By Robert E. Mechanic, Palmira Santos, Bruce E. Landon, and Michael E. Chernew

Medical Group Responses To Global Payment: Early Lessons From The ‘Alternative Quality Contract’ In Massachusetts

**ABSTRACT** The largest insurer in Massachusetts, Blue Cross Blue Shield, began a new program in 2009 that combines global payments—fixed payments for the care of patient populations during a specified time period—with large potential quality bonuses for medical groups. In interviews with representatives of the participating medical groups, many of which could be considered prototype accountable care organizations, we found that most groups initially focused on two goals: building the infrastructure to help primary care providers earn quality bonuses; and managing referrals to direct patients to lower-cost settings. Groups are working to overcome numerous challenges, which include improving their data management capabilities; managing conflicting incentives in their fee-for-service contracts; and establishing cultures that emphasize teamwork, patient-centered care, and effective stewardship of medical resources. The participating medical groups are diverse in terms of size, organizational structure, and prior experience with managed care contracting. If the groups can succeed in reducing annual growth in health spending by half over the five-year contract, it could signal that even newly formed accountable care organizations can navigate a shift from fee-for-service to population-based payment models.

Policy makers interested in delivery system reform have recently focused on the potential for accountable care organizations to improve both the quality and the efficiency of health care. Accountable care organizations are groups of providers organized to deliver efficient, well-coordinated health services to defined populations across the continuum of care. In the health policy community, there is widespread hope that these organizations will be able to achieve better quality at lower cost, when combined with payment mechanisms that support these objectives. However, skeptics argue that most health care providers are ill prepared to implement the principles of accountable care organizations effectively. Nevertheless, the Affordable Care Act of 2010 has prompted many providers to begin preparing to become accountable care organizations in anticipation of the new Medicare shared savings program, which would reward them for meeting certain spending and performance standards. The draft Medicare rules, which were released for public comment in March 2011, have been criticized extensively and are being revised. The Centers for Medicare and Medicaid Services has also proposed other accountable care organization models—most notably the proposed “Pioneer” program and the proposed “Transitions” program for organizations that previously participated in the Medicare Group Practice Demonstration Project.

The advent of these various models raises a
fundamental question for the health care field: Who is prepared to become an accountable care organization?

Some insight may be found in the experience of the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract program, launched in 2009. In this program, medical groups agree to manage spending for designated groups of Blue Cross members within an annual risk-adjusted global budget—and to receive financial incentives for improving the quality of care for these members. The program’s aim is ambitious: reduce annual growth in health spending by half over the five-year contract period.

Although different from Medicare’s proposed shared savings or Pioneer programs, the Alternative Quality Contract shares these programs’ objective of holding medical groups accountable for the cost and quality of care. By the end of 2009, eight groups—including more than 25 percent of the state’s primary care physicians and 305,000 enrollees—had signed an Alternative Quality Contract agreement. By 2011, twelve groups had signed, expanding the program to 470,000 enrollees—nearly 11 percent of the state’s privately insured population.

This program has national policy implications because it is one of the few new large-scale efforts that fundamentally shift medical groups’ financial incentives toward accountable care. Blue Cross contracted with groups that vary widely in their apparent readiness to manage patients’ use of services within predetermined budgets. Therefore, the results of this five-year contract will provide some indication of the broader potential for organizations to navigate a shift from fee-for-service to population-based payment models.

**Study Data And Methods**

In the summer of 2010 we conducted a qualitative study of eight medical groups that had signed the Alternative Quality Contract. Our study focused on the first year of the contract and on the first cohort of groups to sign up. We conducted ninety-minute semistructured interviews with the senior executives and medical leaders of each group, as well as those of two systems that Blue Cross approached in 2008 but that did not sign the contract.

Our interviews focused on identifying the motivations of each organization for deciding whether or not to sign a global payment contract; the organizations’ strategic priorities; their investments in management infrastructure; and the importance of this initiative in driving organizational changes that could improve performance beyond the contract.

**The Alternative Quality Contract**

**CHIEF COMPONENTS** The Alternative Quality Contract has been described elsewhere. Its principal elements are a five-year term; an annual global budget based on each group’s historical per member per month spending; a quality-based system of performance bonuses; and regular reports from Blue Cross on the group’s spending, service use, and quality of care.

Although the medical groups each have an annual global budget, Blue Cross pays them fee-for-service throughout the year. All payments for medical care are debited against the group’s budget, whether the services are delivered by providers inside an Alternative Quality Contract group or by unaffiliated providers. At the end of each year, Blue Cross conducts a reconciliation exercise with each group, paying it any money left in the budget or recouping what the provider spent over the agreed-upon global budget.

The contract’s quality program tracks sixty-four measures (thirty-two each for inpatient care and for ambulatory or outpatient care) covering the process of care, outcomes, and patient experience. Groups must meet a minimum overall quality score to begin receiving bonuses. If a group achieves optimal quality, it can receive a bonus of up to 10 percent of its overall medical budget: 5 percent for performance on ambulatory quality measures and 5 percent for performance on inpatient quality measures.

**DIFFERENCES WITH MEDICARE’S SHARED SAVINGS PROGRAM** There are a few important differences between this contract and Medicare’s proposed Shared Savings Program (a summary is available in Appendix Exhibit 1). First, the Alternative Quality Contract applies only to members of health maintenance organizations whose insurance requires that they select a primary care provider and obtain referrals before seeking specialty care. In contrast, Medicare will assign beneficiaries to accountable care organizations, but the beneficiaries may seek care from any Medicare-certified provider.

Second, medical groups in the Blue Cross contract bear 50–100 percent of the financial risk for meeting their budget targets. In Medicare’s principal shared savings option—known as the “onesided option,” in which savings, but not losses, are shared—groups can earn bonuses for spending less than their target budget but are not penalized for exceeding it until the third year of the program.

Third, the Alternative Quality Contract includes quality incentive payments that groups can earn independent of their performance on spending. In the Medicare program, accountable care organizations do not receive quality incentive payments, although they must meet quality
thresholds to qualify for shared savings payments.

Fourth, the Alternative Quality Contract is five years long, whereas the Medicare program lasts three years. And finally, Blue Cross negotiates each contract and can customize arrangements for individual groups. In contrast, Medicare’s Shared Savings Program has fixed terms that providers must accept if they want to participate.

**Participating Medical Groups**

The eight groups in this study varied in terms of size, geographical location, organizational form, and prior experience with risk contracting. Five groups were formally affiliated with hospitals, while three were independent physician organizations. Roughly half of the participating doctors were employed by physician groups or hospitals, but among the groups, the share of physicians who were employed ranged from 5 percent to 100 percent. Roughly 18 percent of the primary care providers were in one- or two-physician practices, and 26 percent were in practices of five or fewer physicians. The two groups we interviewed that did not sign the contract in 2009 were both affiliated with academic medical centers.

We divided the participants into “experienced groups” and “new entrants” based on their history with risk contracts (Exhibit 1). All of the experienced groups had participated in global payment-type risk contracts for at least fifteen years and had such contracts with multiple payers in 2009. Three of the four groups had prior risk contracts with Blue Cross. All of them also had utilization review and case management capabilities, as well as mechanisms for working on performance improvement with clinicians, before they signed the Alternative Quality Contract.

The remaining four groups were new to global risk contracts. All were hospital owned or affiliated; only one existed prior to 2005; and none had global risk contracts with other payers in 2009—although subsets of two groups had prior risk contracts independent of the larger organizations. These newer groups expressed more caution about the Blue Cross contract, and several said that not all of their members had favored signing it.

Their reasons for joining included the belief

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**EXHIBIT 1**

*Characteristics Of Medical Groups In The Alternative Quality Contract In Massachusetts*

<table>
<thead>
<tr>
<th>Group name</th>
<th>Description</th>
<th>Year formed</th>
<th>No. of primary care MDs</th>
<th>No. of specialist MDs</th>
<th>No. of hospitals</th>
<th>Prior global risk contract with BCBSMA</th>
<th>2009 global risk contract with another payer</th>
<th>Delegated for UM</th>
<th>Delegated for high-risk CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXPERIENCED GROUPS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atrius Health</td>
<td>Multispecialty group IPA</td>
<td>1969</td>
<td>400</td>
<td>444</td>
<td>0</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hamden County IPA</td>
<td>IPA</td>
<td>1996</td>
<td>72</td>
<td>0</td>
<td>0</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mt. Auburn Cambridge IPA</td>
<td>IPA with aligned hospital Hospital PHO</td>
<td>1985</td>
<td>112</td>
<td>399</td>
<td>0</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>South Shore PHO</td>
<td>Hospital PHO</td>
<td>1995</td>
<td>98</td>
<td>281</td>
<td>1</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>NEW ENTRANTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steward Health Care Networka</td>
<td>Hospital PHO</td>
<td>2008</td>
<td>276</td>
<td>843</td>
<td>6</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Lowell General PHO</td>
<td>Hospital PHO</td>
<td>1995</td>
<td>80</td>
<td>200</td>
<td>1</td>
<td>No</td>
<td>Subset only</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>New England Quality Care Alliance</td>
<td>Hospital-owned IPA</td>
<td>2005</td>
<td>369</td>
<td>982</td>
<td>1</td>
<td>Subset only</td>
<td>Subset only</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Signature Healthcare</td>
<td>Integrated systemb</td>
<td>2007</td>
<td>50</td>
<td>109</td>
<td>1</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*Source:* Blue Cross Blue Shield of Massachusetts and participating medical groups. *Notes:* “Delegated” means that Blue Cross Blue Shield of Massachusetts (BCBSMA) gave the group formal responsibility for this function. UM is utilization management. CM is case management. IPA is independent practice association. PHO is physician-hospital organization. *Harvard Vanguard Medical Associates provides care for about 75 percent of Atrius Health’s patients and is the only Atrius medical group that is delegated for high-risk patient management. *7The group formed during the 1970s but entered its first risk contract in 1996. *The Mt. Auburn Cambridge IPA is closely aligned with the Mt. Auburn hospital but is organizationally independent. *Formerly called Cantas Christi Network Services. This group signed the contract in 2009 but did not begin the Alternative Quality Contract until 2010. *The contract covers only a subset of network providers, or certain practices have risk contracts outside of the larger medical group to which they belong. *Signature Healthcare is an integrated system that contains a hospital and an employed physician group.
that the contract offered more favorable financial terms overall compared to what would be available through straight fee-for-service rate increases. Several also said that having a contract holding them financially accountable for their performance would help them encourage physicians to support initiatives such as referral management and reductions in practice variation that they believed would be necessary to manage spending growth.

Many of the groups also felt a need to boost physician income. Blue Cross and other health insurers pay rates that vary widely across different groups, affecting the relative incomes of physicians. Medical groups on the low end of the fee scale fear that other groups will lure their most productive physicians away unless they can offer competitive compensation. Groups commonly believed that the potential for quality bonuses and surplus distributions in the Alternative Quality Contract gave them an opportunity to boost physician pay, which was an important factor in their decision to sign the contract.

The two groups that initially declined to sign the contract told us that they were not ready to accept a full-risk contract in 2008, nor did they feel pressure to do so at that time. In mid-2010 both were reconsidering their decisions, attributing the change to their improved readiness; the availability of a shared-risk contract that had not been offered in 2008; and political concerns over spending, reflected in Massachusetts’ ongoing debate over comprehensive cost control legislation.

**Strategies For Success**

We asked each group that signed the Alternative Quality Contract to describe its principal strategies for success and its progress with implementation.

**IMPROVING QUALITY SCORES** All eight medical groups identified quality improvement as a top priority because the Alternative Quality Contract offers much greater financial rewards for high quality than typical pay-for-performance programs. For example, a 2006 review of twenty-seven pay-for-performance programs found that average physician performance bonuses were about 2.3 percent of total physician payments, compared with the potential bonuses of up to 10 percent of total medical spending under this contract.6

Groups are free to allocate quality bonuses inside their own provider networks, allowing them to direct physicians’ financial incentives where they will be most effective. Three of the eight groups allocated the full ambulatory care bonus to primary care physicians, while two paid the full amount to network subgroups, letting them distribute the money among their physicians. Because standard payments to primary care physicians represent less than 10 percent of total medical spending, groups that earn the full ambulatory care bonus (5 percent of total medical spending) could increase primary care physicians’ compensation by more than 50 percent above their existing Blue Cross fee schedule.

In addition to providing financial incentives, the groups gave primary care clinicians regular feedback on their quality scores; data on specific patients who did not receive recommended preventive or chronic care management services; and, in many cases, assistance in contacting and scheduling appointments with these patients to provide the services needed to improve their quality scores.

**CHANGING REFERRAL PATTERNS** After quality improvement, the groups’ next most common strategy was encouraging physicians to refer patients to less expensive sites of care. This involved reducing “leakage”—the percentage of patients receiving routine care outside of groups’ core hospital and physician network—as well as directing patients from more expensive to less expensive facilities and settings, both inside and outside of their own networks.

To accomplish this, some groups began monitoring referral requests and flagging those they believed could be redirected. One group distributed its entire leadership team a daily leakage report at the level of the individual physician. Most groups did not deny referrals that physicians had already made. However, they used those referrals to educate physicians about the cost of “outside utilization” and the availability of services in their own network. Some groups considered adding more specialists to reduce the length of time that patients would have to wait for appointments, thus reducing the need for outside referrals.

Five groups told us that controlling leakage was their highest priority. Meeting that goal offered multiple benefits. First, for those groups with low costs, serving patients directly instead of referring them to more expensive out-of-network providers would lower the total cost of patient care and thus would have an immediate positive impact on the group’s spending. This is particularly true in Massachusetts because nearly half of all hospital admissions are to high-cost teaching hospitals and because private insurers’ payment rates can vary by as much as 100 percent for comparable types of services.7 Reducing the cost of referrals to these expensive out-of-network providers offers great potential for savings.

Second, reducing leakage would help groups
coordinate care more effectively. It would do so by ensuring that care is delivered by providers that had a shared interest in such coordination and the communication infrastructure to accomplish it. Many of the groups had formal systems to ensure that patient information was accessible to affiliated providers, but these systems rarely extended beyond the primary network. Furthermore, providers outside of the network were usually unaware of or unconcerned about the contract’s quality or efficiency goals. One medical director commented, “What we really want to avoid is our patients receiving unnecessary care in the most expensive places in town.”

Some of the groups are also aligning themselves more closely with preferred hospitals to manage care transitions more effectively. For example, in 2010 one physician group, Atrius Health, announced that it would move half of its 7,200 annual Brigham and Women’s Hospital admissions to the Beth Israel Deaconess Medical Center. The move was expected to reduce inpatient costs because Beth Israel’s fees were lower than those at Brigham and Women’s. Atrius officials said that the decision also reflected Beth Israel’s willingness to collaborate on clinical care coordination and to return patients to outpatient settings as quickly as possible. As part of this arrangement, Beth Israel also gave Atrius physicians online access to the medical records of Atrius patients who were receiving care at the Beth Israel Deaconess Medical Center.

More-effective referral management systems would clearly help groups improve their Alternative Quality Contract performance. Moreover, if the changes extended to fee-for-service patients who were not part of the contract, it would also help groups increase patient volume and profitability. However, groups that reduce leakage may gain financial benefits that allow them to delay more difficult cost-cutting measures or clinical redesign.

COORDINATING CARE FOR HIGH-RISK ENROLLEES A top strategic priority for five of the groups was improving the management of high-risk enrollees—for example, members with multiple chronic diseases who are susceptible to rapid deterioration that could result in expensive hospitalizations. The experienced groups had generally made more progress toward this goal than the newer groups had. Two of these experienced groups had already implemented multidisciplinary approaches to coordinating services for complex patients, using programs such as StatusOne and Guided Care, in their capitated Medicare health maintenance organization contracts, and were expanding these programs to their commercially enrolled patients.

A major objective of high-risk case management is reducing avoidable hospital admissions, readmissions, and emergency department visits. Groups described various initiatives. One such initiative was automatically contacting all patients discharged from hospitals or skilled nursing facilities to ensure that they understood their discharge instructions, were taking prescribed medications, had access to necessary support services, and were not experiencing complications or side effects.

Another initiative involved expanding home visits for high-risk patients to assist them with following prescribed care plans and to monitor their condition between medical visits. A third involved sending clinicians on regular rounds at hospitals and skilled nursing facilities to ensure effective discharge planning. Still another initiative placed case managers in hospital emergency departments to prevent unnecessary admissions.

LINKING PHYSICIAN COMPENSATION TO PERFORMANCE The eight groups had a variety of approaches to physician compensation, but we found no pattern distinguishing experienced groups from new entrants. Two groups did not reward physicians for quality or efficiency, although both expressed intentions to do so in the future. Several groups relied heavily on incentive compensation to improve quality and manage service use. The leaders of one group told us that its primary care physicians typically each earned $100,000 in annual bonuses from managed care contracts.

REDESIGNING CARE PROCESSES FOR DELIVERY SYSTEM REFORM Only one group, Atrius Health, said that delivery system restructuring was an immediate strategic priority. Atrius began a four-year redesign of clinical and administrative processes using “lean,” a method of eliminating waste in production processes. It engaged consultants, hired ten team facilitators, trained physicians and staff in lean methods, and began a range of redesign projects at a cost of about $4 million annually.

Other groups, although interested in clinical redesign, focused on building managed care infrastructure (described below) and addressing what they termed “low-hanging fruit,” such as basic clinical quality improvement and referral management. Several groups established teams to help practices become more efficient through improved workflow and more-effective drug prescribing practices. Some also were developing patient-centered medical homes, but most of these were small-scale programs and in their early stages. For most groups, delivery reform is a gradual process that will become more urgent over time, as the annual rate of growth in the contract’s global budget declines.
Managed Care Infrastructure
The Alternative Quality Contract groups all relied to some degree on Blue Cross for analytic support and medical management. Blue Cross has formally delegated responsibility for utilization review and complex case management to only three of the eight groups (Exhibit 1). However, both the groups and Blue Cross believe that practice-based managed care infrastructure—such as data analysis and reporting capacity, formal processes for engaging physicians in performance improvement, and programs for managing patients with complex chronic illnesses—is critical for long-term success. As a result, Blue Cross made temporary payments to some groups of up to 2 percent of their annual budgets to support infrastructure development.

DATA ANALYSIS AND REPORTING Blue Cross shared claims data and regular analytic reports with the participating groups to help them manage their performance. These included reports on spending and service use by category of service (for example, inpatient, hospital outpatient, imaging, and laboratory); out-of-network leakage for inpatient and high-cost outpatient services; variations in practice patterns for specific conditions; and performance on the contract’s quality measures.

Most groups said that the Blue Cross reports were better than they expected but that the cost and service use reports did not provide information at the level of the practice or individual physician. Therefore, those groups were building new data management systems and purchasing analytic tools, such as risk-adjustment software, to help them develop credible data to better engage physicians in performance improvement.

All eight groups have invested in registries—continuously updated lists of patients with chronic illnesses that include information about the care they have received and diagnostic test results—to systematically identify patients who have not received recommended care, such as hemoglobin A1c testing for patients with diabetes. Many have also established centralized outreach and appointment scheduling systems to ensure that patients with gaps in recommended care can receive prompt appointments without putting new administrative burdens on individual practices. Because groups can improve their quality scores by eliminating such care gaps, all of them now share these data with their primary care physicians.

ENGAGING PHYSICIANS Engaging the “frontline” physicians who directly care for patients is essential for performance improvement. A strong, hands-on leadership team; ongoing performance reporting; and regular operational meetings at the practice level are also critical for translating support activities into improved performance.

All of the experienced groups entered the Alternative Quality Contract with established processes for working with frontline physicians. Some groups had “pods”—ten to fifteen primary care physicians with shared financial incentives—who met regularly to review performance, discuss goals, and share best practices. Many of the groups also had active medical directors who had strong personal relationships with practicing physicians. In contrast, the new entrants spent much of the first contract year establishing structures to improve physician communication and collaboration.

The groups focused their initial efforts to engage physicians primarily on quality initiatives, both because physicians preferred this approach and because quality improvement yielded sizable financial rewards under the contract. Many groups concentrated on a subset of quality measures that they believed had the greatest potential for improvement. For example, the Mt. Auburn Cambridge independent practice association discussed a “measure of the month” at its regular physician meetings.

Regardless of the structure, the bulk of formal improvement activities focused on primary care physicians. Many groups described specialists as being disengaged from the current initiatives and recognized that future work—particularly to reduce the current variation in treatment for conditions where evidence-based best practices exist—will require greater involvement on the part of specialists.

Medical Group Performance
A statistical analysis of Blue Cross claims data found that although average 2009 medical spending for groups in the Alternative Quality Contract did increase, the growth was $15.51 per quarter (1.9 percent) less than average spending for Blue Cross health maintenance organization enrollees whose providers did not participate in the contract. The strongest performance was achieved by groups that had not been in a Blue Cross risk contract before they entered the Alternative Quality Contract. These groups achieved spending growth that was $44.20 per quarter (6.3 percent) less than the average of groups that did not participate in the contract. The savings accrued largely from shifts in services toward providers with lower outpatient facility fees.

The reduction in the rate of relative medical spending growth does not imply that Blue Cross reduced total spending in the first year of the contract. This is because savings largely accrue...
to providers under global budget arrangements, and because groups received new quality and infrastructure payments. The Alternative Quality Contract was associated with a 2.6-percentage-point increase in enrollees who met quality thresholds for chronic care management and a 0.7-percentage-point increase for pediatric quality, although it was not associated with significant improvements in adult preventive care. As a result, participating groups received quality bonuses of 3–6 percent of their global budgets. Several groups also received initial payments of up to 2 percent for infrastructure to support care integration and quality improvement. Thus, the first year of this contract was a financial success for participating medical groups.

Concerns About Total Costs
A recent report by the Massachusetts attorney general pointed to growth in the Alternative Quality Contract’s 2009 “total medical expenditures” to support its conclusion that “a shift of payment methodology itself is not the panacea to controlling costs.” The report defined total medical expenditures as total payments by health insurers, instead of distinguishing among actual spending for medical care; quality bonuses paid to medical groups; budget surplus payments; and payments to support development of infrastructure. However, such distinctions are essential in assessing whether new incentive structures are affecting underlying behavior and outcomes within the delivery system.

The attorney general’s assessment that spending levels depend on negotiations that reflect prevailing market forces, irrespective of particular contracting mechanisms, is correct. Nevertheless, bundled payment systems such as the Alternative Quality Contract give medical groups strong incentives to achieve efficiencies that, even if not initially captured by payers, are essential for ultimately slowing systemwide spending growth.

The success of this contract must ultimately be judged over its full five-year duration. Blue Cross actuaries designed the contract to save money over five years, largely by limiting the growth of global budgets in the later years of the contract. Thus, increased Blue Cross spending in 2009 does not imply that the contract will not save money in the long run. What’s more, the finding that the groups succeeded in reducing 2009 medical spending, relative to groups paid by traditional fee-for-service, signifies important initial changes in practice.

Challenges For Accountable Care Organizations
As health care providers consider forming accountable care organizations, the early experience of the Alternative Quality Contract highlights several issues.

**The Need for Data** Successful groups must be able to generate performance data, distribute them to physicians, engage the physicians in efforts to improve performance, and link financial incentives to results. Most physicians today receive virtually no meaningful information on their performance. In contrast, the Massachusetts groups we studied have been able to influence their physicians’ practice with relatively basic performance reports that accountable care organizations could generate in collaboration with health plans, or with access to claims data for covered populations.

**Conflicting Incentives for Hospital Use** For most groups, reducing avoidable hospital use offers the largest opportunity for savings. This fact is problematic for hospital-based groups because declining patient volume has a significant impact on hospitals’ profitability. The potential for accountable care organizations to control spending will be greatly diminished if they are unwilling to adopt practices that reduce hospital use. Hospital-based accountable care organizations may attempt to expand market share in order to keep their beds full, but if volume growth rather than reduction of unneeded hospital capacity is a predominant strategy, it will create upward pressure on spending.

**Beneficiary Acceptance** The long-term sustainability of accountable care organizations will also depend on acceptance by beneficiaries. The Blue Cross health maintenance organization is popular in Massachusetts because most physicians and hospitals in the state participate in it, and because most patients can easily get specialist referrals from their primary care providers. But the Alternative Quality Contract groups now
have stronger incentives to manage referrals, as will providers in Medicare’s Shared Savings Program.

Given the history of managed care in the 1990s, some policy makers fear that such financial arrangements could ultimately lead to another consumer backlash, resulting in reforms’ being rolled back in response to beneficiaries’ resistance. Thus far, however, there is no evidence suggesting that enrollees’ satisfaction with Alternative Quality Contract groups has changed since the contract began, nor that it differs from the satisfaction of members who use other provider groups with more traditional Blue Cross contracts.

Ultimately, accountable care organizations must begin to educate patients about the benefits of coordinated care and to involve them more closely in medical decision making. Doing so will help counter patients’ concerns about real or perceived network restrictions.

LEADERSHIP Finally, the Alternative Quality Contract groups understand that they will need strong leadership to build the systems and group culture required for success. The biggest challenges will be social, rather than technical. Leaders in many groups, especially those new to risk contracting, will face resistance as they try to establish cultures that emphasize teamwork, patient-centered care, and effective stewardship of medical resources. Accountable care organizations will need to find ways to promote a shared vision of medical practice among their clinicians if they are to prosper in a new economic environment that holds providers accountable for both cost and quality.

Policy Implications Most of the organizations commonly cited as models of accountable care, such as Kaiser Permanente and Geisinger Health System, are characterized by leadership and cultures that have developed over decades. Some in the health policy community are therefore skeptical that newly formed or loosely organized accountable care organizations can rapidly transform themselves into high-performing systems.12

TYPICAL PROVIDERS AND ACCOUNTABLE CARE ORGANIZATIONS A critical question is whether the recently formed groups in our study can adapt to a 50 percent reduction in the growth of their global budget over five years. These groups look nothing like Kaiser Permanente. They are typical American health care providers, linked together by umbrella organizations that provide leadership, management, and infrastructure support.

If this contract’s unique features—setting initial payments based on each group’s historical spending; reducing budget growth gradually; offering shared- and full-risk options; transmitting regular performance data; and providing modest infrastructure support—can facilitate the success of these more typical groups, the experience of the Alternative Quality Contract would suggest a promising approach to financing accountable care organizations. Although new entrants still face challenges, their performance during the contract’s first year suggests improvements in their capacity to respond to spending and quality goals.

MOTIVATING PROVIDERS TO IMPROVE QUALITY Under the Alternative Quality Contract in Massachusetts, the groups reported activities such as setting up or expanding quality departments, forming physician-led quality committees, and hiring new staff to lead quality improvement activities that they unanimously said were a direct result of the contract’s financial incentives for quality. In contrast, Medicare’s Shared Savings Program does not offer quality bonuses per se. Therefore, it will be up to individual accountable care organizations to create a level of enthusiasm for quality improvement similar to what we observed in the Massachusetts groups.

INCREASING PRESSURE FOR PROVIDER ACCOUNTABILITY Many provider groups are hesitant to enter accountable care organizations, especially if they are doing well with fee-for-service payments. Payers can encourage these groups to move forward by making the status quo less comfortable for them. Indeed, in January 2011, Andrew Dreyfus, the chief executive officer of Blue Cross Blue Shield of Massachusetts, sent letters to 400 leaders of hospitals and physician groups, warning them that if they remained in traditional fee-for-service arrangements, their payment rates would remain level or be reduced.

Payers can also facilitate movement to new payment models by making them transparent. Before they signed the Alternative Quality Contract, the groups in our study knew their baseline

Payers can facilitate movement to new payment models by making them transparent.
quality scores, the performance levels they would have to meet to earn bonuses, and their annual spending targets. In contrast, the absence of benchmarks for many of the proposed quality measures in Medicare’s shared savings program makes it impossible for providers to determine whether they have a realistic opportunity of earning shared savings payments, even if they can reach the program’s spending targets.

Although other innovative private experiments are being developed, transforming the health care system will require bold public policy. Very few organizations will reach a point at which they can prosper by delivering better care, rather than more care, without Medicare and Medicaid payment models that offer financial incentives that complement these goals. The Affordable Care Act sets the stage for bold policy initiatives. It is now time for the administration, Congress, and the states to see these efforts successfully through.

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NOTES

5 To access the Appendix, click on the Appendix link in the box to the right of the article online.
7 For example, the 2009 median severity-adjusted private insurer payments ranged from $9,684 to $19,059 for acute myocardial infarction (diagnosis-related group, or DRG, 190) and from $3,430 to $6,185 for normal delivery (DRG 560). See Division of Health Care Finance and Policy. Price variation in Massachusetts health care services (statistical appendix). Boston (MA): The Division; 2011 May.