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

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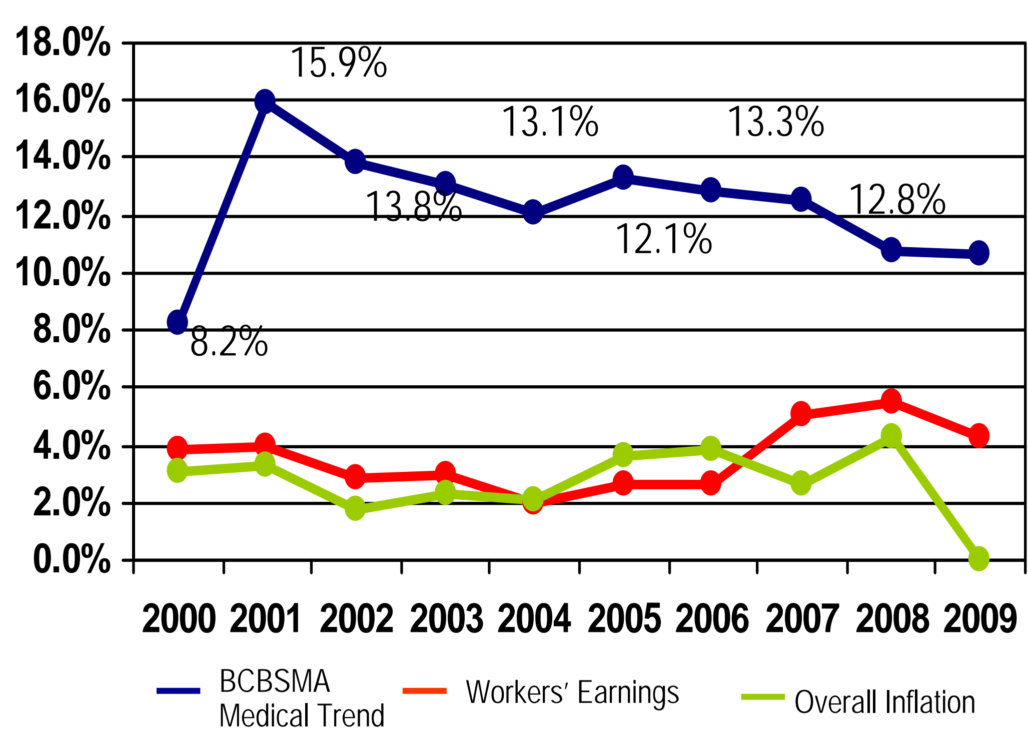
Twin Goals of Improving Quality & Outcomes While Significantly Slowing Spending Growth

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 health reform law (2006) caused a bright light to shine on the issue of unrelenting double-digit increases in health care spending growth ("Health Care Reform II).



Sources: BCBSMA, Bureau of Labor Statistics

Key Components of the AQC Model

Unique contract model:

- Accountability for quality and resource use across full care continuum
- Long-term (5-years)

Controls cost growth:

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

Improved quality, safety & outcomes:

- Robust performance measure set creates accountability for quality, safety & outcomes across continuum
- Substantial financial incentives for high performance

Performance on quality
Inflation tied to CPI
Identify savings within budget

EXPANDED MARGIN OPPORTUNITY

INITIAL GLOBAL PAYMENT LEVEL

Year 1 Year 2 Year 3 Year 4 Year 5

AQC Measure Set for Performance Incentives

	AMBULATORY	HOSPITAL

PROCESS	• Preventive screenings
	• Acute care management
	• Chronic care management
	    • Depression
	    • Diabetes
	    • Cardiovascular disease
		• Evidence-based care elements for:
		    • Heart attack (AMI)
		    • Heart failure (CHF)
		    • Pneumonia
		    • Surgical infection prevention

OUTCOME	• Control of chronic conditions
	    • Diabetes
	    • Cardiovascular disease
	    • Hypertension
	
	****Triple weighted****
		• Post-operative complications
		• Hospital-acquired infections
		• Obstetrical injury
		• Mortality (condition –specific)

PATIENT EXPERIENCE	• Access, Integration • Communication, Whole-person care	• Discharge quality, Staff responsiveness • Communication (MDs, RNs)
DEVELOPMENTAL	Up to 3 measures on priority topics for which measures lacking	

Performance Payment Model: Original

% Payout

10%
8%
6%
4%
2%
0%

10.0%
9.0%
5.0%
3.0%
2.0%

1.0
2.0
3.0
4.0
5.0

Performance Score

Performance Payment Model: Updated (2011)

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.

AQC Growth: Network Expansion

PCPs

6,000
4,500
3,000
1,500
0

60%

2009	2010	2011	2012
1,373	1,420	2,313	3,750

SCPs

12,500
10,000
7,500
5,000
2,500
0

75%

2009	2010	2011	2012
2,577	2,618	5,027	11,223

Note: Rates for 2012 as of Nov 2011. Continued expansion in 2012 expected.

AQC is Significantly 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
    - 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.
- Year-2 showed continued significant quality improvements among AQC groups relative to others
    - Some groups are nearing performance levels believed to be best achievable for a population

Ambulatory Quality: Summary Results

The 2009 AQC groups continue to improve quality and outcomes – sometimes approaching “best achievable” performance.

The 2010 AQC groups made significant quality improvements in their first year.

Ambulatory Quality

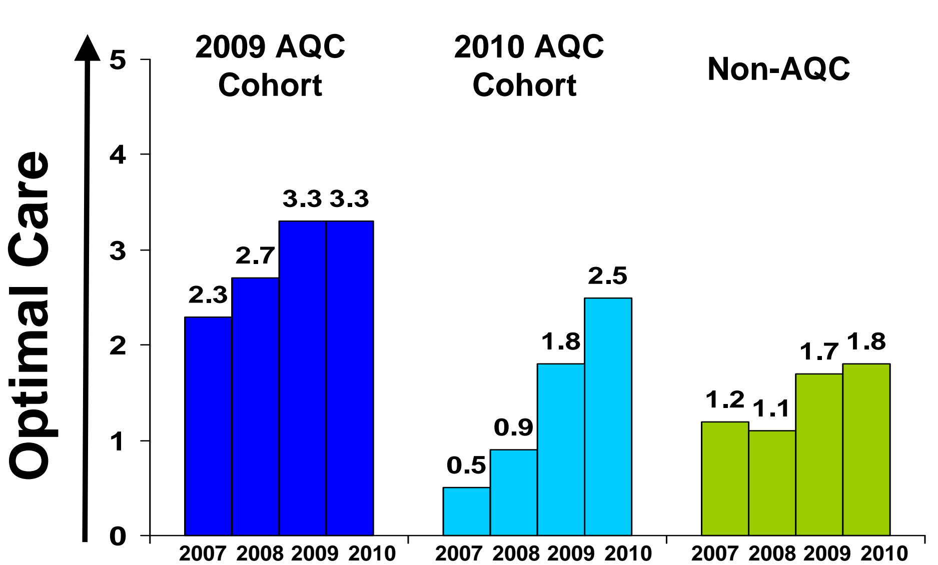
Optimal Care (scale 0–5)

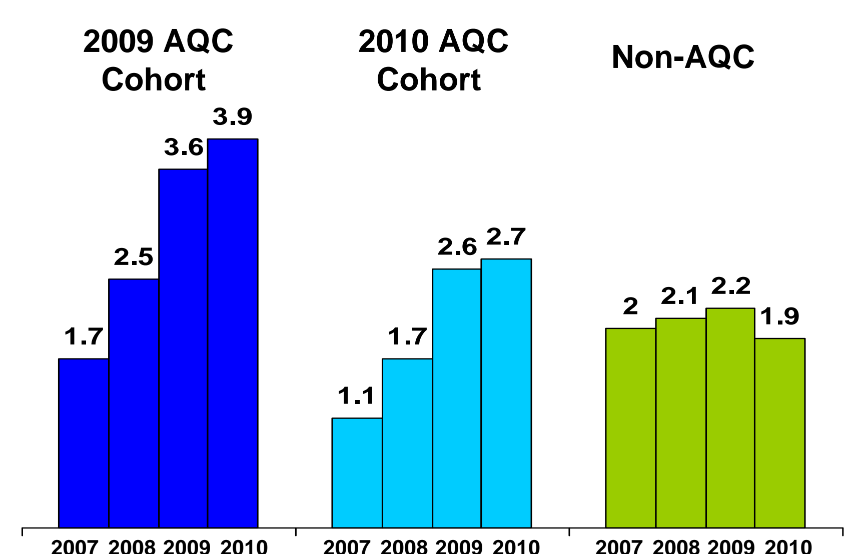
	2007	2008	2009	2010
2009 AQCs	2.1	2.3	3.0	3.3
2010 AQCs	0.9	1.3	1.7	2.4
Non-AQC	1.5	1.4	1.7	1.9

AQC Improving Preventive and Chronic Care

The 2009 AQC cohort continues to demonstrate success improving quality – achieving benchmarks significantly higher than non-AQC peers.

The 2010 AQC cohort made significant quality improvements in year-1 of their contract (2009 vs. 2010).





AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease (2009 Cohort Only)

Optimal Care

	2009	2010
Diabetic Cholesterol In Control	3.3	3.6
Diabetic Blood Pressure in Control	4.3	4.9
Cardiovascular Disease Cholesterol in Control	4.5	4.7

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

Year-1 Results: Formal Academic Evaluation

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Health Care Spending and Quality in Year 1 of the Alternative Quality Contract

Zirui Song, B.A., Dana Gelb Safran, Sc.D., Bruce E. Landon, M.D., M.B.A., Yulei He, Ph.D., Randall P. Ellis, Ph.D., Robert E. Mechanic, M.B.A., Matthew P. Day, F.S.A., M.A.A.A., and Michael E. Chernew, Ph.D.

"The AQC system was associated with modestly lower medical spending in the first year after implementation…a 1.9% savings relative to the control group (non-AQC)."

AQC is Significantly Reducing Costs

BCBSMA is on track to reach our goal of reducing annual cost growth (trends) by 50% over 5 years

In Year-1, medical spending among AQC groups grew more slowly (2-pts) than the non-AQC network. Savings deepened in Year-2.

Site-of-Service (Price). In year-1, AQC groups focused largely on site-of-service issues as a key driver of cost and opportunity to improve integration of care. Over first 2 years, approximately $2.5M savings due to use of lower cost settings.

Use. In year-2, AQC groups began to also show significant changes in use

- Medical/surgical admissions trend was 2% lower than non-AQC, which translates into approximately 300 admissions prevented (approximately $6M)
- High tech imaging trend was lower than non-AQC, which translated into about 1500 fewer scans (approximately $2M, reduced radiation exposure)

Five Keys Ingredients to AQC Success

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

2 **Financial Incentives** Real dollars are at stake for improvement.

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

5 **Leadership** Each group has strong engaged leadership driving to success on integrating care, significantly improving quality and reducing costs.

Payment & Delivery System Reform

Global budgets

Payment Integration

Fee-for-Service

AQC

Pioneer ACOs

Medicare Shared Savings Plan

Comprehensive Primary Care Initiative

Small isolated practices

Delivery System Integration

Integrated delivery system

Adapted from: A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, *Organizing the U.S. Health Care Delivery System for High Performance* (The Commonwealth Fund, Aug. 2008).

Summary & Next Steps

- A payment model that establishes provider accountability for both medical spending and quality appears to be a powerful vehicle for realizing the goal of a high performance health care system with a sustainable rate of spending growth
- Rapid and substantial performance improvement appears to follow when:
  - Substantial financial incentives for improvement on well validated measures
  - Ongoing and timely data to inform improvement efforts
  - Organizational structure and leadership commitment to the goals
- Clinically-specific, specialty-specific approach to displaying practice pattern variations appears powerful to engaging physicians in addressing clinical waste
- We will continue to develop, expand and refine the AQC model, including
  - Implementation in PPO
  - Align member incentives through product design
- In 2012, we will continue working with providers who would like to be part of Medicare and/or Medicaid payment reform demonstrations under similar accountability models

For More Information

Doctor and the Doll by Norman Rockwell

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