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Alternative payment model boosts quality of care for low-income patients

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People receiving care by providers participating in a type of alternative payment model experienced improvements in quality of care, with the greatest gains observed among patients living in lower socioeconomic status areas, according to results of a newly published study led by researchers in the Department of Health Care Policy at Harvard Medical School.

The program, Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract (AQC), launched in 2009, is a population-based payment model. It pays health care providers a lump sum to cover all the costs of a person's care, in contrast with traditional fee-for-service systems, which pay for each service provided.

Such alternative payment models were designed to motivate physicians and hospital administrators to focus on providing the highest-value care and improving quality while reducing waste, but some have cautioned that the approach could result in rationing of care and reduced access to services, especially for some vulnerable populations. The findings of the new study, however, provide evidence suggesting that such concerns may be exaggerated.

In their analysis, published in the January issue of *Health Affairs*, investigators compared changes in health care quality, health outcomes and total spending between members of the AQC in lower and higher socioeconomic status areas both before and after their physicians entered the AQC. The results show that while spending for different groups in

the AQC was similar, quality improvements were greater for low-income patients compared with high-income patients.

"On average, quality of care improved for all members in the AQC, but we noticed a larger improvement for members who live in areas with lower socioeconomic status," said Zirui Song, a resident physician at Massachusetts General Hospital and a clinical fellow at HMS who was the lead author of the study.

Specifically, process measures that involved adult preventive care, pediatric care and chronic disease management improved on average 1.2 percentage points higher among members in lower socioeconomic areas than among those in higher socioeconomic areas in the first four years of the AQC.

"While the overall effects were admittedly small," said Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy at HMS and a co-author of the study, "it is encouraging to see that the alternative-quality model hit a trifecta of outcomes: it lowered cost, improved care and narrowed the gaps in quality of care for the most disadvantaged of patients."

The results suggest that the AQC likely helped to narrow disparities in quality of care between different socioeconomic groups, the researchers say. Therefore, the authors write, payment models that provide incentives for quality of care and an adequate budget could be one way to improve quality of care for disadvantaged populations.

"Our findings are encouraging because they suggest payment models that emphasize and reward quality of care, outcomes and cost could provide the right mix of incentives that motivate providers to improve care for disadvantaged populations," Chernew said.