The Alternative Quality Contract (AQC): Improving Quality While Slowing Spending Growth

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Presented at:
MAHQ
16 April 2015

Context for AQC Development
The increasing cost of health care in MA compared to other public spending priorities

<table>
<thead>
<tr>
<th>Category</th>
<th>FY2011</th>
<th>FY2014</th>
<th>Change</th>
</tr>
</thead>
</table>
| Health Coverage (State Employees/GIC; Medicaid/Health Reform) | $5.4 B  
(+37%) | |        |
| Public Health                   | $12    | $11    | -8%    |
| Mental Health                   | $10    | $51    | +41%   |
| Education                       | $51    | $35    | -21%   |
| Infrastructure/Housing          | $10    | $51    | +41%   |
| Human Services                  | $51    | $35    | -21%   |
| Local Aid                       | $35    | $35    | 0%     |
| Public Safety                   | $35    | $35    | 0%     |

Source: Health Policy Commission, 2013 Cost Trends Report, data from the Massachusetts Budget and Policy Center

The increasing cost of health care in MA compared to other public spending priorities
The Alternative Quality Contract: Twin goals of improving quality and 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.


The AQC Model
The Alternative Quality Contract

Global Budget
- Population-based budget covers full care continuum
- Health status adjusted
- Based on historical claims
- Shared risk (2-sided)
- Trend targets set at baseline for multi-year

Quality Incentives
- Ambulatory and hospital
- Significant earning potential
- Nationally accepted measures
- Continuum of performance targets for each measure (good to great)

Long-Term Contract
- 5-year agreement
- Sustained partnership
- Supports ongoing investment and commitment to improvement

AQC Measure Set for Performance Incentives

<table>
<thead>
<tr>
<th>AMBULATORY</th>
<th>HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROCESS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preventive screenings</td>
</tr>
<tr>
<td></td>
<td>• Acute care management</td>
</tr>
<tr>
<td>OUTCOME</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Control of chronic conditions</td>
</tr>
<tr>
<td></td>
<td>• Diabetes</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease</td>
</tr>
<tr>
<td>PATIENT EXPERIENCE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Access, Integration</td>
</tr>
<tr>
<td>EMERGING</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Up to 3 measures on priority topics for which measures lacking</td>
</tr>
</tbody>
</table>

** Triple weighted **
Performance Payment Model: Updated (2011)

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

- **Quality Performance Incentive**
- **Provider Share of Surplus (increases as quality improves)**
- **Provider Share of Deficit (decreases as quality improves)**

**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 Results: The First Four Years
Results Under The AQC:
Improvement of the 2009 Cohort of AQC Groups from 2007-2012

These graphs show that the AQC has accelerated progress toward optimal care since it began in 2009. The first two scores are based on the delivery of evidence-based care to adults with chronic illness and to children, including appropriate tests, services, and preventive care. The third score reflects the extent to which providers helped adults with serious chronic illness achieve optimal clinical outcomes. Linking provider payment to outcome measures has been one of the AQC’s pioneering achievements.
AQC Results: Formal Evaluation Findings

As compared with similar populations in other states, Massachusetts AQC experienced lower spending growth and generally greater quality improvements than other states. The AQC experience may be instructive to other states and other settings where quality improvement efforts are being undertaken.

Total Cost Results

In Year 3, we met our goal of cutting trend in half. By 2012, AQC trend was 1.3% and declining.

AQC Total Cost Trend

- Pre-AQC Trend
- MA State Benchmark (3.6%)
- AQC Trend (1.2%)
Five Keys Ingredients to AQC Success

<table>
<thead>
<tr>
<th></th>
<th>Measures. The measures are nationally accepted as clinically appropriate so there is wide support for improving performance on these indicators.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Financial Incentives. Real dollars are at stake for improvement.</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>Leadership. Each group has strong engaged leadership driving to success on integrating care, significantly improving quality and reducing costs.</td>
</tr>
</tbody>
</table>

AQC Support & Improvement Analytics
Components of the AQC Support Model

Our four-pronged support model is designed to help provider groups succeed in the AQC.

Data and Actionable Reports

- Daily Census, Discharge, PCP Referrals and Inpatient & Outpatient Authorization Reports
- New Member Report
- ED Utilization Report
- AQC Member Call Tracking Grid
- Monthly Ambulatory Quality Report
- Monthly AQC Ambulatory Quality Measures Group Comparison Report
- Chronic Condition Opportunities Report
- Quality Diabetic Composite Score
- Case Management Report
- Ambulatory Care Sensitive Conditions Report
- AQC Financial Dashboard
- Non-Emergent ED Report
- Top 100 Rx Report
- Practice Pattern Variation Report—Episode Treatment Groups (ETG)
- Practice Pattern Variation Report—Emergency Department Use for Specific Conditions
- Readmission Report
- AQC Ambulatory Quality Measures Score/Results
- AQC Hospital Quality Measures Score/Results
- Cost and Use Report
- Site of Service Report
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

- The 12 primary care physicians in this group have rates of ARB use ranging from 13% to 55%.
- 9 physicians have rates above the network average.

Delivery System Innovation: Four Themes

There are four domains in which we see AQC Groups innovating to improve quality and outcomes while reducing overall spending.

- Staffing Models
- Approaches to Patient Engagement
- Data Systems & Health Information Technology
- Referral Relationships & Integration Across Settings
Local & National Context

Key Affordability / Cost-Related Developments in Massachusetts

<table>
<thead>
<tr>
<th>Year</th>
<th>Developments</th>
</tr>
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<tbody>
<tr>
<td>2006</td>
<td>Health reform passes (Ch. 58) Begins path to near universal coverage</td>
</tr>
<tr>
<td>2007</td>
<td>Much of Chapter 58 enacted, e.g.: MassHealth expansion Consumer affordability schedule New health plan options for young adults Employer Fair Share</td>
</tr>
<tr>
<td>2008</td>
<td>Cost Containment Part 1 (Ch. 305) passes Increased transparency about cost drivers Reports on health insurer and hospital &quot;reserves&quot;</td>
</tr>
<tr>
<td>2009</td>
<td>Special Commission on Payment Reform Recommends move to global payment</td>
</tr>
<tr>
<td>2010</td>
<td>Government reports and hearings on cost drivers Governor rejects small group premiums</td>
</tr>
<tr>
<td>2011</td>
<td>- Cost Containment Part 2 (Ch. 286) passes - Aims to control premiums for small business, individuals</td>
</tr>
<tr>
<td>2012</td>
<td>- Governor Patrick files payment reform legislation - Payment Reform (Ch. 224) passes Sets health care cost growth target at state GDP Requires public payers (Medicaid, GIC, Connector) to transition to alternative payment models Establishes ACO licensing process Increased transparency of health care prices for patients</td>
</tr>
</tbody>
</table>
Impact of the AQC on Medicare spending and quality

"These results make it clear: There is no free lunch. There may be free chips or fruit salad, but if you want the lunch, you have to come to the table." – Paul Grundy, MD, Director of IBM Global Healthcare Transformation

Account View: Illustration

While the charges associated with incentive payments rose relative to traditional contracts, the overall medical trend declined significantly.
Account View: Putting FFS and Incentive Costs in Perspective

<table>
<thead>
<tr>
<th></th>
<th>Allowed FFS</th>
<th>Incentive Payments for Performance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$445</td>
<td>$5</td>
<td>$451</td>
</tr>
<tr>
<td>2010</td>
<td>$465</td>
<td>$10</td>
<td>$475</td>
</tr>
<tr>
<td>2011</td>
<td>$472</td>
<td>$32</td>
<td>$504</td>
</tr>
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</table>

Components of Trend

<table>
<thead>
<tr>
<th></th>
<th>2010/09</th>
<th>2011/10</th>
<th>2 year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allowed FFS</td>
<td>4.4%</td>
<td>1.4%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Incentive Payments for Performance</td>
<td>1.0%</td>
<td>4.7%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>5.4%</td>
<td>6.1%</td>
<td>5.8%</td>
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ABC Account Report

Report Key

**ABC Account**
- **Green** – Account-specific AQC performance favorable when compared to account-specific non-AQC performance
- **Red** – Account-specific AQC performance unfavorable when compared to account-specific non-AQC performance

**BCBSMA Network**
- **Green** – AQC performance favorable when compared to non-AQC performance
- **Red** – AQC performance unfavorable when compared to non-AQC performance

**Note:** Colored cells plus (†) indicate that the account population is large enough that we are confident of your results.
PPO Market Penetration

PPO comprises about half of our in state providers’ commercial revenue.

% PPO (+non/HMO) penetration by state, July 2012

- 85%-100%
- 70%-85%
- 50%-70%

Summary and Priority Issues Ahead

- Payment reform gives rise to significant delivery system reform
- Rapid, substantial performance improvements are possible in the context of meaningful financial incentives; rigorously validated measures and methods; ongoing, timely data sharing and engagement; and committed leadership
- For payment reform, deep provider relationships and significant market share are advantageous
- Expanding payment reform to include PPO presents unique challenges
  - Gaining strong employer buy-in and support will be important – this means models must offer value from day-1
- Continued evolution of performance measures to fill priority gaps
  - Focus on outcomes, including patient reported outcomes (functional status, well being)
- Continued delivery system reform, including
  - Evolving the role of hospitals in the delivery system
  - Building deeper engagement of specialists
  - Bringing incentives (financial and non-financial) to the front lines
  - Advancing innovations in virtual care
For More Information

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