Advancing the Twin Goals of Improving Health Care Quality While Slowing Spending Growth: The Alternative Quality Contract (AQC)

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

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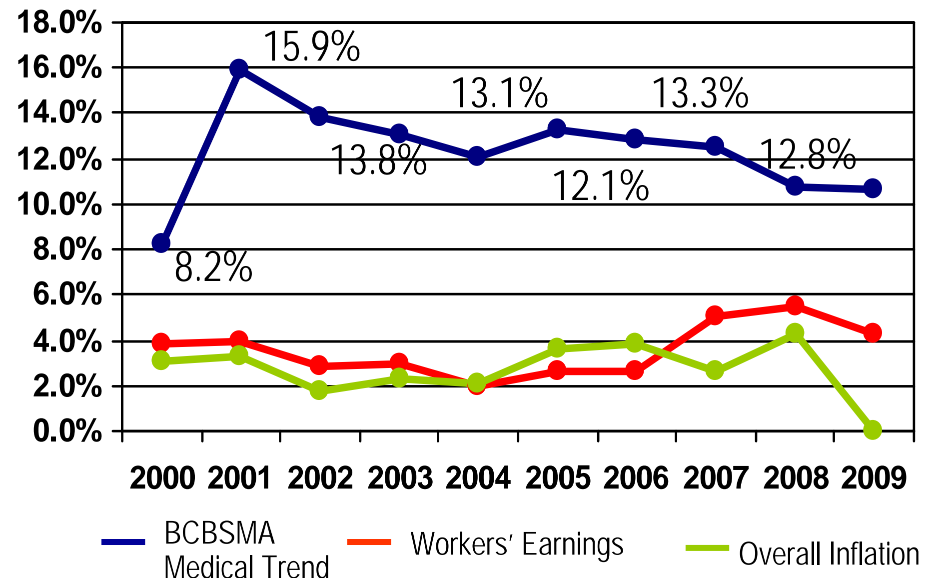
In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.

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



Sources: BCBSMA, Bureau of Labor Statistics

Key Components of the Alternative Contract Model

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Unique contract model:

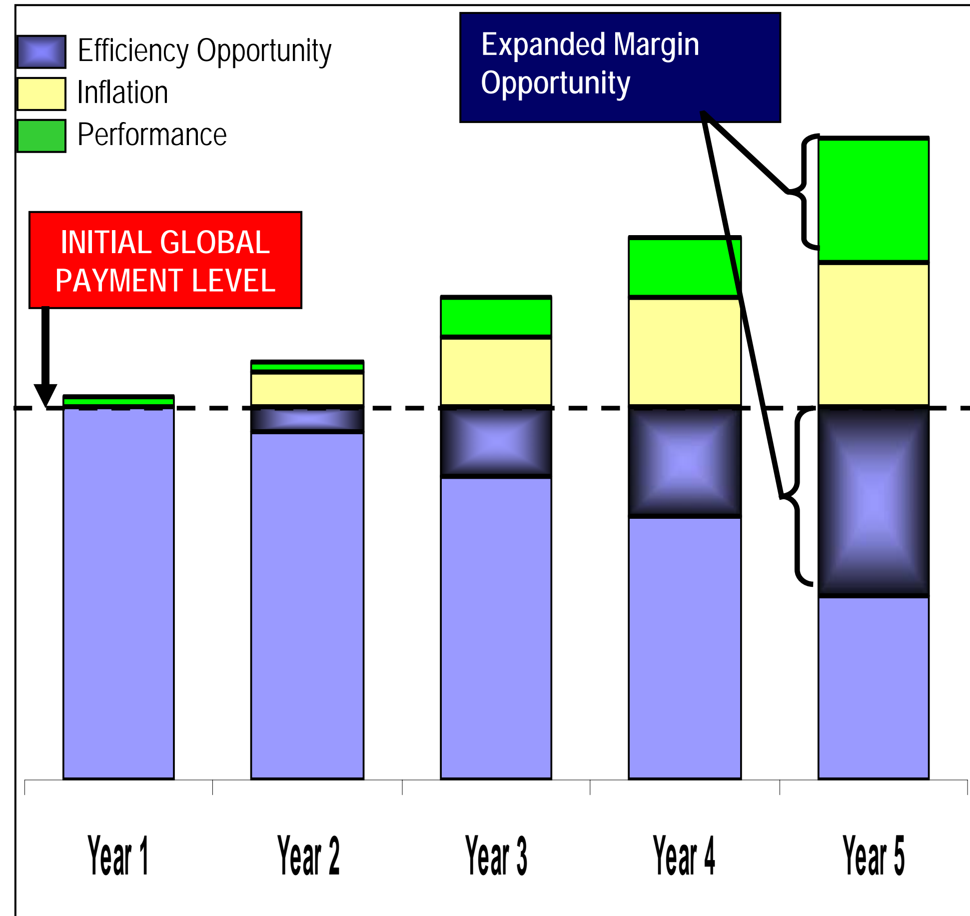
- Physicians & hospital contracted together as a "system" – accountable for cost & quality across full care continuum
- Long-term (5-years)

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)



AQC Measures - Illustration Only - Not Actual Provider Scores

Ambulatory Measures

Category	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

Category	Measure	Score	Weight
Process	**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
Outcomes	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
Patient Exper.	**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
Experimental	33 Experimental Measure C	5.0	1.0

Weighted Ambulatory Score 2.2 | Weighted Hospital Score 2.3

Aggregate Score 2.3

Performance Achievement Model

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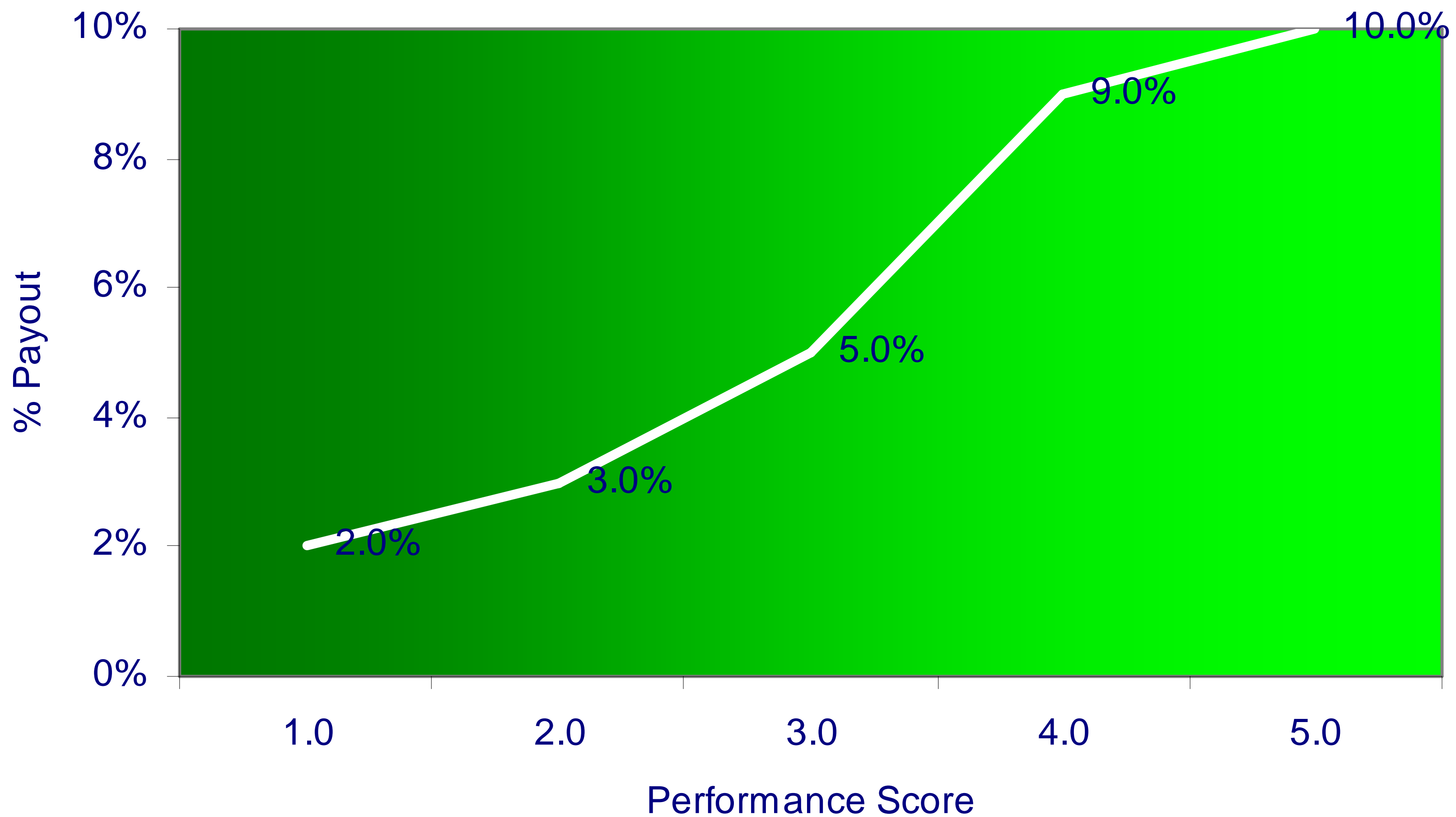

Significant Growth, 2009-2011

In-State HMO Membership	2009	2010	2011
Membership	305,000	355,000	470,000
Percentage	26%	32%	44%

Y-axis: 300,000; 350,000; 400,000; 450,000; 500,000; 600,000; 700,000; 800,000; 900,000

First Year Results show the AQC is Improving Quality

- Year-1 improvements in the quality were greater than any one-year change seen previously in our provider network
- Every AQC organization showed significant improvement on the clinical quality measures, including several dozen clinical process and outcomes measures
- For important preventative care measures, like cancer screenings and well-child visits, as well as for important measures of chronic disease care, *AQC groups' performance was three times that of non-AQC groups* and *more than double* the AQC groups' own improvement rates before joining the AQC.
- 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
- There were no significant changes in AQC groups' performance on patient care experience measures overall.

AQC Groups Surpass Network on Key Preventive and Chronic Care Measures

Preventive Screenings

Optimal Care

	2007	2008	2009
AQC	1.5	2.0	2.7
Non-AQC	1.2	1.1	1.7

Chronic Care Management

	2007	2008	2009
AQC	1.1	2.0	3.2
Non-AQC	2.0	2.2	2.2

AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease

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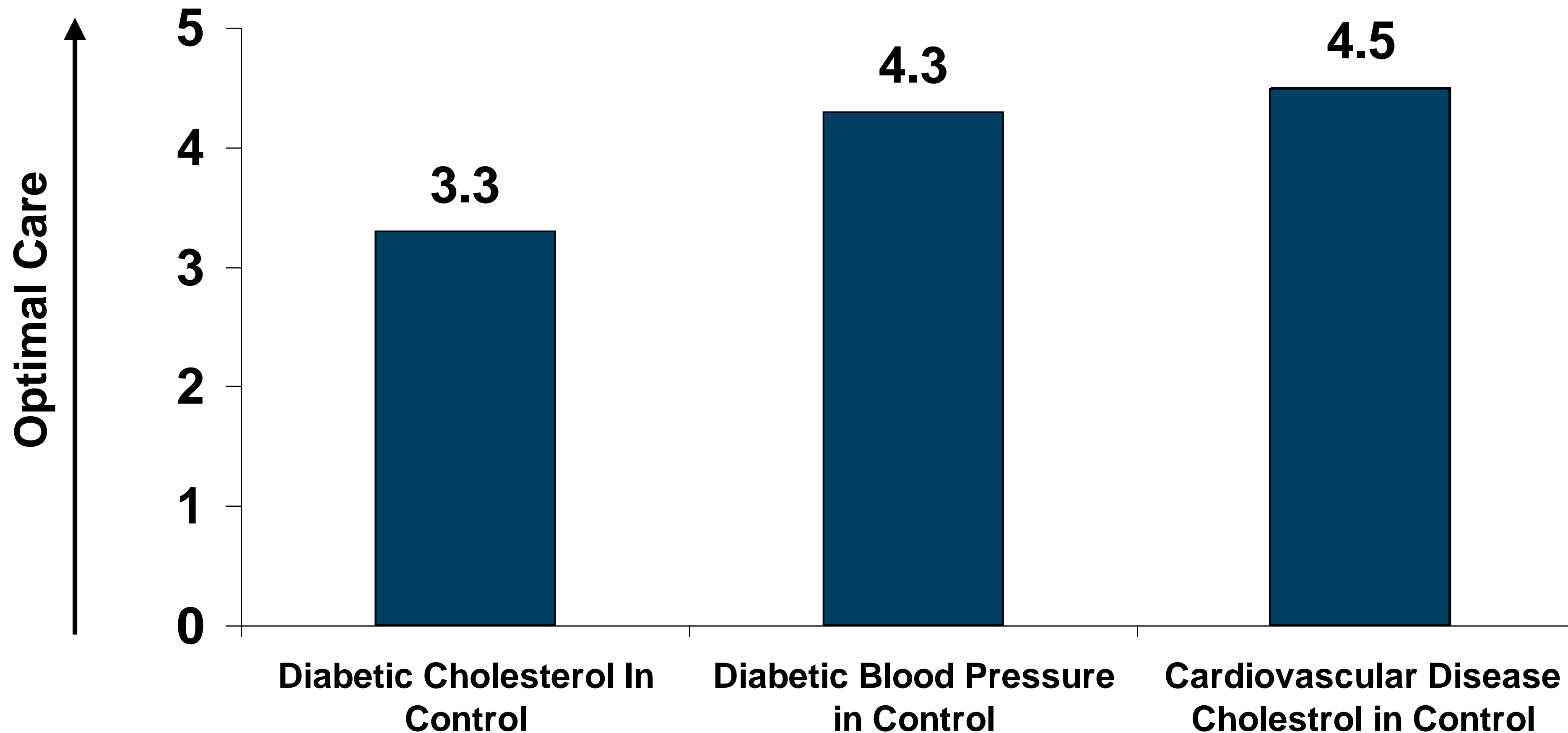

Results limited to AQC groups that received financial incentives for these measures in 2009.

What AQC Groups are Saying

"Our community case managers monitor whether patients are getting recommended care such as colonoscopies for patients over 50, and whether their asthma or diabetes is under control. Very frail patients may have home visits from a nurse practitioner or receive regular phone calls. Fee-for-service would not reimburse us for any of this."

—Dr. Barbara Spivak, President of MACIPA

"Our AQC relationship with BCBSMA drove this entire process [to develop a data warehouse]. Now that we've seen the impact, we're planning to expand this resource to all of our patients…It's exciting to see the results and to know that patients might lead a healthier lifestyle because of the data."

Mitchell Selinger, M.D., Signature's Senior Medical Director

Key Components of the Alternative Contract Model

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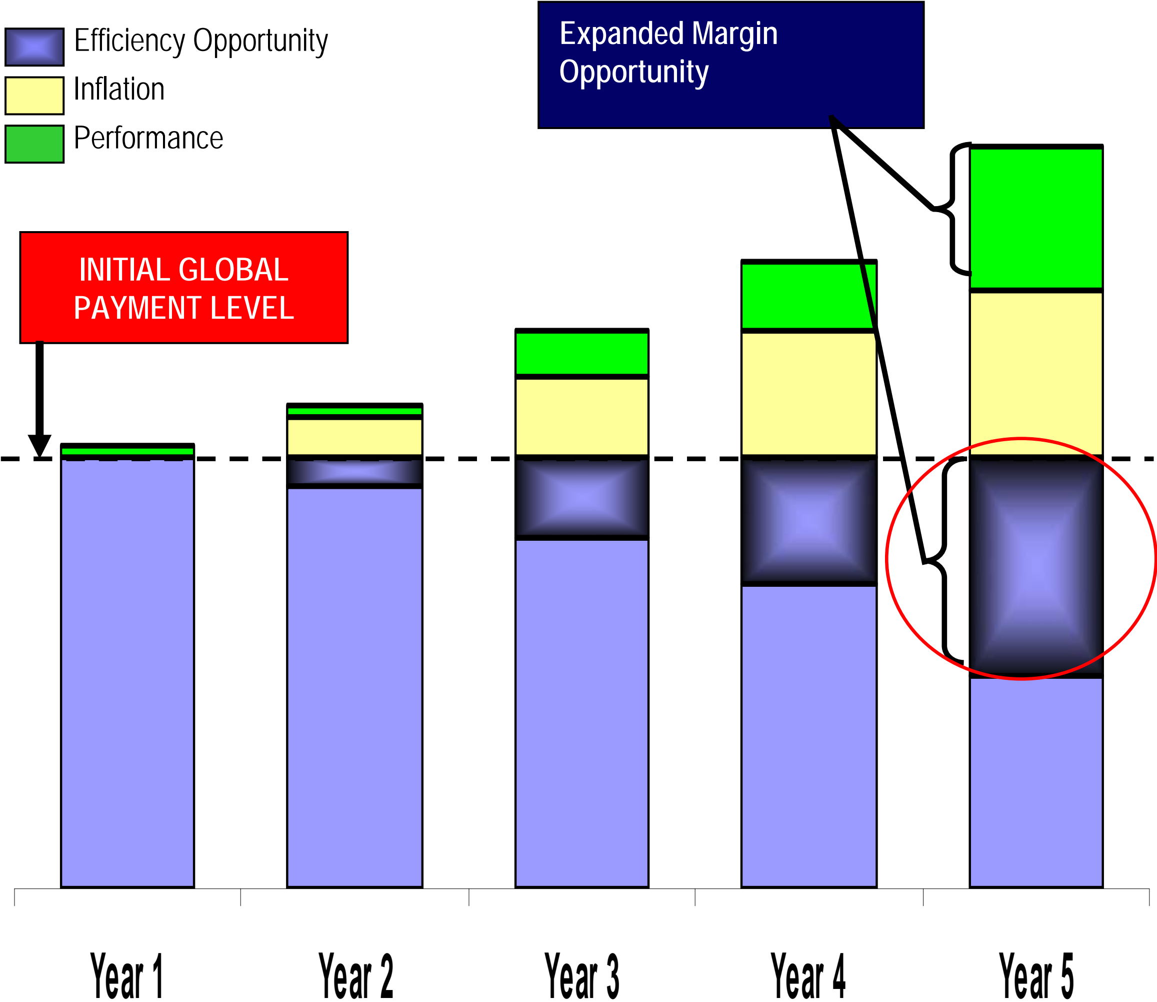
Performance Improvement: Cost and Efficiency



Practice Pattern Variation Analysis (PPVA)

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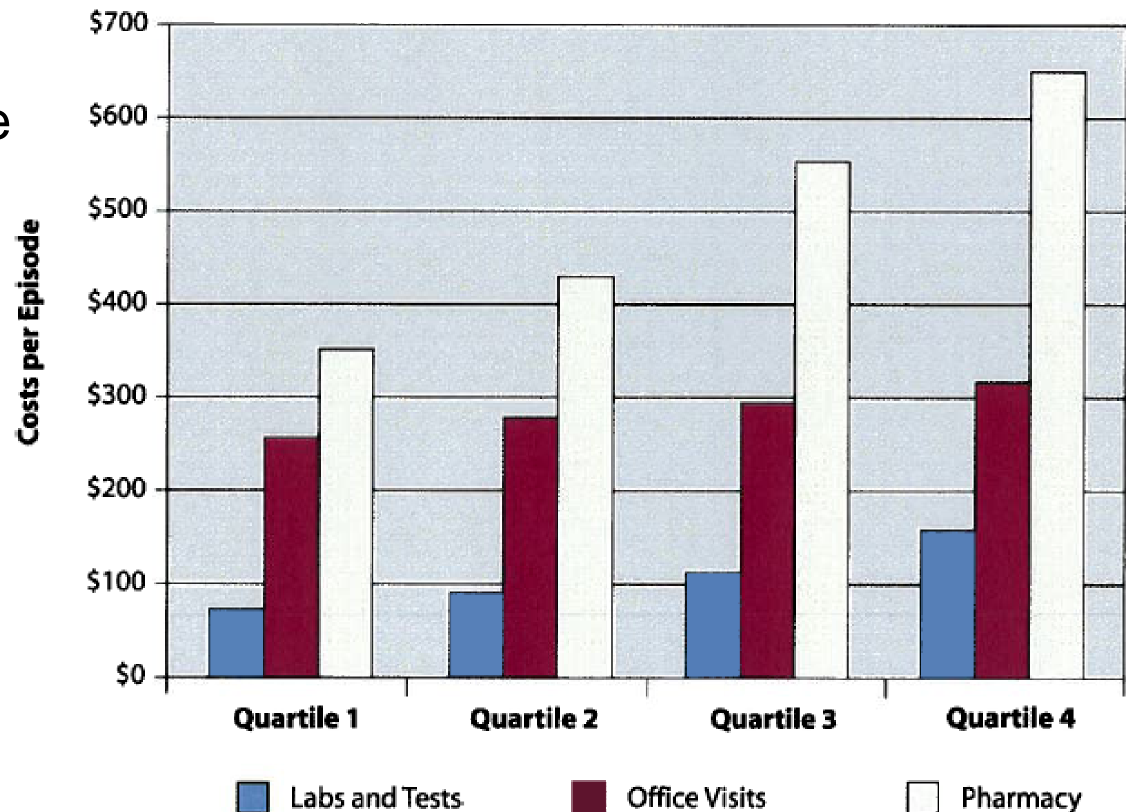
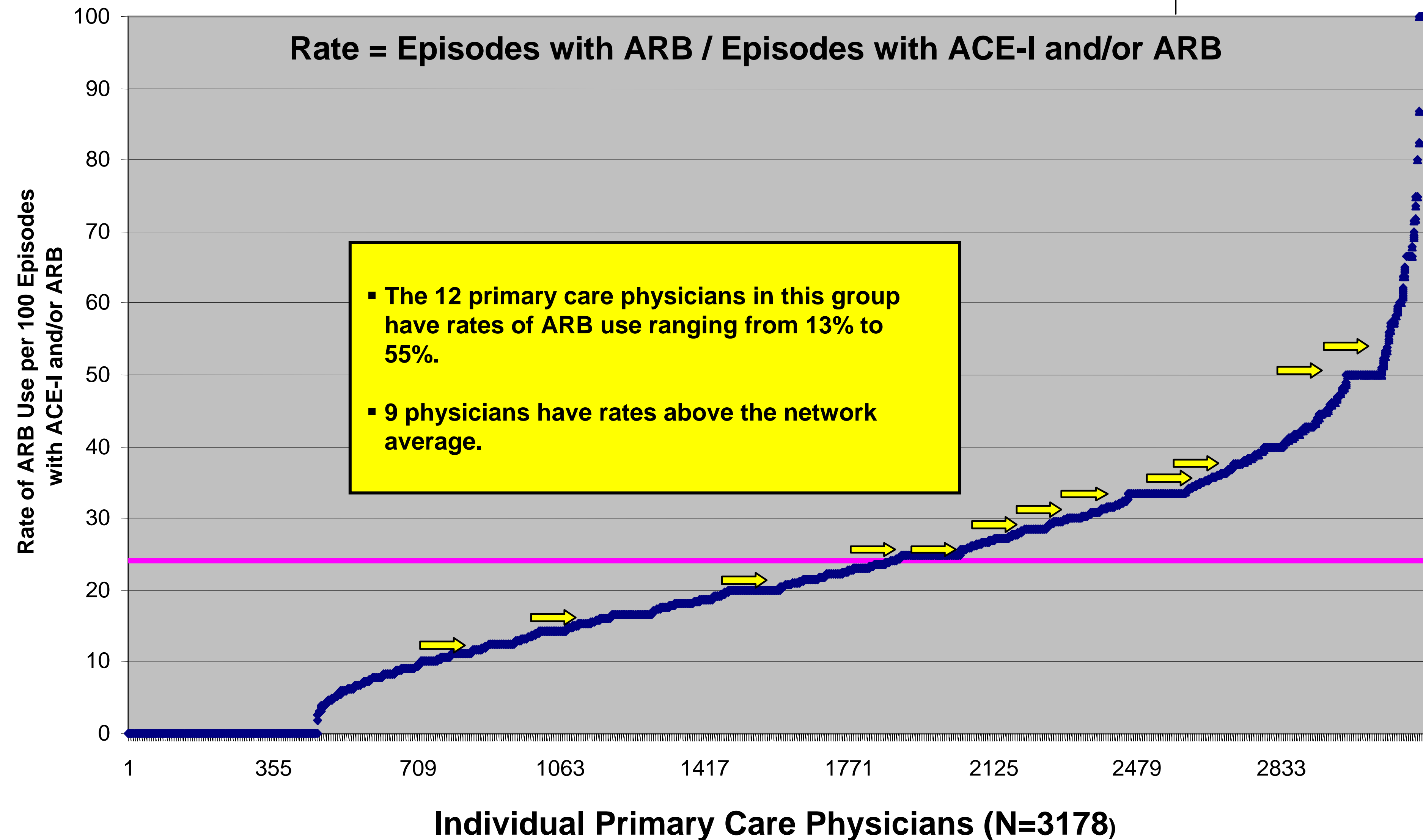
Unpacking differences in the treatment components of specific episodes across clinicians in a single, defined medical specialty

The results are highly actionable because they get to the root of variations in treatment costs for a defined and highly-specific clinical circumstance among physicians of the same specialty



Source: Greene RA, et al. *Health Affairs* 2008; w250-259

Variation in PCP Medication Choice in Treating Benign Hypertension



Variations in PCP Referral for Low Back Pain

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Low Back Pain as subset of Joint Degeneration of the Neck & Back, with & without surgery
Med Grp XYZ PCP Groups
Rate of Referral to Orthopedic Surgeon or Neurosurgeon per 100 Episodes
2006 - 2007

Rate = Episodes with at least 1 Referral to Ortho. Surg. or Neurosurg. / Total Episodes per PCP Group

- **The 21 PCP groups associated with NEQCA have referral rates to orthopedic surgeons and neurosurgeons ranging from 0 to 35 per 100 episodes.**
- **3 groups have a rate of 0.**
- **9 groups have rates at or above the network average.**

Rate of Referral to Orthopedic Surgeon or Neurosurgeon per 100 Episodes

100
80
60
40
20
0

1 65 129 193 257 321 385 449 513 577 641 705

PCP Groups (N=767)

Variations in Days-to-MRI for Low Back Pain

Low Back Pain as subset of Joint Degeneration of the Neck & Back, with & without surgery
Medical Group XYZ's PCP Groups
Average # of Days from Initial Visit to MRI
2006 - 2007

Rate = Sum of Days from Initial Visit to MRI / # of Episodes with MRI per PCP Group

- **The 21 PCP groups associated with Medical Group XYZ have average days between initial visit and MRI ranging from 0 to 311 days.**
- **12 PCP groups have average days less than the network average.**

Average # of Days from Initial Visit to MRI

500
450
400
350
300
250
200
150
100
50
0

1 65 129 193 257 321 385 449 513 577 641 705

PCP Groups (N=720)

Select PPVA Topics Provided to AQC Groups

Condition	Primary Drivers of Variation			
	Rx	Imaging	Specialty Referral	Procedure
Hyperlipidemia	X		X	
Benign Hypertension	X	X	X	
Inflammation of Esophagus			X	X
Joint Degeneration of Knee			X	X
Depression	X			
Migraine	X	X	X	
Inflammation of Skin	X		X	X
CAD, Ischemic Heart Disease (except CHF, w/o AMI)	X	X	X	X
Sinusitis (Acute & Chronic), Allergic Rhinitis	X		X	X
Arthritis	X		X	
Low Back Pain	X	X	X	X

Avoidable Use of Hospital Resources
Ambulatory Care Sensitive Admissions
Non-Urgent Emergency Department Utilization
30 Day All-cause Readmissions

Within-Group Variation in ED Visits for Otitis Media

There are 87 PCPs in this analysis for Group X with 35 having rates of ED use above the network average.

Rates of ED use for Group X physicians range from 0 to 33%.

The average count of ETG episodes per Group X physician in this analysis is 48.

Updates to AQC Model for 2011

Methodology for Setting Trend Targets

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2009 AQC Feature

Global budget with annual adjustments including: 1) inflation 2) total trend 3) unit cost trend and 4) new mandated benefits

Lessons Learned

- With these necessary adjustments, absolute trend targets did not have the desired simplicity
- The adjustments created a connection to the market but were complicated to administer.

2011 AQC Feature

Global budget with trend targets tied to the network trend at the regional level (East, Central, West).

Performance Incentives Linked

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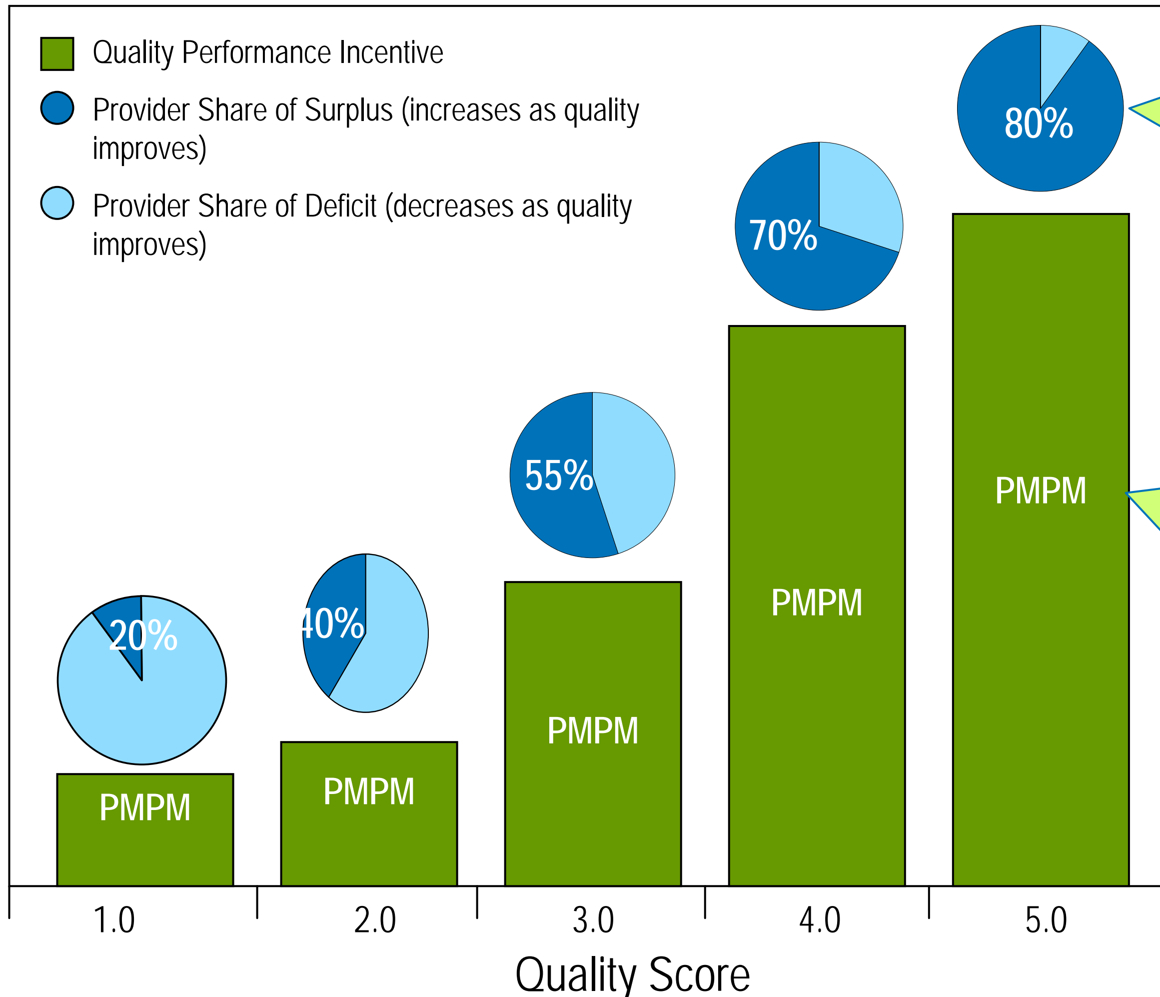
As quality improves, provider share of surplus increases/deficit decreases



Linking Quality and Efficiency
The 2011 AQC ensures that providers have a strong incentive to focus on both objectives.

PMPM Quality Dollars
The 2011 AQC also allows groups to earn PMPM quality dollars regardless of their budget surplus or deficit. High quality groups earn more PMPM quality dollars.

Summary

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- Without measurement, we don't know where we are on the journey
- But imprecise measures used in "high stakes" ways undermines our collective efforts
- Rapid and substantial performance improvement appears to follow when:
  - Substantial financial incentives for improvement on measures that are well accepted, widely validated and clinically important
  - Ongoing and timely data to inform improvement efforts
  - Organizational structure and leadership commitment to the goals
- Under a payment model that creates accountability for resource use (e.g., global budget), cost and efficiency measures do not need to meet criteria for "high stakes" use.
  - Incentives for improvement on this domain is built into the payment model
  - Measurement is needed to support accountability and success – but not for high stakes
- Clinically-specific, specialty-specific approach to displaying practice pattern variations appears powerful to engaging physician leaders and front line in (passionately) addressing clinical waste.

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For More Information

Doctor and the Doll by Norman Rockwell

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