Lower costs from commercial Alternative Quality Contract spill over to patients not covered by the plan

27 August 2013

A commercial health insurer's large scale demonstration program designed to improve quality and lower costs for subscribers also lowered costs for Medicare patients who used the same health care providers but were not covered by the plan.

"These findings suggest that provider groups are willing—and able—to make systemic changes that result in higher-value care for patients across the board," said author J. Michael McWilliams, assistant professor of health care policy and medicine at Harvard Medical School and a practicing general internist at Brigham and Women's Hospital.

The results are in the August 28 issue of *JAMA*.

McWilliams, along with Michael Chernew and Bruce Landon, both HMS professors of health care policy, examined whether the Blue Cross Blue Shield of Massachusetts (BCBS) Alternative Quality Contract (AQC), an early commercial accountable care initiative associated with reduced spending and improved quality for BCBS enrollees, was also associated with changes in spending and quality for Medicare beneficiaries who were not covered by the AQC.

The researchers found that, within two years, providers who were part of the AQC achieved significant savings (more than 3 percent) for the Medicare beneficiaries they served relative to a control group served by other providers. Quality metrics for the patients in the intervention group either went up or stayed level, meaning the overall value of care rose.

In an accountable care organization (ACO), health care providers assume some financial risk for the costs and quality of the care they deliver. For example, instead of receiving a set fee for each service delivered , provider organizations might receive an annual global budget to care for their patient population. In a two-sided risk-sharing agreement like the AQC, if spending exceeds the budget, the ACO loses money; if spending falls below the budget, the ACO shares in the savings. ACOs also have financial incentives to meet certain quality-of-care goals. Typical goals might include decreased levels of readmissions for patients who are hospitalized, and increased levels of preventive care to help patients remain well.

ACOs are an integral part of many public and private efforts to reform health care. As an alternative strategy for provider payment, they were a key feature of Medicare reforms in the 2010 Affordable Care Act. Since these reforms are relatively recent, however, questions remain about how well they will perform and the extent of their impact. The Alternative Quality Contract— a commercial accountable care organization contract— was shown to reduce spending for the Blue Cross Blue Shield enrollees it covered, as intended, but how did it affect care for other patients of the same practices? Would providers make up for cutting back on the number of procedures performed on patients covered by the AQC by performing more for their non-AQC patients? The findings suggested much more encouraging responses by providers than that.

"The spillover savings in Medicare that we found suggest that at least some of the interventions providers adopted in response to the AQC changed the way care was delivered for all patients," McWilliams said. For example, provider organizations might implement new clinical decision support tools that discourage physicians from ordering popular but medically unnecessary imaging studies, such as MRIs for back pain; such

tools could work just as well for patients in or out of the ACO contract. However, spillover was not observed for all outcomes. For example, the quality gains associated with the AQC did not seem to spillover to Medicare, suggesting that only AQC enrollees experience those benefits.

These findings have several implications for payment and delivery system reforms, the researchers said.

On the one hand, the cost-reducing spillover effects suggest that providers who are in a plan like the AQC will be likely to enter similar contracts with additional insurers, where they can be similarly rewarded for the savings and quality improvements achieved for the additional insurers' enrollees. If this occurs, ACO-like payment reforms should continue to spread.

However, cost-reducing spillovers also present a free-riding problem to commercial insurers engaged in ACO contracts, since some of the efficiencies stemming from the AQC will benefit competing insurers.

This dilemma highlights the importance of understanding the system-wide effects of health care reforms.

"Additional efforts such as recent state initiatives to contain spending may be needed to foster multipayer participation in new payment systems," McWilliams said. "Our study of an early ACO program in Massachusetts suggests the potential for these payment models to drive systemic changes in care delivery."

More information: *JAMA*. 2013;310(8):829-836

Provided by Harvard Medical School

APA citation: Lower costs from commercial Alternative Quality Contract spill over to patients not covered by the plan (2013, August 27) retrieved 3 May 2021 from https://medicalxpress.com/news/2013-08-commercial-alternative-quality-patients.html

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