The Alternative Quality Contract (AQC): Overview of Year-1 Results & How They Were Achieved

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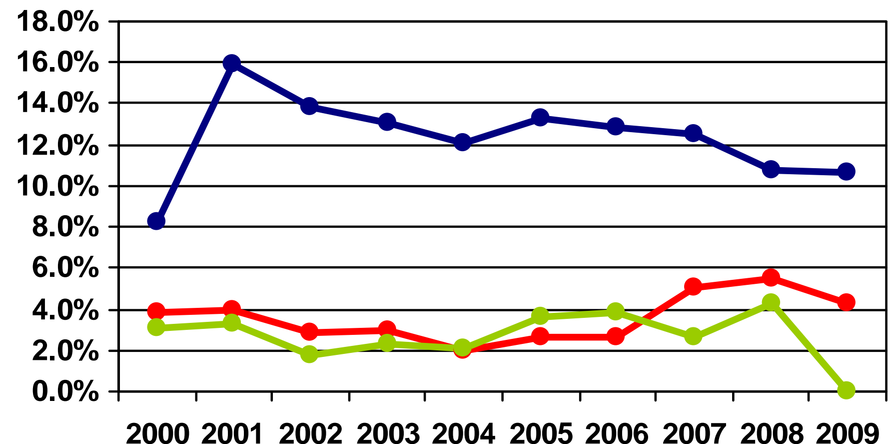
Twin Goals of Improving Quality & Outcomes While Significantly Slowing Spending Growth

MASSACHUSETTS

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 individual mandate (2006) caused a bright light to shine on the issue of unrelenting double-digit increases in health care spending growth.



Key Components of the Alternative Contract Model

Unique contract model:

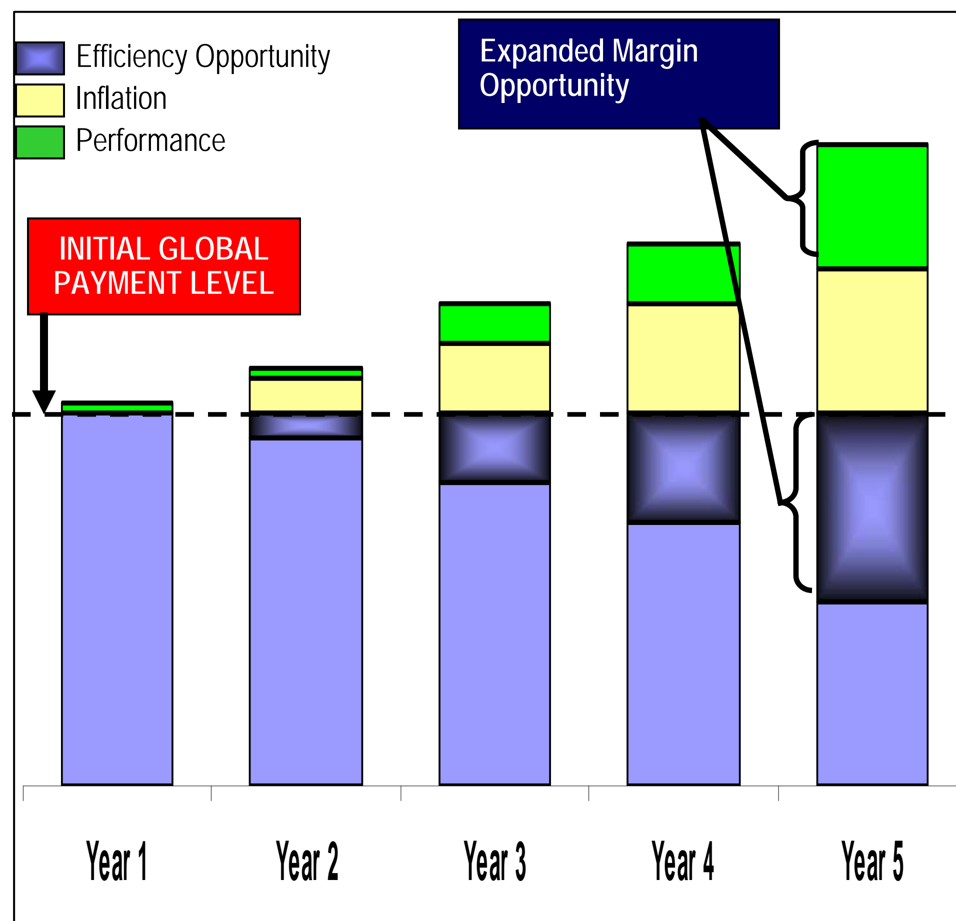
- Physicians & hospital contracted together as a "system" – accountable for cost & quality across full care continuum
- Long-term (5-years)

Controls cost growth

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

Improved quality, safety and outcomes

- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)



SETTS

Ambulatory Measures

Section	Measure	Score	Weight
Process	**Depression**		
	1 Acute Phase Rx	2.5	1.0
	2 Continuation Phase Rx	1.5	1.0
	Diabetes		
	3 HbA1c Testing (2X)	3.0	1.0
	4 Eye Exams	1.0	1.0
	5 Nephropathy Screening	1.2	1.0
	Cholesterol Management		
	6 Diabetes LDL-C Screening	2.8	1.0
	7 Cardiovascular LDL-C Screening	2.1	1.0
	8 Breast Cancer Screening	1.2	1.0
	9 Cervical Cancer Screening	1.3	1.0
	10 Colorectal Cancer Screening	2.4	1.0
	Preventive Screening/Treatment		
	Chlamydia Screening		
	11 Ages 16-20	3.1	0.5
	12 Ages 21-25	1.8	0.5
	Pedi: Testing/Treatment		
	13 Upper Respiratory Infection (URI)	1.6	1.0
	14 Pharyngitis	1.4	1.0
	Pedi: Well-visits		
	15 < 15 months	2.6	1.0
	16 3-6 Years	2.0	1.0
	17 Adolescent Well Care Visits	1.5	1.0
Outcomes	**Diabetes**		
	18 HbA1c in Poor Control	3.2	3.0
	19 LDL-C Control (<100mg)	2.4	3.0
	Hypertension		
	20 Controlling High Blood Pressure	1.3	3.0
	Cardiovascular Disease		
	21 LDL-C Control (<100mg)	2.4	3.0
Patient Exper.	**Patient Experiences (C/G CAHPS/ACES) - Adult 3**		
	22 Communication Quality	1.9	1.0
	23 Knowledge of Patients	1.9	1.0
	24 Integration of Care	2.1	1.0
	25 Access to Care	2.4	1.0
	Patient Experiences (C/G CAHPS/ACES) - Pediatric 3		
	26 Communication Quality	1.0	1.0
	27 Knowledge of Patients	1.5	1.0
	28 Integration of Care	2.5	1.0
	29 Access to Care	2.8	1.0
Experimental	30 Experimental Measure A	5.0	1.0
	31 Experimental Measure B	5.0	1.0

Hospital Measures

Measure	Score	Weight
AMI		
1 ACE/ARB for LVSD	2.0	1.0
2 Aspirin at arrival	2.5	1.0
3 Aspirin at discharge	1.5	1.0
4 Beta Blocker at arrival	1.5	1.0
5 Beta Blocker at discharge	1.3	1.0
6 Smoking Cessation	1.0	1.0
Heart Failure		
7 ACE LVSD	1.3	1.0
8 LVS function Evaluation	1.0	1.0
9 Discharge instructions	1.8	1.0
10 Smoking Cessation	3.0	1.0
Pneumonia		
11 Flu Vaccine	2.5	1.0
12 Pneumococcal Vaccination	2.9	1.0
13 Antibiotics w/in 4 hrs	1.4	1.0
14 Oxygen assessment	1.0	1.0
15 Smoking Cessation	3.1	1.0
16 Antibiotic selection	3.0	1.0
17 Blood culture	3.5	1.0
Surgical Infection		
18 Antibiotic received	1.3	1.0
19 Received Appropriate Preventive Antibiotic	1.4	1.0
20 Antibiotic discontinued	3.0	1.0
21 In-Hospital Mortality - Overall	3.0	1.0
22 Wound Infection	2.1	1.0
23 Select Infections due to Medical Care	2.8	1.0
24 AMI after Major Surgery	2.4	1.0
25 Pneumonia after Major Surgery	3.4	1.0
26 Post-Operative PE/DVT	2.0	1.0
27 Birth Trauma - injury to neonate	1.0	1.0
28 Obstetrics Trauma-vaginal w/o instrument	1.5	1.0
Hospital Patient Experience (H-CAHPS) Measures		
29 Communication with Nurses	4.0	1.0
30 Communication with Doctors	3.0	1.0
31 Responsiveness of staff	2.5	1.0
32 Discharge Information	2.8	1.0
33 Experimental Measure C	5.0	1.0

Weighted Ambulatory Score 2.2 — Weighted Hospital Score 2.3

Aggregate Score 2.3

The AQC Drives Changes in How Care is Delivered

Group A	Is using Case Managers directly in the PCP practices to assist with managing the complex, high risk population. The concept is that by being more proactive, they can avoid the ER visit and the admission to the hospital.
Group B	Placed nurses in physician practices to focus only on the sickest patients.
Group C	Launched aggressive screening reminder campaign and in one year saw a 6.2% improvement for preventive care measures. For diabetic eye exams, they improved by 13.6% over their 2008 results.
Group D	Invested in and developed an innovative technology solution that links BCBSMA claims and health status data with internal practice data.

First Year Results show the AQC is Improving Quality

- BCBSMA is on track to reach our goal of reducing annual health care cost trends by 50% over 5 years
- All AQC groups produced budget surpluses that enable them to make infrastructure investments that will further improve efficiency.
- Year-1 improvements in the quality were greater than any one-year change seen previously in our provider network – several fold higher than groups were achieving prior to the AQC and higher than non-AQC segment of our network.
- Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes measures
- AQC groups exhibited exceptionally high performance for all clinical outcome measures with *more than half approaching or meeting the maximum performance target* on measures of diabetes and cardiovascular care

AQC Groups Surpass Network on Key Preventive and Chronic Care Measures

AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease

	Optimal Care
Diabetic Cholesterol In Control	3.3
Diabetic Blood Pressure in Control	4.3
Cardiovascular Disease Cholestrol in Control	4.5

Results limited to AQC groups that received financial incentives for these measures in 2009.

Keys to AQC's Success

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

2. Real dollars are at stake for improvement.

3. 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 is made available monthly, enabling the organizations to track progress and take action to manage their patient population.

5. The groups have strong support from their leadership to implement new systems and act on the data.

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

Components of the AQC Support Model

- Best Practice Sharing
- Financial Reports/Settlement
- Communication & Training
- Actionable Data
- Consultative Support

Best Practice Sharing

- Three times a year, BCBSMA hosts forums on topics of interest to AQC organizations. Forums have addressed:
  - Practice Pattern Variation Analysis (PPVA)
  - Culture Change and Physician Engagement
  - Sharing Best Practices
  - Motivational Interviewing: Strategies for Effective Health Behavior Change.
- We also facilitate several user groups to provide AQC groups with opportunities to network and share resources.
  - Case Management
  - Data Analysts User Group
  - Medical Management User Group
  - Pharmacy User Group
  - Technology User Group

Financial Reports/Settlement

- Every quarter providers receive their AQC Financial Dashboard
- This report provides a snapshot of a group's overall expenses vs. budget, as per the group's contractual terms

Communication & Training

- AQC group leadership training
- Provider Welcome Kit
- Provider webinars and on-demand training
  - Claim Data Fundamentals
  - DxCG Scores
  - Practice Pattern Variation Analysis (PPVA)
  - Patient-Centered Care
  - Blue Care Line
  - Health and Wellness
- BCBSMA Member Service training/scripts
- AQC Resource Center website www.bluecrossma.com/aqc
  - AQC overview
  - Patient engagement materials
  - Physician resources
  - Information on user groups
  - Training
  - News and updates

Actionable Data

- Monthly claims data
- Monthly efficiency & quality overview reports
- Practice pattern variation data (PPVA)
- DXCG health status scores
- Daily census, authorization and referral reports
- Case Management/Disease Management reporting
- Comparative rank ordered quality performance data
- Weekly new member reports
- Readmission, Emergency Department (ED), Pharmacy, and Site-of-Service reporting

Consultative Support

- Monthly clinical meetings are held between the AQC group's Medical Director and the BCBSMA Medical Director
  - Purpose is to identify individualized opportunities in the areas of quality, efficiency, patient experience, technology, leadership and operations
- Initial and annual "deep dives" to identify key themes and suggest strategies for goals discussions
- Consultation on a range of topics: building registries, marketing, patient satisfaction, etc.

AQC Lessons Learned

Medical Expense Accountability	Provider Organizations must assume accountability for both total medical expenses across the entire continuum of care and for the quality of care for patients empaneled to its PCPs.
Provider Organizational Structure	A variety of provider organizational structures are suitable for the AQC. However, the structure must have a primary care practice that will function as the center of the AQC organization.
Global Budget Adjustments	The initial global budget is based specifically on each organization's historical rate of spending for its patient population and is adjusted for changes in that population, relative to overall region changes that may be expected, throughout the contract term.
Risk-Sharing	The risk-sharing parameters around total medical expenses are tailored to meet the Provider Organization's ability to assume accountability for spending.
Nationally Accepted Quality Measures	A robust set of nationally accepted, validated measures of clinical quality, outcomes and patient experience should form the basis for significant financial incentives related to performance and performance improvement.

AQC Lessons Learned, *continued*

Fee-for-Service Reimbursement	Continuing to reimburse on a fee-for-service basis allows Provider Organizations to use existing infrastructure to take in PMPM capitation payments and to build reporting systems that track claims against the global budget targets.
Patient Attribution	A prospective means of "attribution" is critical for the AQC organization's ability to assume accountability for care across the entire continuum for all its patients.
Relationship Between Efficiency and Quality Rewards	It is important to link financial rewards for savings with rewards for quality and outcomes.
Widespread Adoption of the Model	Once there is demonstrated success under a payment model such as the AQC that creates accountability for both quality and spending, a common approach across all payers, particularly Medicare and Medicaid, will be important.

Questions?

Doctor and the Doll by Norman Rockwell

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