Incentives for Quality Improvement: The Alternative Quality Contract (AQC)

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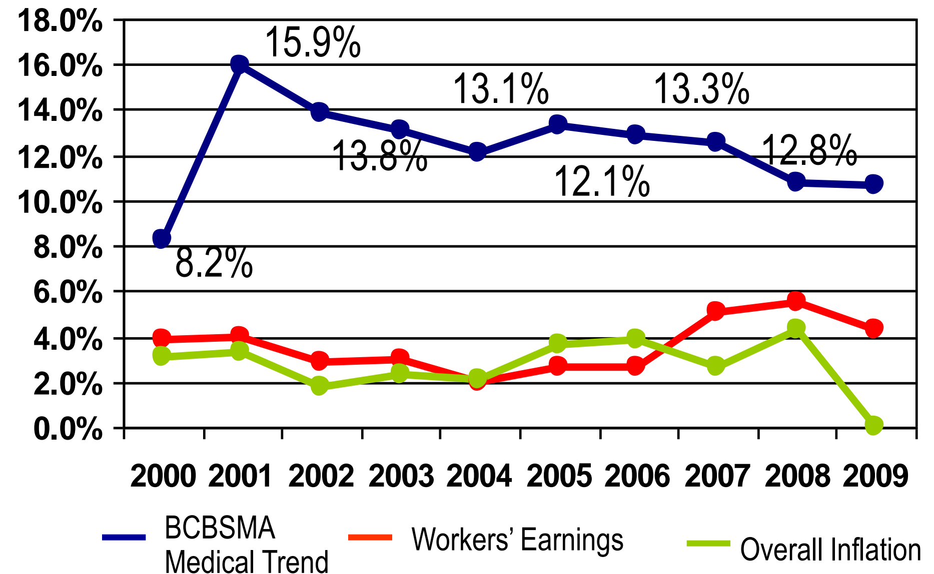
Twin Goals of Improving Quality & Outcomes While Significantly Slowing Spending Growth

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 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 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

AQC Measure Set for Performance Incentives

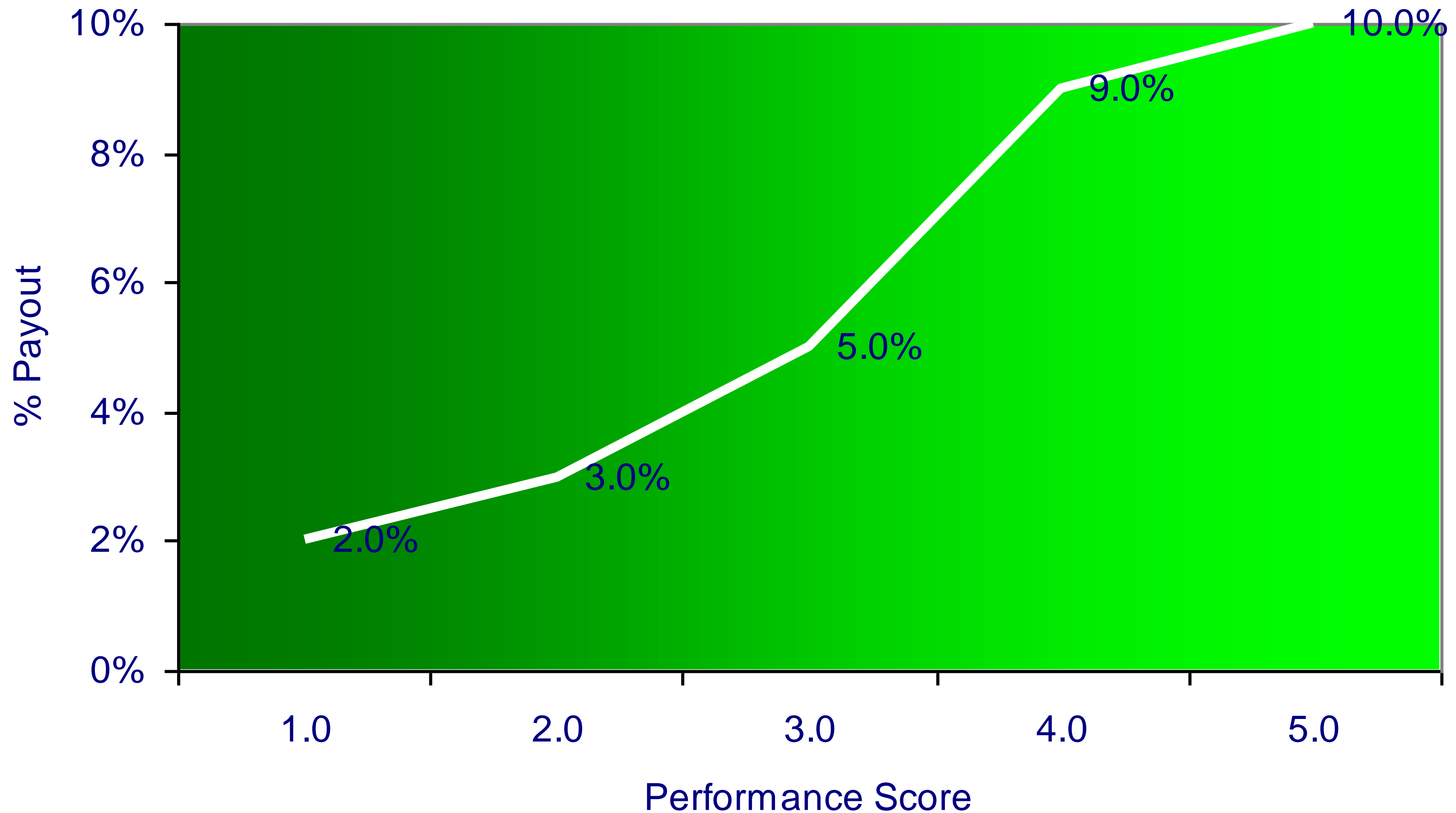
	AMBULATORY	HOSPITAL

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 Achievement Model



Significant Growth, 2009-2011

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In-State HMO Membership

	2009	2010	2011
Membership	305,000	355,000	470,000
	26%	32%	44%

900,000
800,000
700,000
600,000
500,000
450,000
400,000
350,000
300,000

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

Optimal Care

Preventive Screenings

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

Chronic Care Management

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

AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease

Measure	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.

Key Components of the AQC Model

Performance on quality
Inflation tied to CPI
Identify savings within budget

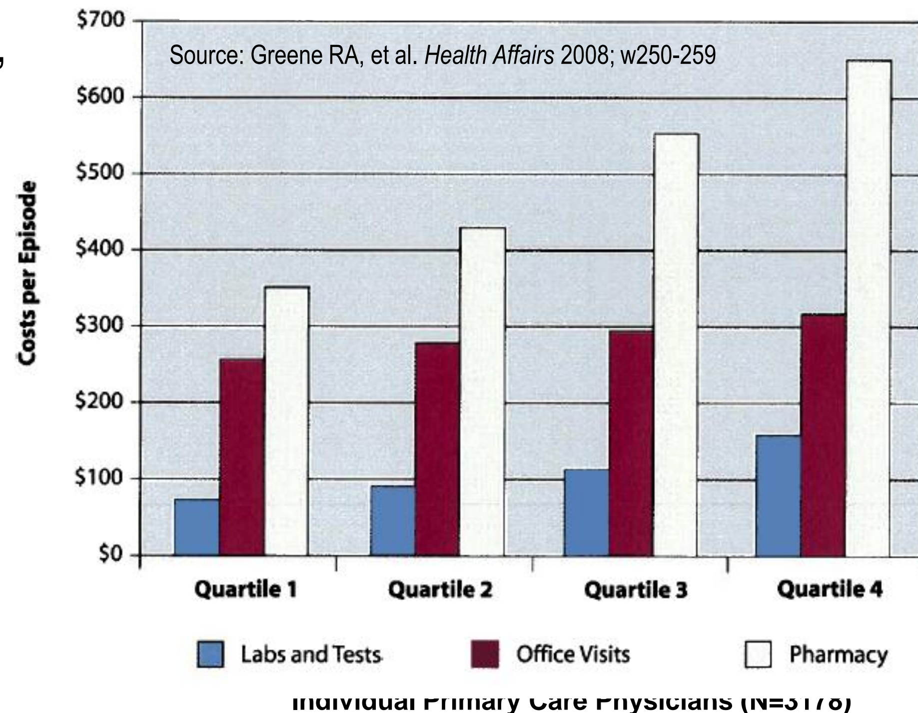
EXPANDED MARGIN OPPORTUNITY

INITIAL GLOBAL PAYMENT LEVEL

Year 1 | Year 2 | Year 3 | Year 4 | Year 5

Identifying & Addressing Clinically Wasteful Care

- Since 1970s, Wennberg et al. have called attention to unexplained practice pattern variations using maps
- Dr. Howard Beckman developed an analytic approach that makes the information clinically meaningful and actionable
- Clinically-specific, specialty-specific approach to displaying practice pattern variations – engages physician leaders and front line in physicians in addressing clinical waste
    - Referral tendencies, use of procedures, use of diagnostics, use of therapeutics
- This is a slow but critical process
- Payment models that create accountability for resource use (e.g., global budget) gives clinicians, groups and hospitals a strong incentive to act on these data



Benign Hypertension, With and Without Comorbidity
Individual Primary Care Physicians
Rate of ARB Use per 100 Episodes with ACE-I and/or ARB - 2007

Rate = Episodes with ARB / Episodes with ACE-I and/or ARB

- **1304 Primary Care Physicians (41%) have rates for ARB use that are above the network average. (N=3178)**
- **The average count of 'Benign Hypertension, with and without comorbidity' episodes per physician in this analysis is 41.**
- **Physicians with rates above network average have an average episode load of 44.**

Rate of ARB Use per 100 Episodes with ACE-I and/or ARB

100
90
80
70
60
50
40
30
20
10
0

1
355
709
1063
1417
1771
2125
2479
2833

Individual Primary Care Physicians (N=3178)

Benign Hypertension, With and Without Comorbidity
Individual Primary Care Physicians
Rate of ARB Use per 100 Episodes with ACE-I and/or ARB - 2007

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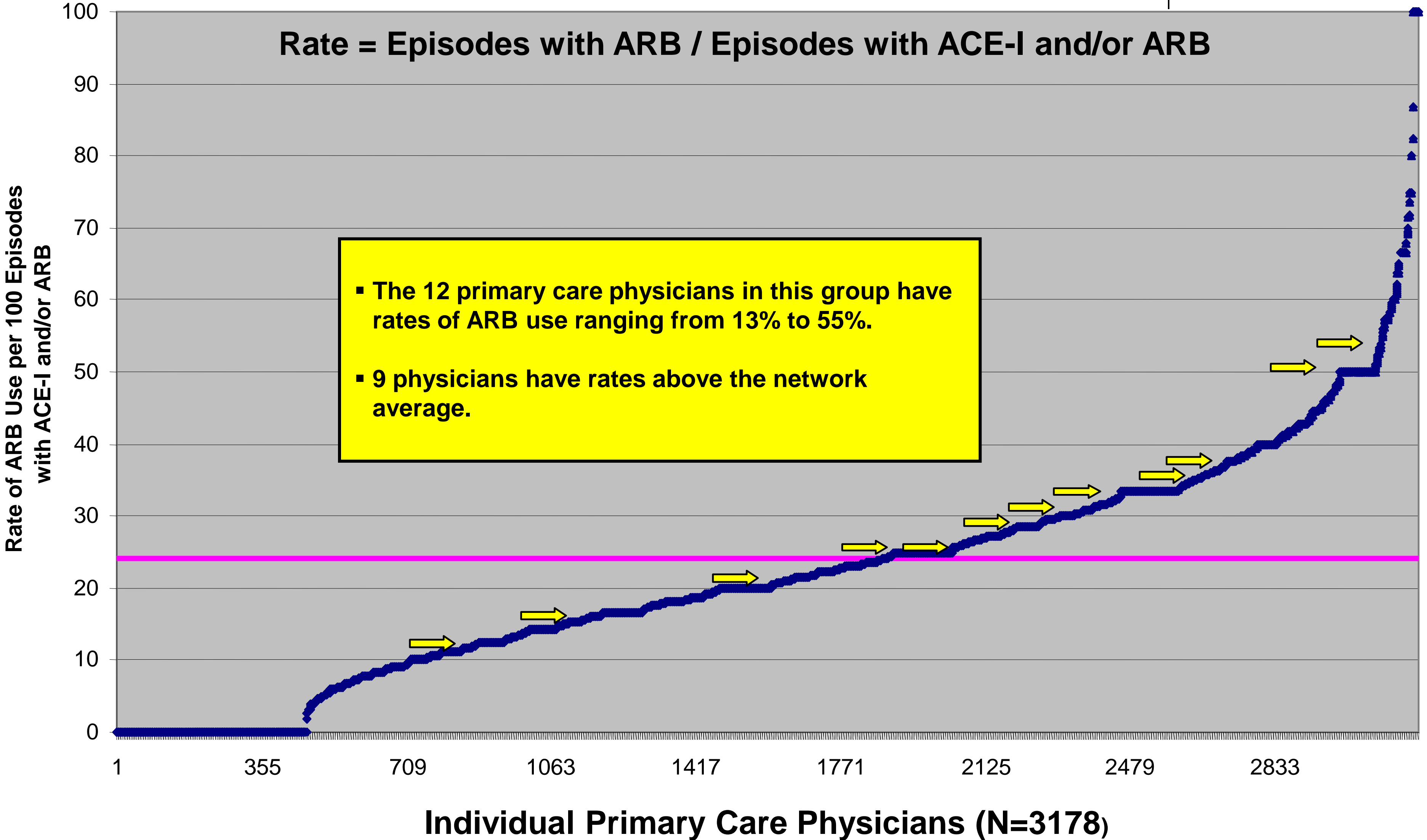

Select PPVA Topics Provided to AQC Groups

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

First Year Financial Results

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

AQC brings stability to medical expense trend because it brings predictability; over 5 years, trend targets move toward CPI

All AQC groups produced budget surpluses that enable them to make infrastructure investments to further improve care

In year-1, AQC groups focused on site-of-service issues as a key driver of cost and opportunity to improve integration of care

Some AQC groups already have reduced avoidable use of hospital care:

- AQC groups reduced hospital readmissions, equal to $1.8 million in avoided costs, while non-AQC groups experienced an increase in readmission rates.
- One AQC group reduced non-emergency ED visits by 22%, equal to $300,000 in avoided ED costs.

Summary & Next Steps

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- 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 2011, we are working with providers who would like to be part of Medicare and/or Medicaid payment reform demonstrations under a similar accountability model

For More Information

Doctor and the Doll by Norman Rockwell

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