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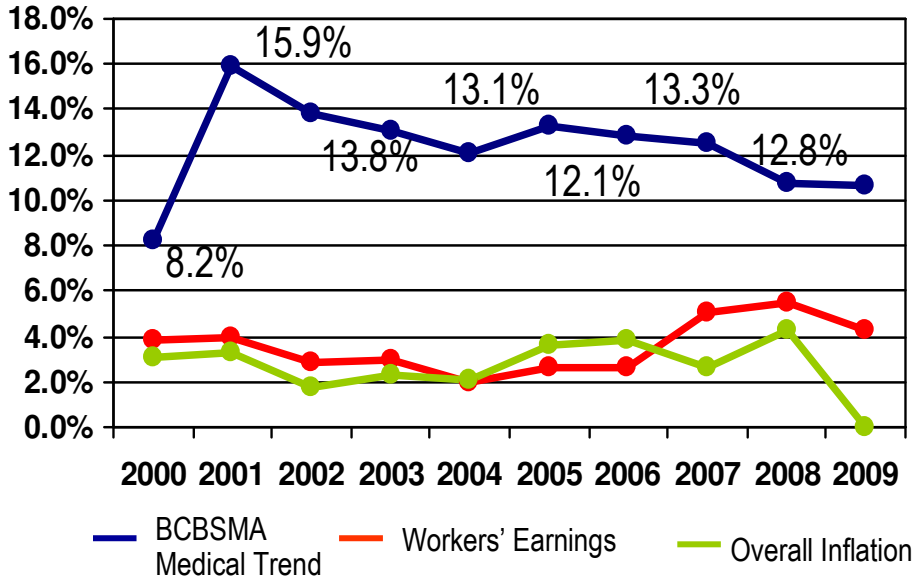
In 2007, leaders at BCBSMA challenged the company to develop a new contract model that would improve quality and outcomes while significantly slowing the rate of growth in health care spending.

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



Sources: BCBSMA, Bureau of Labor Statistics

Key Components of the AQC Model

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Unique contract model:

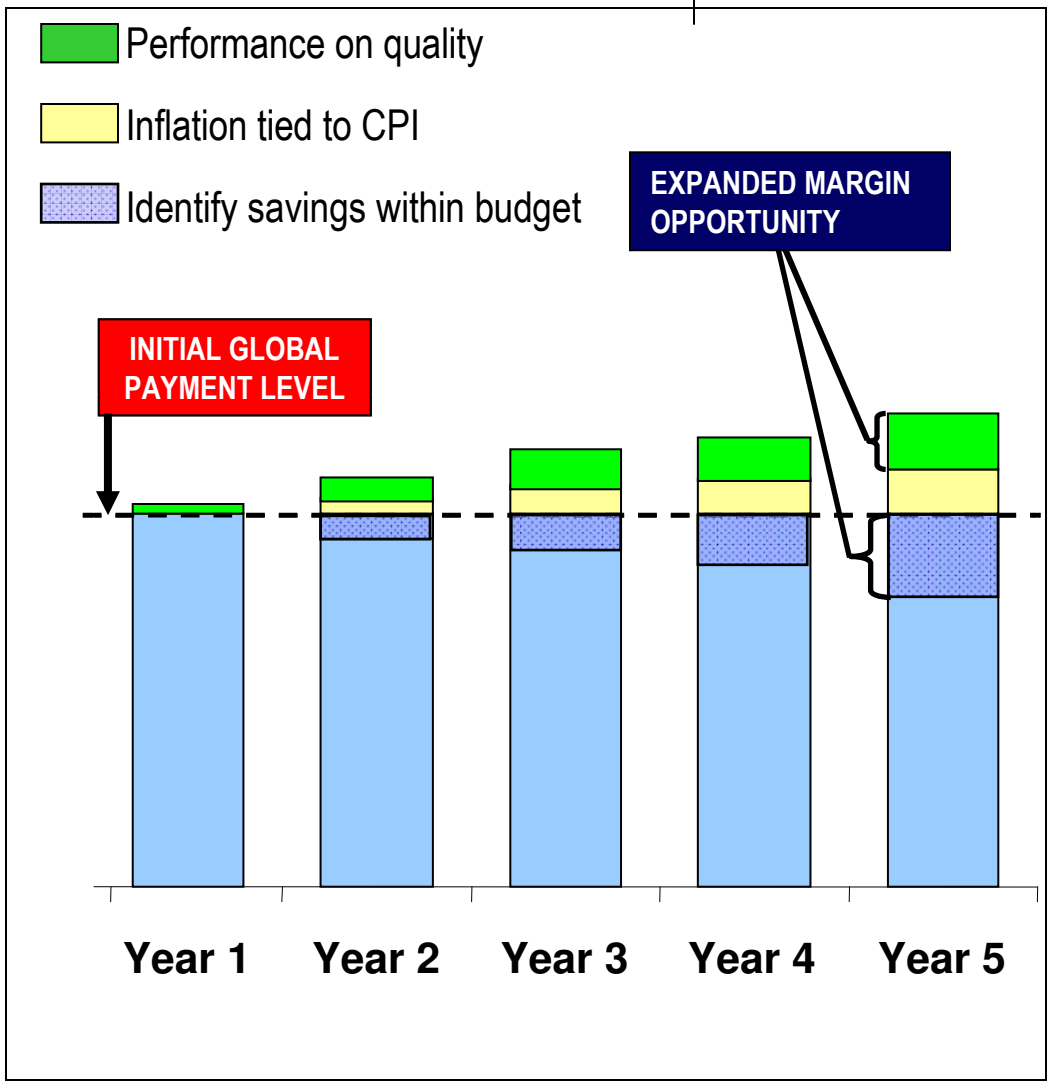
- Accountability for quality and resource use across full care continuum
- Long-term (5-years)

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

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	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

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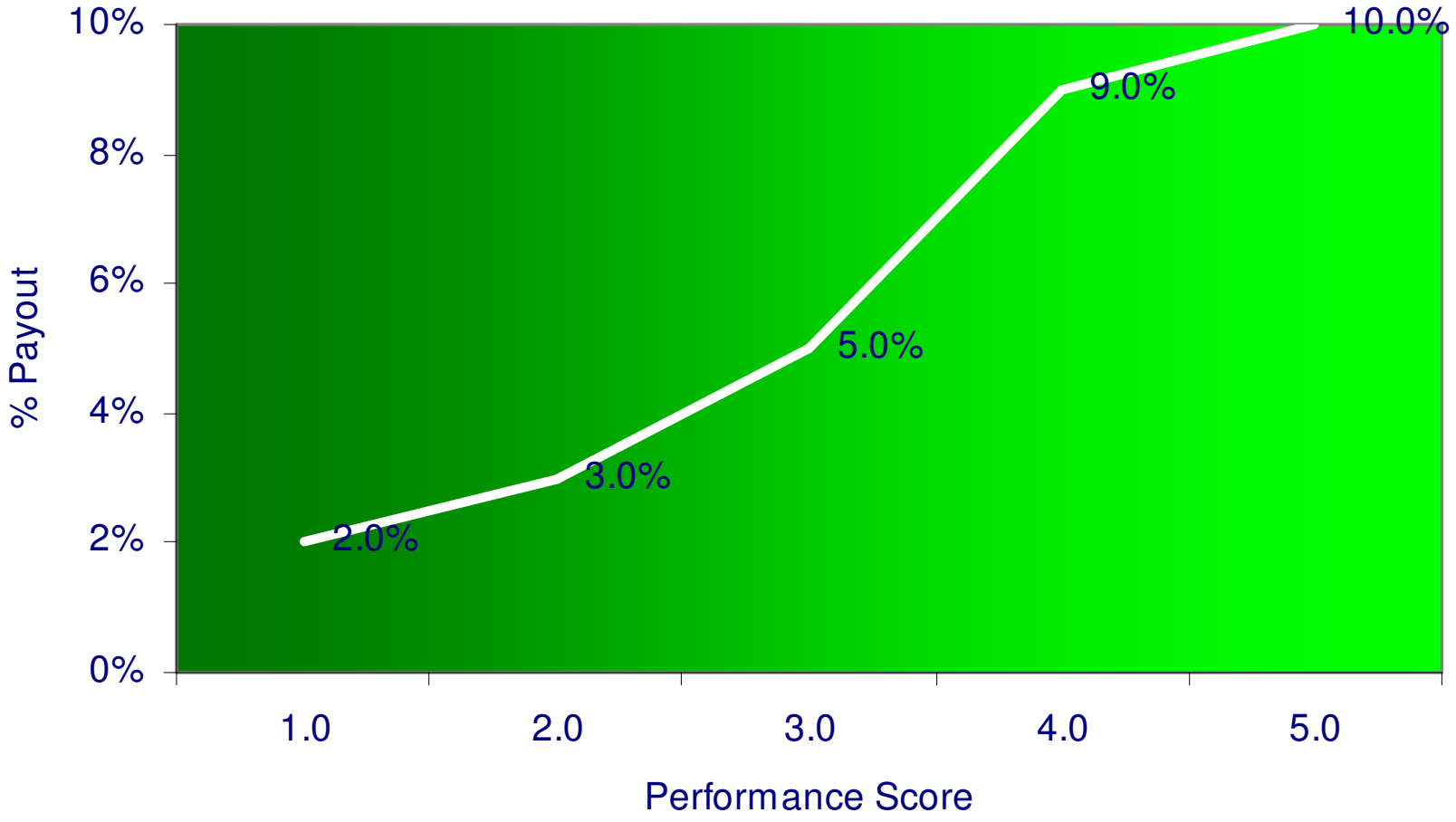
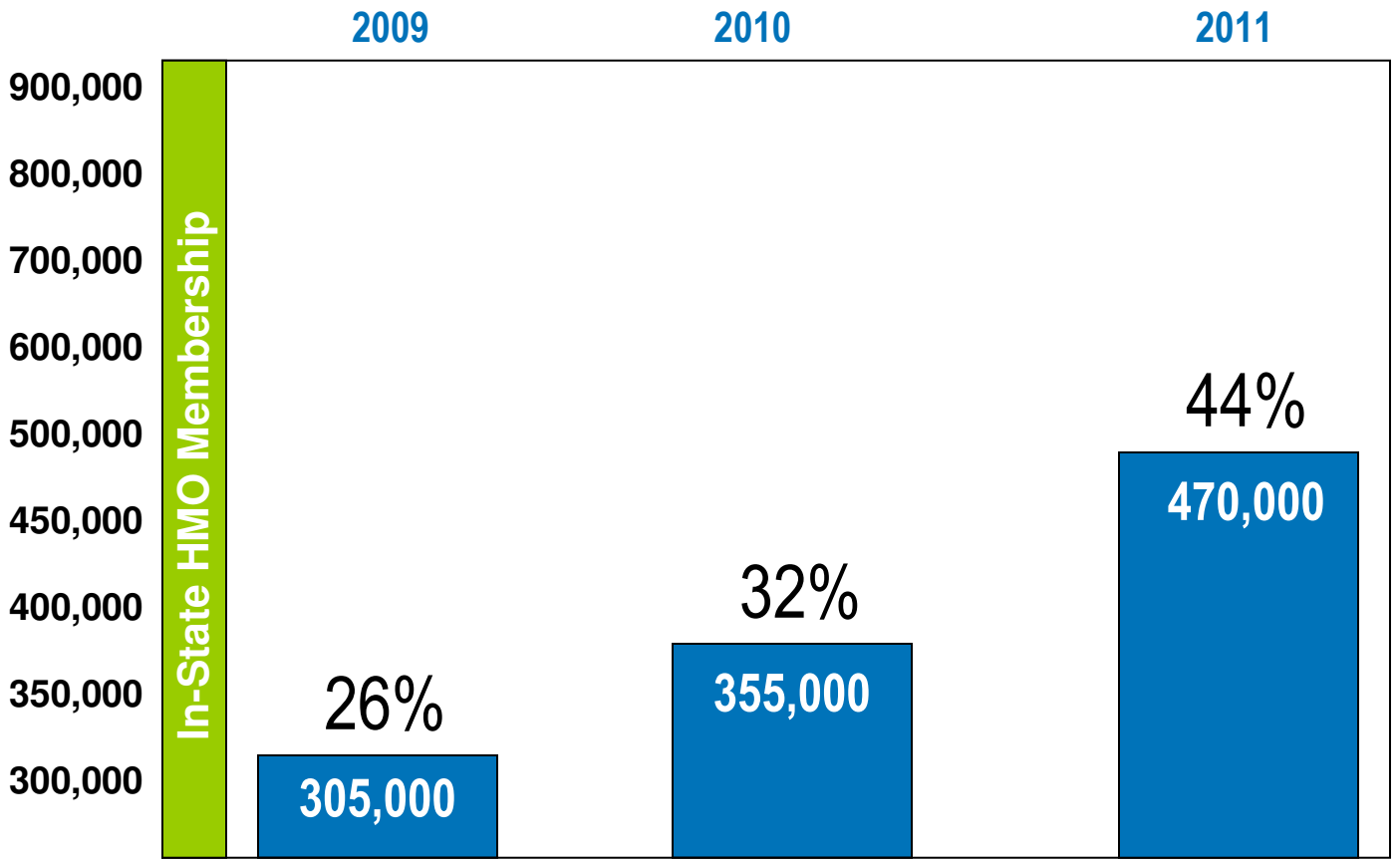
Performance Payment Model



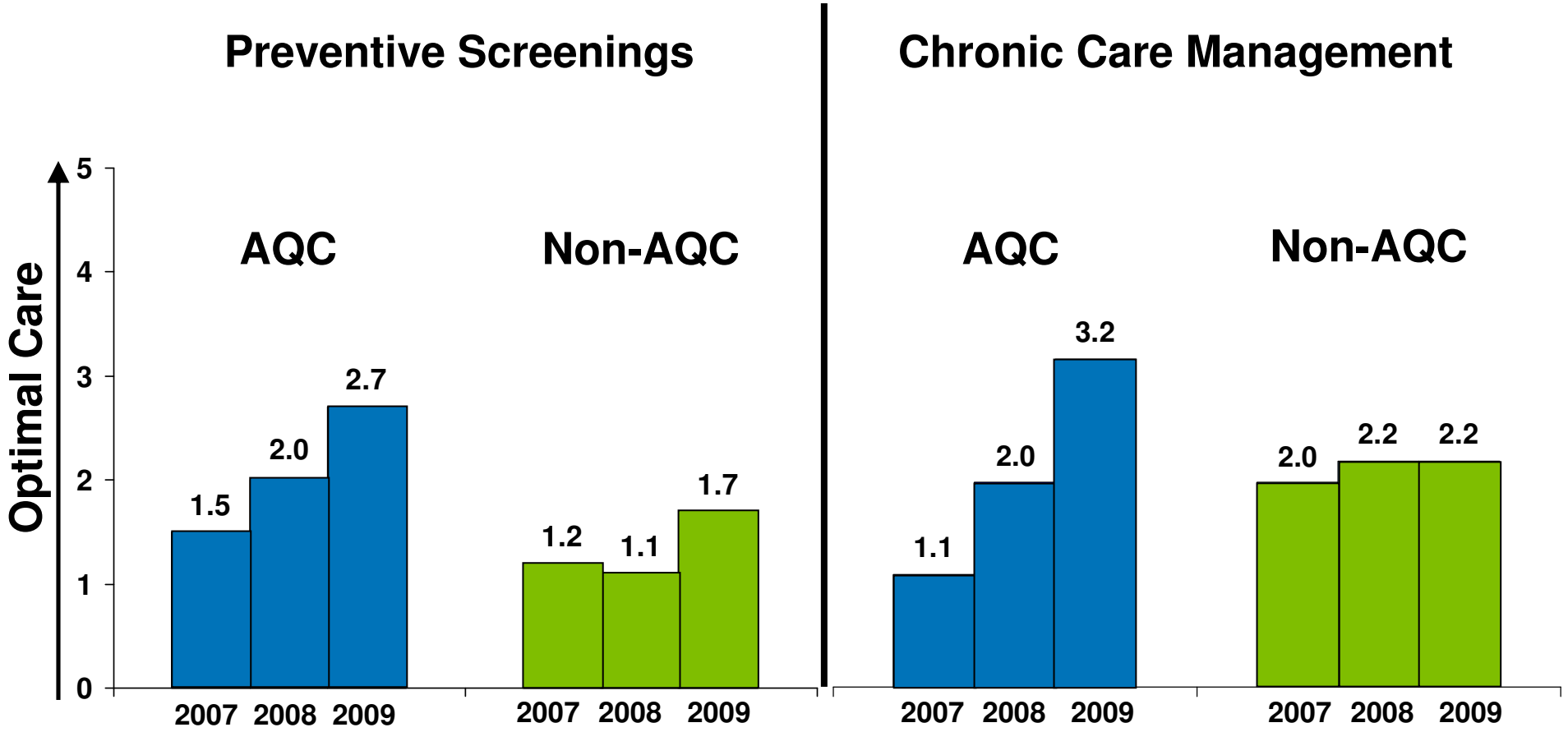
Significant Growth, 2009-2011



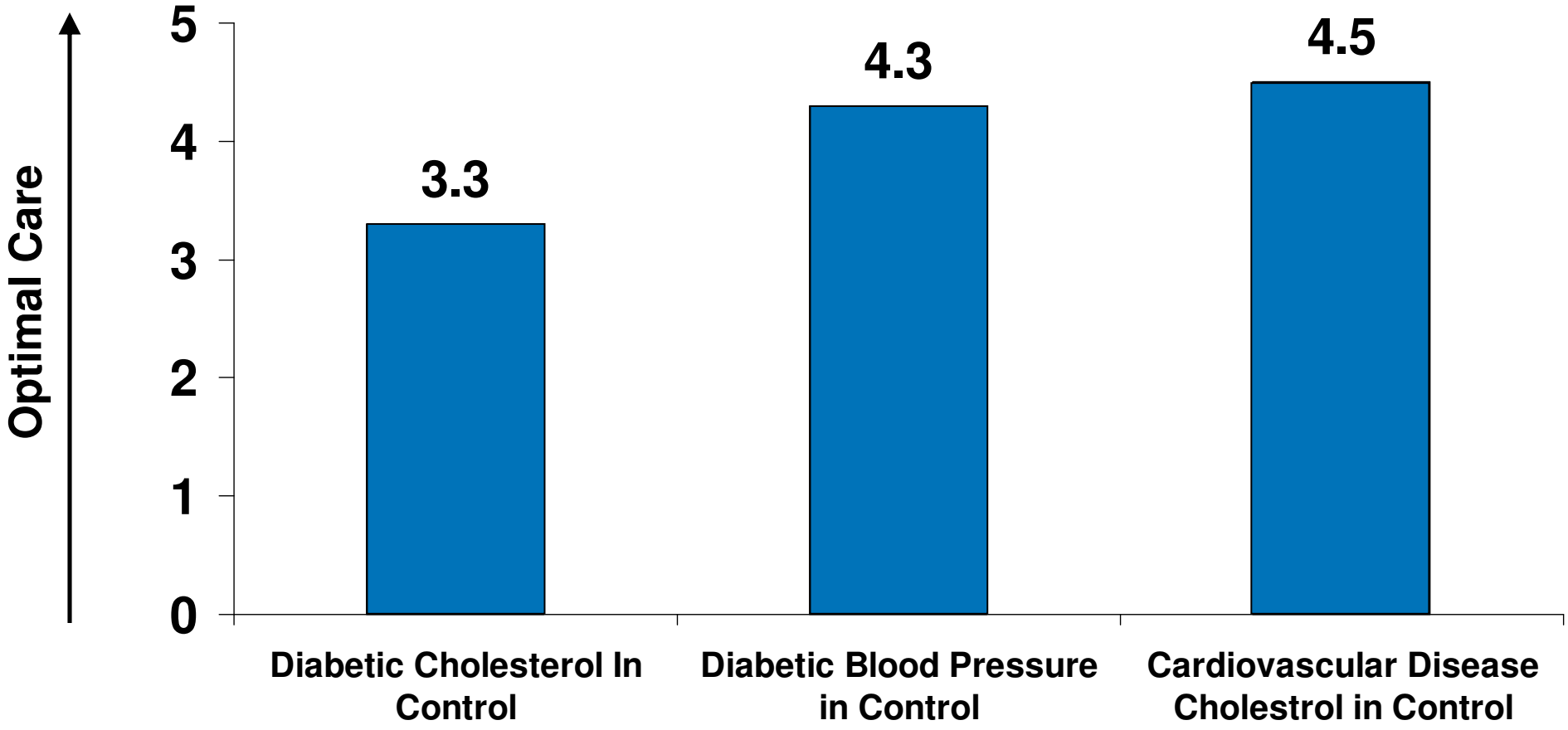
First Year Results show the AQC is Improving Quality

- 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



AQC Groups Achieving Excellent Outcomes for Patients with Chronic Disease



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

Key Components of the Alternative Contract Model

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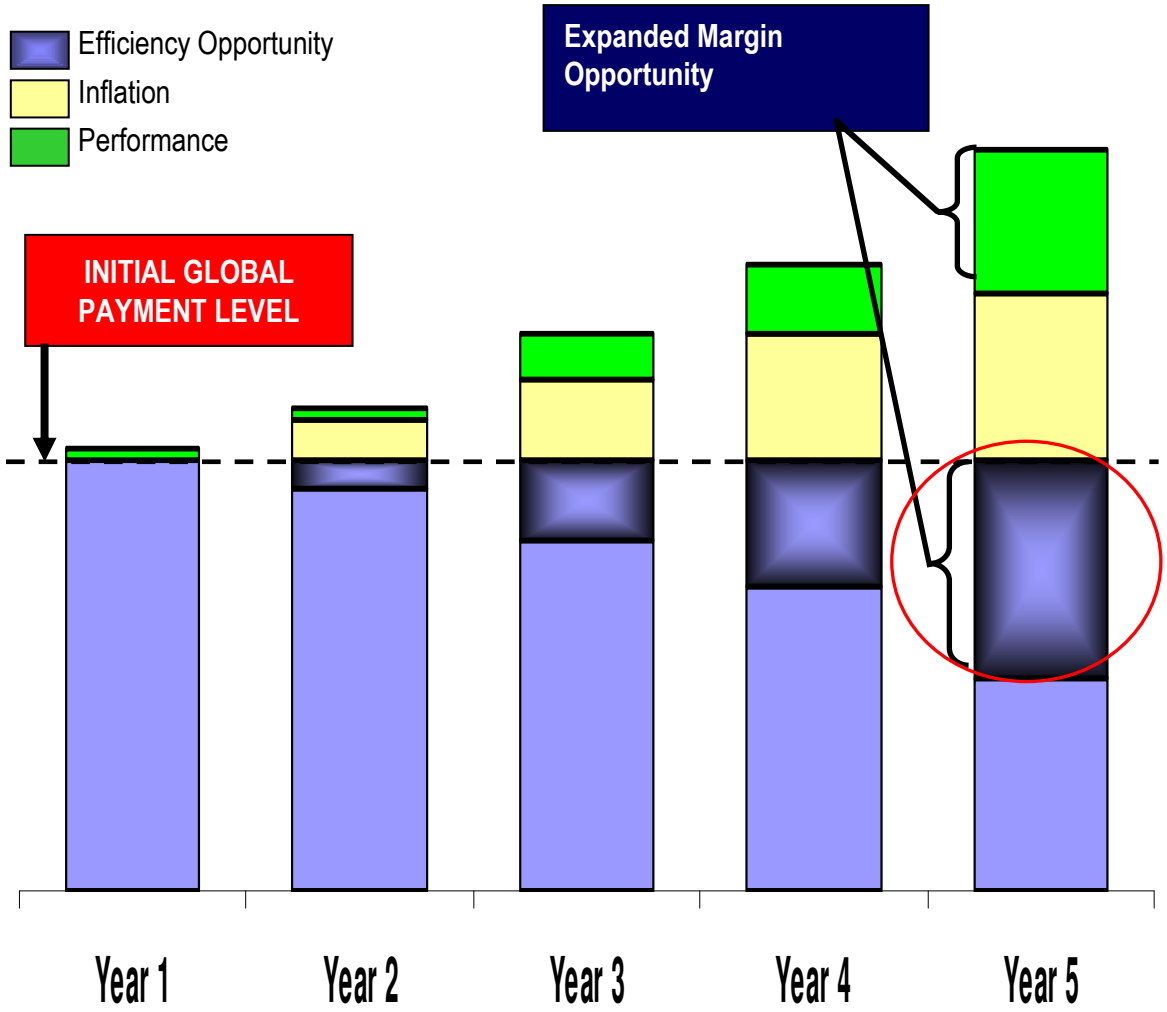
Performance Improvement: Cost and Efficiency



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

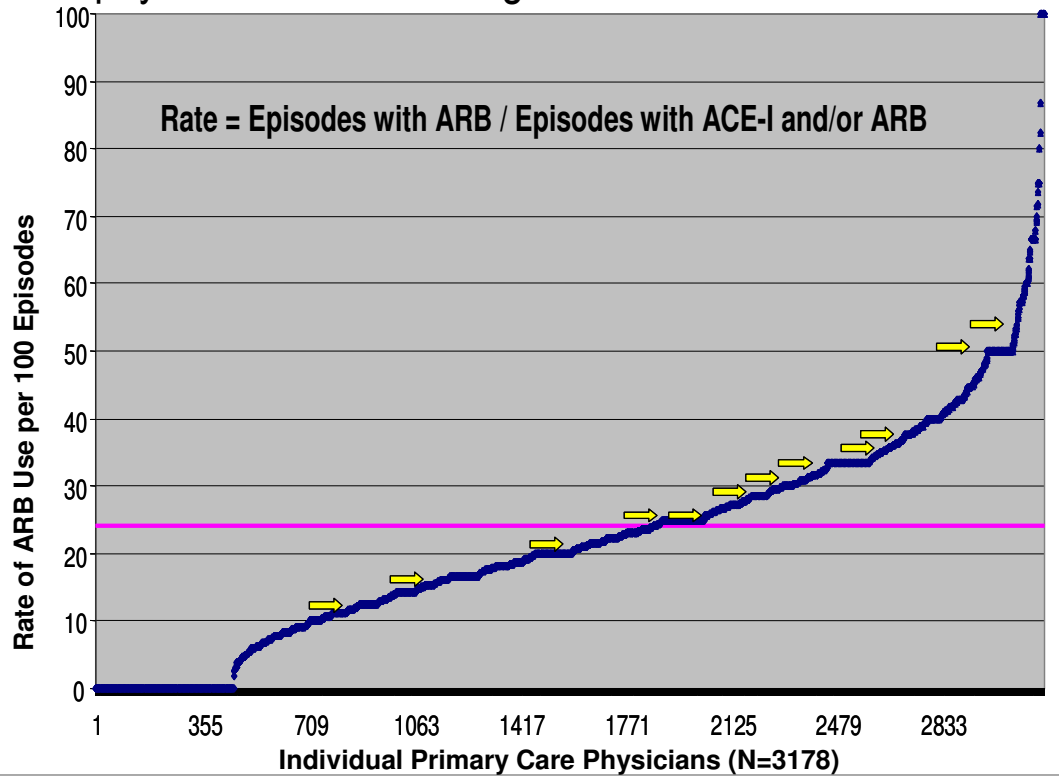
In year-1, AQC groups focused on site-of-service issues as a key driver of cost and opportunity to improve integration of care

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.

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



Select PPVA Topics Provided to AQC Groups

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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

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.