AQC to ACO: As goes Massachusetts, so goes the nation?

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About four years ago here in Beantown, survivors of the last big ill-conceived or poorly-executed (depends who you ask) wave of health care management and finance innovation were kicking around for a new approach to aligning payor and provider incentives, focusing on quality and cost containment. To hear Andrew Dreyfus, CEO of Blue Cross Blue Shield of Massachusetts, tell the story, the Blues wanted to address both quality and cost, and therefore (after looking in vain for a model elsewhere that could be transplanted to Massachusetts) developed the Alternative Quality Contract, or AQC, which features a global payment model hybridized with substantial performance incentives, plus design features intended to lower the cost of care over time.

Many of the features put in place under the AQC will allow participating provider networks in Massachusetts to make the leap to ACO (once the beast is defined by the federales), despite the difference in payment methodology (global cap for AQC vs. FFS for ACO).

I was invited to hear Andrew present the AQC story this week together with Gene Lindsey, CEO of Atrius Health, a Massachusetts multispecialty physician network of some 700 physicians that participates in the AQC. (Atrius' largest group is Harvard Vanguard Medical Associates, whose docs used to be employed by Harvard Community Health Plan, the pioneering staff model HMO 'round these parts.)

After mulling over **Jeff Goldsmith's "Plan B" for ACOs** in the commercial sector a few weeks back -- he thinks they need a radical redesign to work well -- it was fascinating to hear from a payor and a provider who have been working together for a few years now in what is effectively a physician-led ACO. (Keep in mind that the vast majority of discussions about ACOs are focused on hospital-led models, with the exceptions of those by **Vince Kuraitis** and **the HealthBlawger**; please feel free to point us to others in the comments.) An important data point in Gene's presentation is the breakdown of the budget: outpatient costs exceeded inpatient costs. In addition to that point, the fact of the matter is that the most expensive piece of medical technology remains the physician's pen. It therefore makes sense to place physician organizations at the center of ACOs; they don't provide all care to all members, but they do coordinate all care.

Andrew and Gene offer glowing reports from the front. More of the details are in their presentations, embedded below.

Payment Reform and ACOs

Atrius ACO Presentation

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Almost half of the BCBSMA HMO members have a PCP who is enrolled in the AQC program. (They have other insurance products in the market, too, but the AQC is limited to providers that participate in the HMO plan.) The program may be distinguished from capitation in the bad old days by three key features:

- The first year's global payment equals the prior year's payment experience for the population served.
- Quality measures are in place to guard against undertreatment
- Global payments are risk-adjusted to account for the health status of individual patients

The results to date have been encouraging. There is improvement in both process and outcome measures for the populations served by providers operating under the AQC, BCBSMA is on track to reducing annual growth in costs by 1/2 within five years and provider groups participating in the AQC are seeing surpluses as a result of their integrated approach to care management.

As is the case everywhere, 50% of costs are incurred for the sickest 5% of the population, so intensive management of those cases will yield the biggest bang for the buck. This is not news, yet effective care management seems to be. Witness the recent Atul Gawande piece on "**hot spotters**" focusing on high-cost chronic care in Camden, NJ.

For Gene Linsdey, long-time physician at Harvard Vanguard Medical Associates and its predecessor, Harvard Community Health Plan, and now CEO of Atrius Health, what rings true is guidance from the founder of HCHP, Dr. Robert Ebert:

The existing deficiencies in health care cannot be corrected simply by supplying more personnel, more facilities and more money. These problems can only be solved by organizing the personnel, facilities and financing into a conceptual framework and operating system that will provide optimally for the health needs of the population.

Ebert said this in 1969, decades before the rise of IHI and the Triple Aim ... though of course Don Berwick must've picked up some of these ideas when he was a practicing pediatrician at HCHP. As Lindsey demonstrated, HCHP and its progeny have been tinkering with the conceptual framework and the operating system ever since.

In order for this model to work beyond the slightly unreal laboratory of BCBSMA and Atrius, where there are many long-term physician-patient relationships (so lack of a required patient buy-in to the AQC or ACO model is not that big a deal), and there are significant numbers of covered lives, a shift in thinking is required, an adoption of the **patient-centered medical home** mindset, and (per Lindsey) a dedication, at a large enough scale to manage the risk involved, to promote the necessary investments in organizational culture, medical management, data reporting analysis, health information and patient engagement.

As the multitude of federal agencies potentially involved in ACO regulation work out their internal differences (the **FTC-DOJ catfight** over who gets to write and enforce the antitrust rules that will govern ACOs is just the latest one; Stark, Anti-kickback, IRS and other rules are implicated as well), and as the elimination of overlapping agency jurisdiction -- as promised in the State of the Union address a few weeks ago -- plays out, we may well be grappling with a seismic shift in the way health care services are organized and delivered. Here's hoping that the shift is less about jockeying for market power, and more about delivering greater value and quality to individuals in a manner that helps achieve the Triple Aim of improved population health, improved experience of care and reduced per capita cost.

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