

# Accountable Care Organizations: The Case For Flexible Partnerships Between Health Plans And Providers

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## Abstract

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Under the Affordable Care Act, the new Center for Medicare and Medicaid Innovation will guide a number of experimental programs in health care payment and delivery. Among the most ambitious of the reform models is the accountable care organization (ACO), which will offer providers economic rewards if they can reduce Medicare's cost growth in their communities. However, the dismal history of provider-led attempts to manage costs suggests that this program is unlikely to accomplish its objectives. What's more, if ACOs foster more market concentration among providers, they have the potential to shift costs onto private insurers. This paper proposes a more flexible payment model for providers and private insurers that would divide health care services into three categories: long-term, low-intensity primary care; unscheduled care, including unscheduled emergency services; and major clinical interventions that usually involve hospitalization or organized outpatient care. Each category of care would be paid for differently, with each containing different elements of financial risk for the providers. Health plans would then be encouraged to provide logistical and analytic support to providers in managing health costs in these categories.

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### Health Reform   Organization and Delivery of Care   Physician Payment

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Slowing the growth of health care spending will require changing how health insurers and providers contract with one another. Medicare payment innovations encouraged by the Affordable Care Act of 2010 aim to shift Medicare's emphasis away from fee-for-service to some form of bundled payment for each episode of illness, or some kind of capitation—fixed payments per member per month, regardless of the amount of services provided—for defined populations of patients. How private health insurers respond to this shift will greatly influence not only the affordability of coverage for people not eligible for Medicare, but also the future of health insurance itself.

In the United States today, private health plans typically pay for their enrollees' health care through fee-for-service physician payments and either per diem or per case hospital payments. As is well known, this approach offers providers powerful financial incentives to increase the volume of services they deliver. Cutting payments to providers simply encourages them to deliver even more services to compensate for lost income.

Historically, health plans used their market leverage to limit rate increases by negotiating contracts with individual providers that limited providers' unit cost increases. But in many markets, this mechanism has become less effective in constraining costs, as hospitals have merged and specialty physicians have consolidated into large, single-specialty group practices—thus increasing their own market share and becoming more able to resist plans' demands.

As a result, insurers have reinstated venerable methods of controlling use that some had abandoned in recent years—for example, requiring prior authorization for expensive services such as hospital admissions and advanced imaging procedures. More recently, some insurers have begun to work directly with patients to counsel them in managing their health risks, completely bypassing providers.<sup>1</sup>

These efforts raise two important questions: Can providers and insurers work together more constructively to manage future health costs, and how can that

kind of cooperation best be developed? A “modular” approach to payment, described below, is one possible solution.

## **Problems With Accountable Care Organizations**

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Some policy advocates believe that the way to stabilize health care costs is to engage providers in a form of population-based cost management—that is, to compel providers to constrain costs across the population of an entire community. The principal embodiment of this idea is the accountable care organization (ACO). The concept originated at the Dartmouth Institute for Health Policy and Clinical Practice and has been articulated by Dartmouth’s Elliott Fisher, Mark McClellan of the Brookings Institution, and others. The idea was incorporated into the Affordable Care Act as the Medicare Shared Savings Program, to be implemented—beginning in 2012—not as a pilot or demonstration project but as an optional method for providers to be paid under the program.

Fisher and his colleagues originally envisioned the accountable care organization as an alternative payment methodology that would reward provider organizations for reducing Medicare spending growth in individual hospital service areas. Hospitals and their “extended medical staffs”—physicians practicing in the same geographic area served by a hospital—would be given a gainsharing incentive to reduce the growth rate in per capita Medicare spending for that geographic area.<sup>2</sup> Physicians and hospitals would get a share of the savings if they could reduce aggregate Medicare spending to a level below a targeted growth rate.

As objections to the original formulation have surfaced, the ACO concept has evolved into an amorphous cluster of possible collaborative models. These models involve many different types of providers in addition to hospitals—such as independent practice associations, multispecialty medical groups, and ad hoc organizations of hospitals and physicians—and varying degrees of possible provider risk assumption.<sup>3</sup>

### **Hospitals Still Central**

Despite the lengthening of the list of possible participants, hospitals are likely to dominate the ACO contracting process for two reasons. First, the largest avoidable Medicare costs are hospital related. And second, in many communities, the hospital is the only organized care delivery entity capable of executing the model.

The realization of this fact is having direct consequences on the private insurance market, even before Medicare implements its ACO program. Many hospital executives view it as essential that hospitals become “prime contractors” in the ACO model. Further, the executives believe that unless they “align physicians’ incentives” with those of the hospital, they will not be able to create and manage successful accountable care organizations. However, for many hospital administrators, *alignment* is a code word for “physicians work for me and will do what I say.”

In the 1990s hospitals rushed to merge and acquire physician practices to create “integrated health systems”—which proponents of the Clinton administration’s health reforms anticipated would contract with insurers—and many incurred catastrophic economic losses in doing so. Another wave of hospital mergers is now taking place, as is an acceleration of hospitals’ acquisition of physician practices.<sup>4</sup> According to a recent Medical Group Management Association survey, almost two-thirds of the physicians who signed employment contracts in 2009, as well as half of the physicians who were just entering practice after training, worked for hospitals.<sup>5</sup> Multiple studies have shown that hospital-led market consolidation increases the overall cost of the US health care system.<sup>6</sup>

It also appears that hospitals are experiencing larger economic losses on the practices they are acquiring now than hospitals did in the wave of acquisitions in the 1990s. This is because hospitals have been buying the practices of more high-earning specialists, such as cardiologists and general surgeons, and are guaranteeing salaries for these physicians that are considerably in excess of

what the hospitals are collecting for the physicians' services. Furthermore, most hospitals are still managing these newly salaried physicians as collections of geographically separate physician practices. It will take many years before these hospitals' clinical services are well enough organized to manage population-level health costs, as the ACO model contemplates.

Hospitals wishing to become accountable care organizations will have to make sizable investments—for instance, in consulting services, new information technology, utilization management tools, and management support—to function according to that model. Those investments and the losses that hospitals face as a result of acquiring physician practices are likely to exceed the potential gainsharing opportunities they will have as accountable care organizations in the Medicare shared savings program.

The obvious way to avoid this risk of economic loss is for each hospital, through horizontal mergers with other hospitals, to become sufficiently dominant in its market to force private insurers to pay higher rates not only for the hospital's services but also for those of its physician-employees. This has already happened in California in response to an earlier wave of "managed care" development. Hospitals and systems that became powerful in the marketplace through mergers and acquisitions aggressively shifted costs onto private insurers through the network contracting process.<sup>7</sup>

Policy makers have not yet had the essential conversation about whether Americans really want hospitals to control the provider marketplace. However, given the extent of physician practice consolidation under hospital control and the pace and intensity of hospitals' horizontal mergers, it may already be too late for that conversation.<sup>8</sup> Without an effective alternative contracting strategy, private insurers are likely to end up indirectly funding much of Medicare's experiment with accountable care organizations.

### **The Troubled History Of Hospital-Physician Collaboration**

The ACO model presupposes collaboration between hospitals and physicians, but that relationship has a troubled history. In fact, in many communities in the southern and western states, the two groups have engaged in bitter competition for control of lucrative ambulatory services, such as advanced imaging, ambulatory surgery, and radiation therapy. The result has been much ill will and duplication of services.<sup>9</sup> In some communities, physicians have controlled the lion's share of ambulatory diagnostic and surgical cases, to the point of damaging the local hospital financially.

#### *Mistrust:*

The economic conflict between physicians and hospitals over highly profitable ambulatory services has left a powerful residue of mistrust between hospital managers and physicians. An essential ingredient of effective managed care is trust among the participants, including among physicians themselves. Sadly, that trust is absent in many health care markets.

The track record of provider-led managed care efforts has not been encouraging, either. During the 1980s and 1990s, hundreds of hospitals and hospital-physician organizations tried to contract with insurers on the basis of capitation or to create their own health plans. Most of these efforts had inadequate resources and weak governance; lacked the clinical discipline and technology capacity to control the use of services or contain expenses; and failed completely.<sup>10</sup> There were a few notable exceptions—such as Geisinger Health System, in Pennsylvania; Intermountain Health Care, in Utah; Aultcare, in Ohio; and the provider system now known as Sanford Health, in South Dakota.

#### *Physicians And Hospital Care:*

Another, newer problem is that about a third of physicians no longer bill for any hospital-related services, because their practices no longer require this kind of care.<sup>2</sup> In addition, hospitals have reduced their dependence on community-based practitioners by hiring hospitalists and intensivists—physicians who specialize exclusively in managing hospitalized patients. Physician communities are bifurcating into those who never or rarely come to the hospital and those who practice entirely within it.

In the real world, there is no such thing as an “extended medical staff.” The medical staff consists of physicians who actually practice at the hospital, which is a shrinking percentage of the physicians in most communities. There are no practical mechanisms for hospitals to hold physicians who no longer use hospital services accountable for their office-based costs, unless those physicians voluntarily choose to participate in the process.

#### ***Infrastructure:***

There are serious infrastructure constraints on the model of the accountable care organization that directly affect the hospital’s ability to bridge the gap between the in-hospital and nonhospital physicians. Although many hospitals and health care systems have automated their own hospital medical records, and a small minority have automated physicians’ clinical ordering in the hospital, the vast majority of physicians still do not have the sort of electronic health record systems that Geisinger and other established group practices use to help manage nonhospital care across their patient populations.<sup>11</sup>

The incentives contained in the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act of 2009 were designed to remedy this problem by accelerating physicians’ adoption of electronic health records. But it remains to be seen how much of this technological gap can be bridged, and how soon. It typically takes health systems five to ten years of operating experience before they can use information technology to change how care is actually delivered.

#### **Weak Incentives And Income Redistribution**

Although the ACO model seeks to blunt the “do more to make more” incentives of fee-for-service payment, the modest rewards that the model offers for cost restraint are unlikely to catalyze major change. This is because the rewards for an accountable care organization—a share of the savings if the providers succeed in lowering the rate at which Medicare costs escalate in their communities—are grafted on top of a payment system that still rewards individuals for increasing the volume of clinical services. That is, ACO participants will continue to be paid fee-for-service.

The sacrifices required to make the accountable care organization work are not randomly distributed within physician communities. High-earning specialists—particularly surgeons and the providers who rely heavily on revenue generated through the use of advanced imaging procedures—have far more compelling incentives to keep their volumes (and incomes) up than do primary care physicians, psychiatrists, or diagnosticians who use less-sophisticated technology.

The ability to redistribute incomes within physician communities—a challenge that doomed many provider-sponsored managed care efforts in the past—will not exist in the many markets where the high earners have consolidated into single-specialty groups precisely to resist such efforts (personal communication from Nathan Kaufman, Kaufman Strategic Advisors, July 9, 2010). These single-specialty groups—which accountable care organizations will find as hard to absorb as gravel in the digestive tract—generally did not exist when the first wave of independent practice associations, provider-sponsored organizations, and other risk-sharing enterprises were created.

#### **Lack Of Patient Involvement**

Another key defect of the ACO model is the lack of any requirement for active patient involvement in joining the organization. Historically, managed care relied on voluntary enrollment by subscribers. The incentives for subscribers—employees and Medicare Advantage beneficiaries—to enroll in managed care plans included reduced patient cost sharing, more-comprehensive services, and less-complicated billing. In exchange for these rewards, managed care subscribers accepted some limits on access to services and to specific providers.

Although regulations to implement the Medicare shared savings program of the Affordable Care Act have not yet been issued, it is likely that patients will not be required to join or enroll in an accountable care organization. Rather, they and

their care will be “attributed” to particular organizations—probably based on the affiliation of their primary care physicians—for the purposes of evaluating whether or not the organization achieves performance metrics in terms of cost and quality improvement. The patients’ aggregate Medicare expenses will be measured after the fact as the basis for calculating the organization’s gainsharing reward. This is sometimes called “shadow” capitation. The precise mechanism for patients’ assignment to an organization will not be certain until the federal government issues the relevant regulations some time in 2011. But because patients will probably have no incentive to stay in the organization, they may also lack incentives to cooperate with strategies to reduce costs. What’s more, an organization’s patient population may fluctuate considerably from year to year. This uncertainty will further hamper the participating providers’ efforts to manage costs.

**A Bridge Too Far**

Private health insurers need a strategy that is real, not speculative, to hold providers accountable for cost on behalf of their subscriber populations. Because many providers lack actuarial and insurance capacity, clinical data, and infrastructure, they are unlikely to be able to manage population health costs successfully, through either “shadow” capitation for a community, as described above, or real capitation for an enrolled population.

In the meantime, the likelihood that physician markets will be consolidated through hospitals’ acquisition of practices will force private insurance costs higher through cost shifting. Such a trend could negate any possible savings through accountable care for Medicare—even if the strategy did manage to contain Medicare’s own spending. It is conceivable that we could have the worst of both worlds: a Medicare policy failure that drives private-sector costs higher.

If health insurers are to survive this transition to less inflationary payment models, they must find a way to make providers more accountable for costs without incurring the risk of further provider market concentration. Private insurers need an alternative approach to population-based payment that recognizes the diversity of providers’ circumstances and degree of integration, yet encourages them to take manageable risks. The ideal contracting model would also preserve a role for patient choice and encourage competition among provider entities—two features that are absent from the ACO model.

**Flexible Contracting: An Alternative Approach**

Private insurers should pursue a “modular” contracting strategy that breaks the costs of health services into the three categories described below and that does a better job of limiting providers’ contractual risk to the changes they need to make to improve the quality of care and reduce its cost.

There are three general categories of health services (Exhibit 1). The first is primary medical care: low-intensity longitudinal care, delivered by primary physicians. The second—unscheduled care—consists of episodic diagnostic services, delivered by office-based physicians, and unscheduled emergency services, which chiefly take place in hospitals. The third is specialty care: major clinical interventions—such as in cancer care—that usually involve hospitalization or organized outpatient services, in which multiple specialists participate.

View this table: <a href="#">In this window</a> <a href="#">In a new window</a>	<b>Exhibit 1</b> Three Types Of Health Services
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These three types of service warrant three different payment approaches. As described below, each would contain different elements of financial risk for the providers. Insurers could use them separately or combine them into a unified approach with organizations of providers that offered all three types of services. Some providers might wish to participate in all three forms of contracting, while others might prefer to remain with their current health plan contracting model.

Instead of holding providers accountable for a population’s health costs over a

full year, as the ACO model does, this more flexible approach would link providers' risk to more easily quantifiable and manageable elements of health costs, such as the cost of primary care services, or the cost of caring for specific complex conditions such as cancer. The approach would also focus more directly on changing providers' behavior within each category of care to improve communication with patients and families and to reorganize how physicians and their support teams manage patient care itself.

In addition, providers' administrative costs could be sharply lowered if health plans standardized their contracting methods for all three types of health services across insurers. In that case, providers would not have to replicate the current costly "every payer for itself" payment interface, in which each insurer imposes its own unique business rules for managing payments.

### **Primary Health Care Through a Medical Home**

Primary care in the United States is in crisis. An entire generation of primary care physicians will retire in the next fifteen years, and—unless major changes are made in the health care delivery system—they will not be replaced by an equal number of younger primary care physicians.<sup>12</sup> During this same period, almost the entire baby-boom generation will enroll in Medicare, beginning in 2011. With the declining number of providers and the growing number of patients, Medicare, too, will face a crisis.

Primary care is no longer economically viable, because fee-based payments for primary care services have not grown as quickly as practice expenses. To cope with this gap, primary care physicians have been forced to see more patients and increase their "ancillary service" income by more frequent use of laboratory testing and imaging. These adaptations have reduced the amount of time that primary care physicians can spend on each visit with a patient and have increased the risk of testing motivated more by financial reasons than by medical ones.

There is great excitement in the field about an enhanced primary care model that incorporates clinical information technology; more continuous, low-intensity contact with patients, such as through telephone calls and e-mail and text messages; and medical management and support services provided by advanced practice nurses and nurse educators. This model is called the patient-centered medical home.<sup>13</sup>

#### *Medical Home Elements:*

The patient-centered medical home is physician led, but it incorporates embedded care management—protocols and guidelines for how specific clinical risks should be managed—as well as allied health care professionals who collaborate to maintain continuity of care for patients. There is evidence that more-effective primary care focused on the patient's specific health risks—such as diabetes, high blood pressure, and asthma—can reduce medical expenses downstream, and that this model deserves a higher level of payment than traditional fees because it offers a wider range of services.<sup>14</sup>

#### *Billing And Payment:*

Primary physicians in this model make money not by maximizing the number of office visits or tests but by expanding their patient populations through the use of improved communication and coordination of care. Services in this model should be paid for through subscriptions: Patients would enroll in the medical home, and physicians would be paid a risk-adjusted amount per enrolled patient per month.<sup>15</sup> Each physician should be able to have enough patients so that their subscription payments would cover the practice's expenses and give the physician a decent income.

If a physician's patient-centered medical home practice is large enough, he or she could eliminate the clerical and administrative costs involved in today's fee-for-service billing. Equally, insurers could eliminate claims management costs because they would no longer have to account for each service that each patient received in order to calculate the physician's payment. Patients would be encouraged to enroll in a medical home by eliminating their copayments, which would further reduce administrative complexity for both providers and health

plans.

#### *Chronic Disease:*

Insurers should consider experimenting with a chronic disease variant of the medical home: one that focuses primarily on managing specific types of serious clinical conditions, such as mental illness, diabetes, or congestive heart failure.<sup>16</sup> Chronic conditions of this sort are not generally episodic, but continuous. Embedded care management could materially reduce the chance that these diseases would progress to more acute stages by anticipating complications requiring hospitalization and helping patients and their families manage their conditions more effectively.

In this variant, the medical home model should not offer the primary care physician incentives to reduce the considerable costs of caring for patients with serious chronic conditions because he or she typically has little or no control over the major institutional costs, such as for skilled nursing care or rehabilitation, incurred by seriously ill patients.

#### *Subscription Approach:*

The subscription payment approach for the general medical home would not be full capitation, as physicians would not be held accountable for downstream costs they cannot control, such as the cost of hospitalization. Nor should physicians be accountable for pharmaceutical expenses, which would continue to be managed through insurers' pharmacy benefit management programs. Although physicians do write prescriptions, they have no control over the cost of the drugs, whether the prescriptions will be filled, or patients' compliance with the drug regimen.

The subscription approach would also not be a gatekeeper model, in which the primary care physician is required to approve payment for specialty services or hospitalizations. The gatekeeper model has a history of increasing both administrative complexity and ill will, antagonizing patients by raising barriers to their access to specialists. Nor did it promote optimal collaboration between primary physicians and their specialist colleagues.

Rather, the medical home is intended to support the primary care physician by capturing and assimilating information from all of a patient's encounters with the health care system. Federally qualified community health centers—which received substantial new funding to expand their service offerings under the Affordable Care Act—should be able to participate in health insurers' medical home programs, because they already have many of the administrative supports and allied health professionals needed to execute this model.

To maximize opportunities for individual primary care physicians and those practicing in small groups to participate in this model, it is vital to keep medical home payments and incentives simple, and to impose as few record-keeping requirements as possible.<sup>17</sup> It would be ideal to include in an electronic health record all of a patient's contacts with physicians. Private insurers can play a crucial role in fostering this care model—which will save them money—if they support it generously through higher payment rates for medical home subscriptions.

#### **Unscheduled Care**

Unscheduled medical services make up the least predictable component of medical costs. Putting providers at risk for these costs is inappropriate because most of them lack the information and decision support to manage the risk. Primary physicians often have no idea that their patients are in a hospital emergency department or have sought diagnostic advice from other providers, because in most communities there are no mechanisms for capturing and relaying to primary physicians information about their patients' health care use. Patients also frequently bypass their primary physicians for treatment of sensitive health issues like sexually transmitted diseases, mental illness, and other conditions that they do not want to be a part of their medical records. In a tripartite payment model, these unscheduled services would continue to be paid for essentially as they are today: fee-for-service, with cost sharing for patients.

Cost sharing should be high enough so that the patient does not seek an unnecessary visit or intervention, but not so high as to raise a financial barrier to necessary care. Insurers would continue applying pressure to reduce costs through negotiating contracts with provider networks and through utilization review and quality assurance.

As suggested above, an effective medical home should provide a viable alternative to many nonurgent emergency visits, as well as a channel to enable patients to avoid some diagnostic visits. This is because medical homes provide consultation on demand through e-mail or phone calls, instead of requiring that patients address all of their medical needs through an office visit. Real-time communication with the medical home could also give a patient or family member a “reality check” on the need for an emergency visit—for example, by calling a nurse at the medical home first, to determine if the visit is really necessary.

Although this component of the model demands little from providers, some providers of diagnostic services, such as advanced imaging, may be eligible for higher unit payments if they assumed responsibility for screening out diagnostic orders that were not clinically appropriate. Similarly, providers might consider how they could refer “unattached” patients with nonurgent problems from emergency facilities to medical homes, to increase patients’ use of the homes and improve their future medical management.

### **Specialty Care**

The most expensive component of health costs is the clinical response to complex conditions—for example, cardiac care, cancer treatment, surgical care, and high-risk obstetric and neonatal care. For clinical interventions of this type, whether they are elective or not, providers should receive a single, severity-adjusted payment when a diagnosis has been made and a clinical approach chosen.<sup>18</sup> This method would reduce billing complexity. It would also increase providers’ economic risk in dealing with complex conditions. But at the same time, it would encourage—indeed demand—a precise division of clinical responsibilities framed by clinical protocols and care pathways for each of the conditions.

Costs incurred in treating patients that exceeded the fixed payment would be absorbed by the contracting providers, while any savings in actual cost below the fixed amount would be retained as an economic incentive. Because it focuses on specific groups of clinical conditions, this payment model would be much more tightly linked to actual care redesign and improved coordination of care.

#### *A New Care Model:*

Specialty care is best provided by groups of specialists working together as a team and using a well-defined model of care. This approach reduces both costs and patient risk. Such collaboration is the basis of the care models at advanced cancer treatment centers such as the Memorial Sloan-Kettering and the M.D. Anderson Cancer Centers, as well as in multispecialty organizations such as Mayo Clinic and Cleveland Clinic.

Many hospitals and health care systems, and some physician groups, have already created multidisciplinary “service lines” or “centers of excellence” such as cardiac or cancer services, centered on specific conditions or specific populations of patients. Even though some of these innovations have occurred primarily for marketing purposes, the clinical infrastructure is already in place in many institutions to support a separate payment approach for this type of care. This contracting model would create private insurance “customers” for these centers. The clinical enterprises could be called “Specialty Care Marts.”

A single, severity-adjusted payment for specialty care would encompass all preintervention workups; the intervention itself, such as surgery or chemotherapy; charges from the facility and physicians; and postintervention costs during a defined time period—perhaps thirty to ninety days. This approach is conceptually similar to that used in the current Medicare Acute Care Episode Demonstration, but it could cover a longer time for each episode and would apply to privately insured patients, rather than those with Medicare.<sup>19</sup> Previous

experiments with care bundling under Medicare, such as the Centers of Excellence demonstrations of a decade or more ago, appeared both to save money and to improve clinical quality.<sup>20</sup>

#### *Specialty Care Marts:*

Specialty Care Marts could be sponsored by a hospital, health care system, physician group, independent practice association, or some combination of organizations. The sponsor would be responsible for collecting and disbursing the payments for services and would distribute any payment in excess of expenses as a bonus. Ideally, multiple Care Marts would be available to patients in a given geographic area, fostering price and service competition.

Specialty Care Marts would attract patients by offering at least partial forgiveness of their deductibles, as the Medicare Acute Care Episode Demonstration projects do. Some sort of enrollment would be required to ensure that all parties understand that the patient has, in fact, selected a particular Specialty Care Mart to provide his or her care. To counteract providers' tendency to increase the volume of services they provide by giving care that is only marginally appropriate, individual providers would be required to adhere to and enforce appropriateness guidelines as a condition of participation.

To qualify as a Care Mart, a provider would have to document that it provided, or could contract with another organization to provide, the full range of services required to resolve the patient's diagnosed complaint. To have their deductibles forgiven, patients would be required to receive all of their care for the covered condition from the chosen Care Mart.

#### *Insurers' Role:*

In addition to paying Specialty Care Marts, health insurers could provide them with management services. These could include radiology and pharmacy benefit management services; actuarial consulting, including assistance with risk adjustment; marketing; enrollment and eligibility verification; and other administrative support services. Insurers could use predictive modeling software to identify people in their insurance pools who are potential candidates for clinical intervention. Insurers could also offer providers their network contract discounts for the postacute care—such as rehabilitation and home health care—provided within the Care Mart's contracted time frame. This would reduce the administrative complexity required to sponsor and support a Care Mart.

Insurers would remain free to pay for specialty services on a fee basis in markets with limited or no access to Specialty Care Marts for a particular service, and would continue paying under present methods for specialty services for providers or patients unwilling to use a Care Mart.

#### **Fewer Barriers To Adoption**

This modular approach to payment does not require as much provider integration or infrastructure spending as global capitation does in order for providers to participate. It encourages delivery system reorganization for both low-intensity or primary care and high-intensity or specialty care, as well as better-coordinated medical practice, without catalyzing a further concentration of ownership of hospitals and physician practices. Both the patient-centered medical home and the Specialty Care Marts would reduce administrative expenses for providers and insurers by consolidating and simplifying the payment process.

This modular approach to payments would replace the fee-for-service system, instead of overlaying it—as the accountable care organization model does—for providers who elect to participate. And, most important, it would give patients and their families a greater choice of providers and would foster competition among primary care providers and specialists.

Instead of delegating to providers the responsibility for managing population health costs that they cannot control, this approach relies on three diverse contracting methods—comprehensive, risk-focused payments for primary care; cost sharing for unscheduled episodic and emergency care; and bundled

payments for acute interventions—to address three different types of clinical problems without necessarily linking them together. Both low-intensity and high-intensity clinical care would rely on using specified clinical pathways, unified payments, and improved coordination of care as the principal ways of saving money. The goal should be better management of care at both ends of the spectrum, to reduce the volume of fee-based care in the middle.

## Insurers' Options Under Health Reform

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Under health reform, insurers have lost considerable flexibility in the ways they can cope with rising medical expenses. They can no longer rely on many of their traditional medical underwriting strategies, such as exclusions of preexisting conditions.

The temptation will be for insurers to rely exclusively upon current cost control mechanisms to manage subscribers' medical expenses—for example, by negotiating lower prices on services from health care providers, or imposing external use controls such as prior authorization for hospitalization.

This would be a mistake, because it would risk damaging what should be collaborative relationships with providers to improve their care management processes and clinical outcomes. Improving the way in which risk is shared between private health insurers and providers can encourage the changes in care management and coordination needed to make the health care system economically sustainable.

The payment approach proposed here would be modest, targeted, and flexible enough to accommodate both differences in readiness for health reform across US regions, and in the capacity of physicians and hospitals to reorganize care in the best interests of patients.

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