than generics; cardiac catheterization and coronary artery bypass graft (CABG) procedures; advanced imaging; non-urgent emergency room care; and treatment of gastroesophageal reflux disease (GERD). BCBSMA's PPVA approach draws from a methodology developed by Dr. Howard Beckman (Rochester, NY) and successfully implemented through his work with Focused Medical Analytics (FMA).[2] In beginning to use this approach in our network and the AQC groups in particular, BCBSMA's aim is to provoke important discussion among clinicians and leaders within each specialty, and ultimately to stimulate the development of best practices and standards of care from within the profession. Such a process is consistent with the incentives of a global budget and preferable to externally-imposed standards that might never be fully accepted by clinicians or patients.

AQC: The Results

In 2009, the first year of the AQC, participating groups made unprecedented improvements in the quality of patient care—greater than any previous one-year change measured in the Blue Cross Blue Shield of Massachusetts provider network. Every AQC organization showed significant improvements in clinical quality, including several dozen process and outcomes measures. In 2010, provider groups that joined the AQC in 2009 continued to improve quality and outcomes, while groups that joined in 2010 made

[2] RA Greene, HB Beckman, T Mahoney, "Beyond The Efficiency Index: Finding A Better Way To Reduce Overuse And Increase Efficiency In Physician Care," *Health Affairs*, 27, no. 4 (2008): w250-w25.9

significant quality improvements in their first year. Participating groups exhibited exceptionally high performance for all clinical outcome measures with many approaching performance levels believed to be the best achievable for chronic conditions such as diabetes, heart disease and hypertension.

Early results also indicate that the AQC is on track to achieve its original goal of reducing annual health care cost growth trends by half over five years. In 2009, all of the AQC groups met their budgets, producing surpluses that enabled them to invest in infrastructure and other improvements that will help them deliver care more effectively and efficiently. Further, medical spending among AQC groups grew more slowly than the non-AQC BCBSMA network. In the second year of the contract, 2010, we saw savings deepen in key areas such as reduced inpatient admissions, improved use of high tech radiology and use of less costly settings of care.

It is important to note that despite the fact that the AQC groups vary widely with respect to geography, size, management structure and experience with taking on risk for patient care, each and every AQC organization was successful in managing the global budget and significantly improving quality and clinical outcomes. The range of organizational models in the AQC includes multi-specialty integrated groups, independent practice associations and several physician-hospital organizations, in which a physician group contracts with a particular hospital. Although all AQC physicians are part of some organizational structure that contracts on their behalf, about twelve percent of participating physicians are in one- or two-physician practices and one-third are in practices with fewer than five physicians. For these more distributed practices, qualitative feedback indicates that the role of the organizational leadership has been critical to their success. In fact, some of the most significant quality improvements come from the more loosely-affiliated, smaller provider organizations in the AQC.

Researchers at the Harvard School of Medicine are conducting a full evaluation of the AQC. Their year one findings, published in the New England Journal of Medicine, showed that the AQC was associated with significant quality improvement and two percent slower growth in medical spending in 2009. Among medical groups without prior risk-sharing agreements, the evaluation found even greater year one savings, with these groups reducing spending growth by 6.3 percent.[3] The research team's analysis of the second year of the contract is forthcoming in 2012.

To accomplish these results, AQC organizations are implementing significant delivery system changes and innovations for better, more integrated patient care. They are investing in new infrastructure and information systems, deploying new staffing models such as employment of case managers and expanded nursing staff, and implementing new approaches to patient engagement that leverage technology while simultaneously focusing on individual patient needs so as to improve outcomes through better adherence and self-care. Better communication within and across health care settings has become critical to avoiding poor outcomes, complications and unnecessary emergency room visits, admissions and readmissions. This compelling need has led to new care models and new approaches to ensure smooth hand-offs, robust information sharing and well-planned care transitions. In short, we see the seeds of sustainability being sown through the innovations that AQC groups are makings in order to succeed

[3] Z. Song, D. G. Safran, B. E. Landon et al., "Health Care Spending and Quality in Year 1 of the Alternative Quality Contract," New England Journal of Medicine, published online July 13, 2011.

under the incentives to manage total resource use while improving patient care and outcomes.

AQC: The Future

The AQC early results offer promise that provider organizations – given the right incentives, information, data and leadership – can quickly accomplish significant improvements in patient care and outcomes while at the same time reducing the growth in health care costs. With the growth of the AQC across our provider network, the delivery system innovations that providers have implemented under the model, and the significant successes they are experiencing as they assume accountability for total medical spending, quality and outcomes, we increasingly see providers who are eager to broaden the set of patients for whom they accept this type of accountability. Among the important future expansions many providers seek to make are the following:

1) PPO population: The AQC model is currently in place for our HMO membership only. We are actively exploring the possibility for expansion of the model to encompass our PPO membership, encouraged by a combination of provider interest, market interest and the demonstrated successes of the AQC model. Among the important operational considerations is how best to identify a primary physician within a PPO population. While a model that employs a claims-based algorithm ("attribution") to identify the primary physician for each member is one possibility, a "Physician of Choice" model, in which members proactively name the physician whom they consider to be their regular personal doctor, has a number of important advantages. These and other operational challenges will need to be addressed in order to successfully implement payment reforms that can apply to our PPO membership.

2) **Accountable Care Organization (ACO) demonstrations**: A majority of AQC organizations are now eager to have other payers adopt a global budget approach to payment. We have worked closely with officials from CMS and Massachusetts' Medicaid program as they have considered how to formulate these models. CMS cited the AQC as a model for its ACO programs in the regulations for the Shared Savings Program in 2011. We offered support and encouragement to AQC providers interested in applying for CMS's Pioneer or Shared Savings, and wrote strong letters of support for their applications to CMS. CMS's Center for Innovation named five AQC groups in Massachusetts Pioneer ACOs out of a total of 32 Pioneer ACOs across the country. Participation in the Pioneer pilot and the AQC means that these providers are now operating under a reformed payment model – with population-based global budgets and significant quality incentives – for the majority of their patients. This synergy will allow the provider groups to not only align operationally by having one global budget model, but also to apply strategies and best practices for care coordination learned in the AQC to the Medicare population.

Key Lessons Learned

For federal and state policymakers, the early findings of the AQC hold several important lessons. Among these is evidence that a payment model that creates provider accountability for both medical spending and health care quality and outcomes appears to be a powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth. Additionally, the demonstrated success of provider organizations that varied widely in size, scope, composition and geography – some with a hospital, others without; most comprised of many small and solo practices

united through a common leadership – is encouraging and should inform delivery system reform efforts nationally. Multi-year contracts based on a global budget, with annual inflation rates that are set at the outset of the agreement can bring important and welcome predictability to health care costs for employers, the public and others purchasing care. Finally, payment models that liberate providers from many of the constraints of fee-for-service payment, and importantly, from a mindset that one only does for patients those things for which h there is a billing code, are almost certainly necessary and fundamental to making real the vision of safe, affordable, effective, patient-centered care.

On behalf of Andrew Dreyfus, President & CEO of Blue Cross Blue Shield of Massachusetts and all of my colleagues, we look forward to working with you as you address the important issues of delivery system reform. Thank you again for the opportunity to testify. I look forward to any questions you may have.