A Discussion of Accountable Care Organizations

New Hampshire Medical Group
Management Association

June 9, 2010

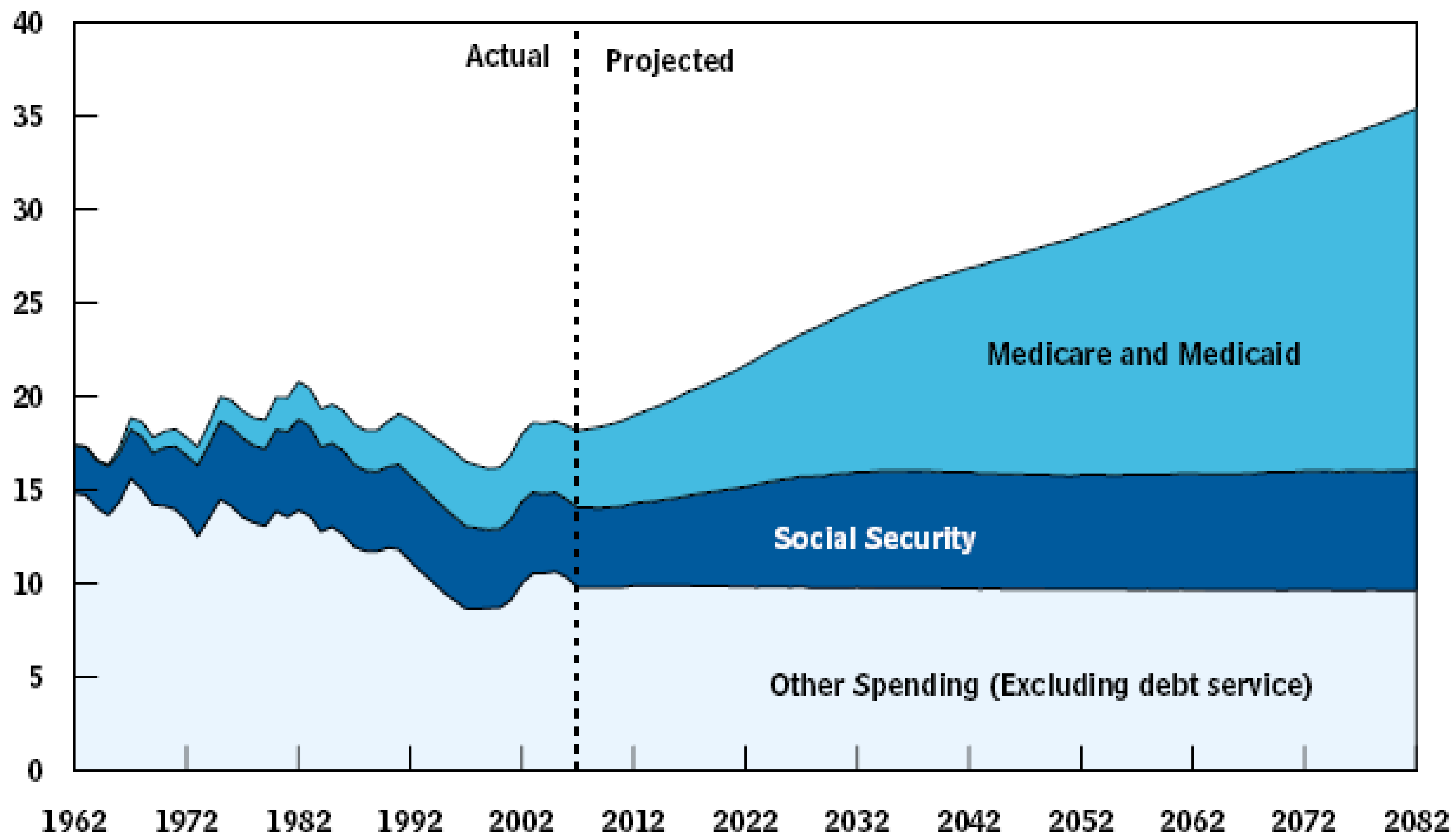
What We Hope to Discuss Today…

- Some background
- What is an ACO?
- Why now?
- How this differs from previous (full) risk or capitation models demonstration projects underway or contemplated
- Types of organizations this will be applicable to
- Opportunities and risks for integrated networks
- Opportunities and risks for private practices, especially specialty practices
- Role of various payers, both government and private
- Strategic concerns for practice administrators
- How it all (may) fit together.

The Major Factors Producing the Perfect Storm

1. **Revenue Declines**
   - Investment Losses
   - Reimbursement Declines
   - Increase in Uninsured
   - Decreased Philanthropy
2. **Increasing Costs**
   - Unfunded Pensions
   - IT and Technology
   - Coverage
3. **Payer Strategies**
   - Believe too much testing today
   - Pay for Performance
   - High Premiums
   - Bundling and Capitation Again
   - Patient Cost Sharing
4. **Regulatory Changes**
   - Increased Government Scrutiny
   - Tax-Exemption Challenges
5. **Demands for Performance**
   - Patients, Payers and Government
6. **Access to Capital Declining**

Projections about where it's all heading are grim



What Should We Expect From Government and Payers?

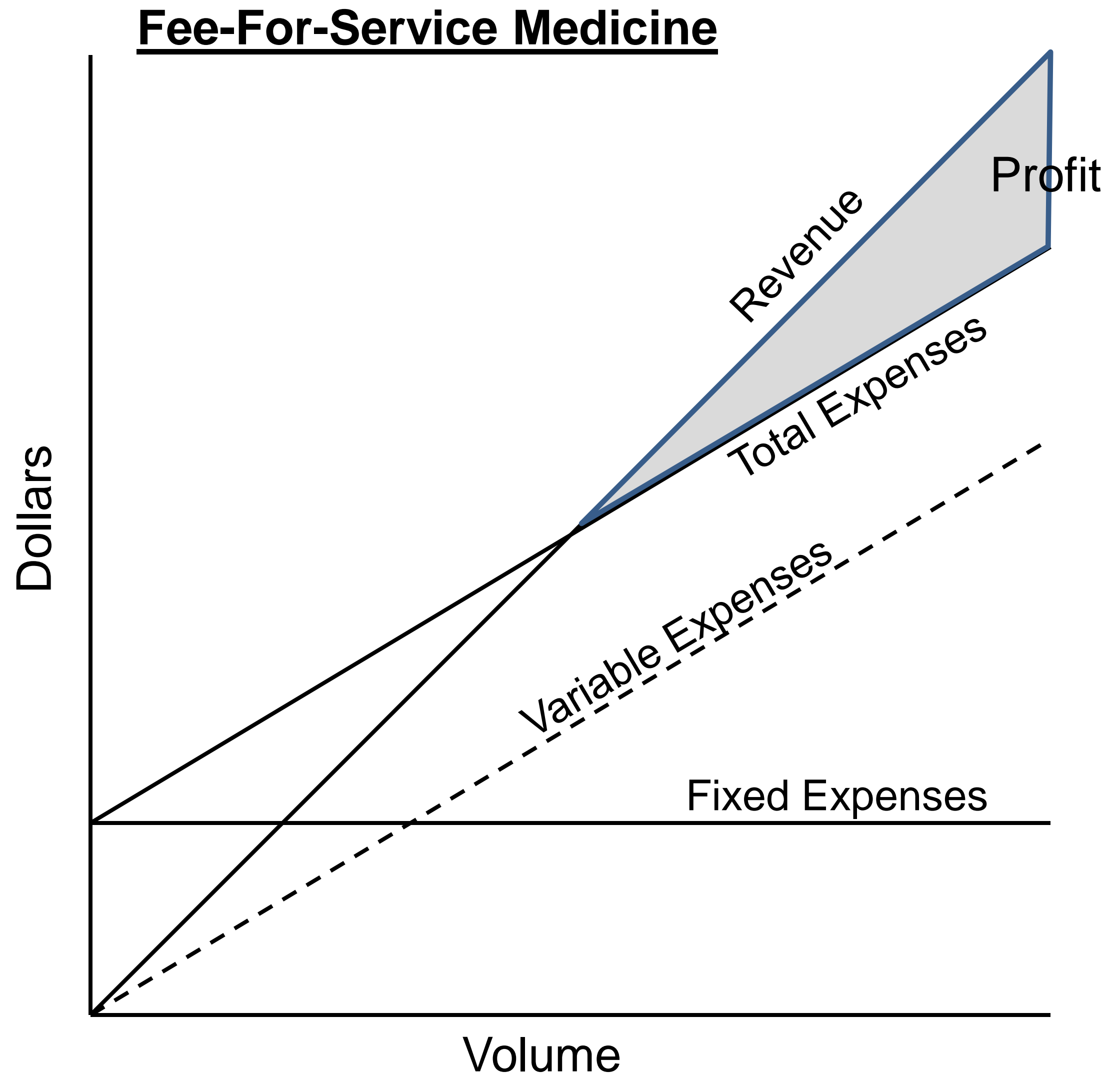
Health Care Expenditures 1980 to 2015

The Problem: How do you control health care costs and reduce the rate of increase in health insurance premiums?

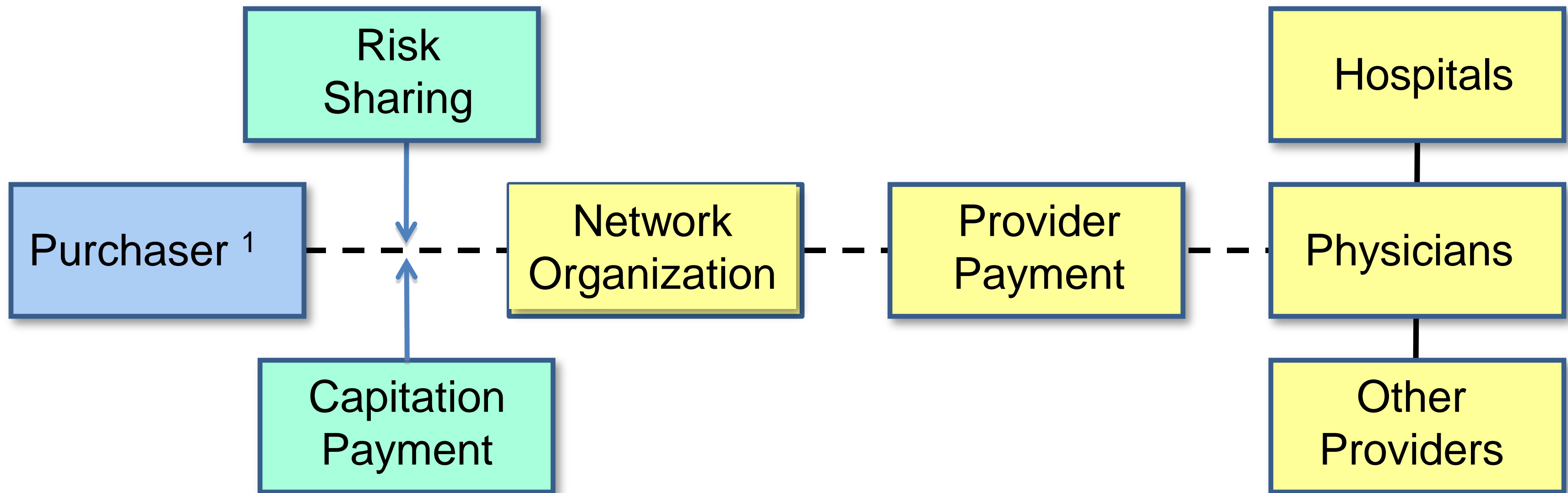
Year	Percent of GDP	Five Yr. GDP % Growth	Annual GDP % Growth	Health Expenses (Billions)	Five Yr. % Growth Exp.	Annual % Growth
1980	8.90%			$247		
1985	10.30%	15.73%	2.96%	$399	61.54%	10.07%
1990	12.20%	18.45%	3.44%	$699	75.19%	11.87%
1995	13.70%	12.30%	2.35%	$994	42.20%	7.30%
2000	**14.30%**	**4.38%**	**0.86%**	**$1,316**	**32.39%**	**5.77%**
2005	15.70%	9.79%	1.89%	$1,983	50.65%	8.54%
2010 **Projected**	17.30%	10.79%	1.96%	$2,750	38.71%	6.76%
2015 Projected	**17.70%**	**2.31%**	**0.46%**	**$3,442**	**25.16%**	**4.59%**

Source: *Centers for Medicare and Medicaid Services, Office of the Actuary, January 2010*

Health Care Reform Advocates 1990's :
Fee for Service Medicine Does Not Work!



Health Care Reform – "Back to the Future?"

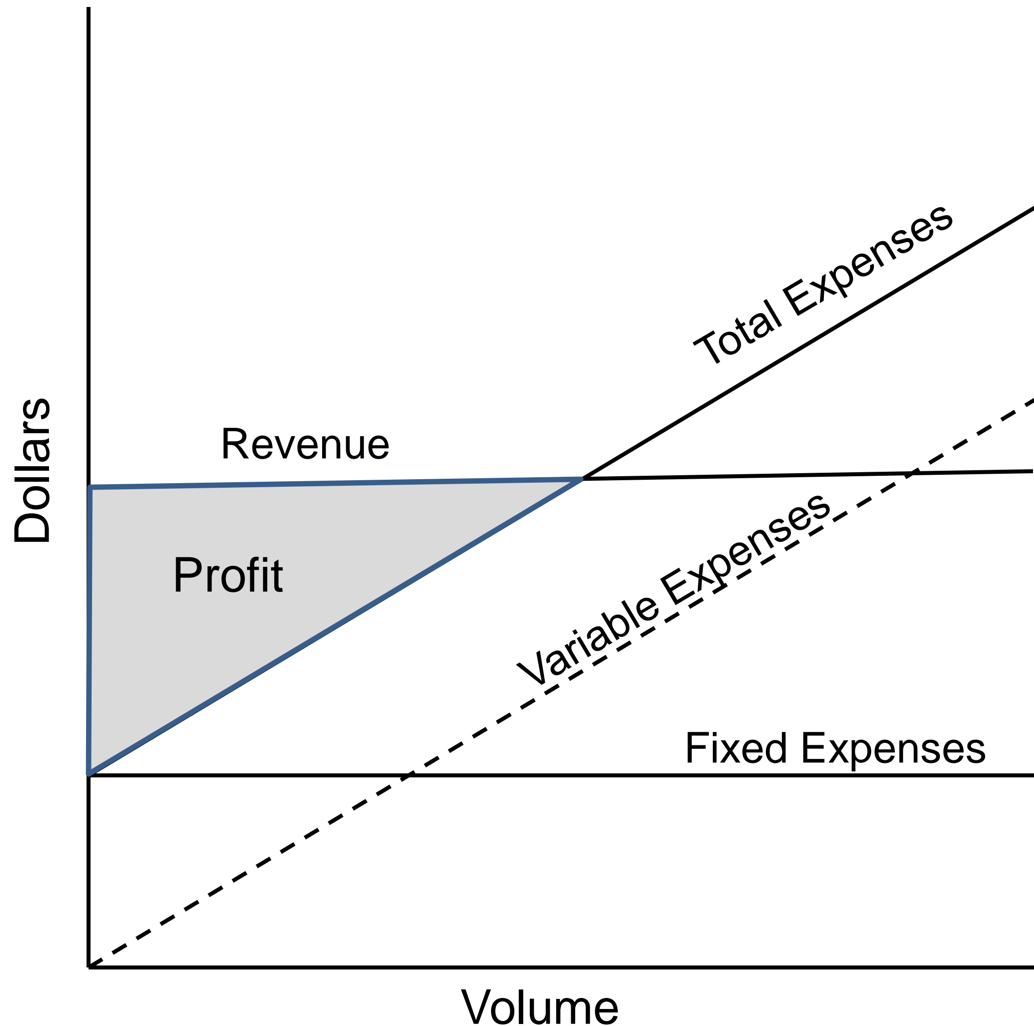


The Network Could Be Organized By A Private Insurer, Hospitals, Other Providers, Either As a Group Or A Single Entity

[1] Purchaser = Insurance Company, Government, Employer, etc.

Source: AHA, Draft "Economic Discipline and Payment Reform: Redefining the AHA's National Health Reform Strategy", **November 13, 1991**

Global Budgets are Being Suggested As One Approach to Control Costs



Strategic Initiatives Considered – 1990's

- Consolidation of Providers (Development of Integrated Delivery Systems) – Yes, in big markets but not always operating in an integrated manner so no impact
- Development of IPAs and PHOs – Yes and many still in existence
- Hospital acquisition of Primary Care Physicians – Yes but many disbanded, now occurring again due to physician shortages and new graduate lifestyle desires
- Restructuring mix of Primary Care and Specialists – Not very successful
- Consolidation of Payers with reduction in health insurance premiums – Yes but NO
- Development of Provider-Sponsored HMO's – Not very successful since not able to take risk
- Development of exclusive contracting – Not very successful; patients didn't want limited provider access

Consolidation of Providers in New England

State	# of Hospitals 1970	# of Hospitals 2009	Change	% Change
Conn	35	32	3	-8.57%
Mass	127	75	52	-59.06%
Maine	45	37	8	-17.78%
NH	**28**	**26**	**2**	**-7.14%**
RI	15	13	2	-13.33%
Vermont	17	15	2	-11.76%

Source: *AHA Guide*

Why Did 1990's *Health Care Reform* Fail?

- Integrated Delivery Systems Were Not in Place
  - Political, management, organizational and professional factors limited the ability of organizations to modify the delivery of care
    - Hospitals and Physicians did not necessarily have the same goals
  - Clinical integration did not occur due to limited IT, ambiguous roles and responsibilities and focus on economics of integration
- Coordination of Care Did Not Exist
  - Quality indicators were not well established
  - Gatekeeper concept did not equal "Medical Home" concept
- Transfer of Financial (Insurance) Risk to Providers Undermined the Providers' Financial Viability
  - Law of Large Numbers (Providers are not insurance companies!)
  - Leakage (inability to understand or control coordination of care and cost of care by various providers)
  - Fragmentation in purchasing power limited financial savings
  - Information technology was not sufficiently advanced or sophisticated
    - Reliable cost information was not available to support the efforts

    - Despite this, some of the organizations that developed to respond to capitation have survived.

Goals of Health Care Reform - 2010
Patient Protection & Affordable Care Act

- Clinical Integration of Providers to Accomplish:
  - Quality Improvement
    - ➢ Incentives to Increase Clinical Integration
  - Improvement in the Coordination of Care
    - ➢ Culture of Providing Coordinated Care is Important
  - Efficiencies Through Organizational Change Which Reduces Cost (?)
- Cost Reduction through a restructured payment system *(How do you BEND the Cost Curve?)*
  - Episode Payment evolving to Global/Bundled Payment
  - ACOs included as voluntary demonstration projects

SHARED SAVINGS PROGRAM Sec. 1899. (a) Establishment- (1) IN GENERAL- Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program--(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO')....that meet certain quality and performance standards....will be eligible to receive bonus payments based on reductions in cost for Medicare patients under their care.

Clinical Integration

"An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality."

Source: FTC/DOJ Statements of Antitrust Enforcement Policy in Healthcare, #8.B.1(1996)

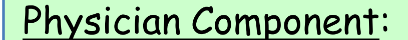
What is an Accountable Care Organization?

A high performing organized system of care and financing that can provide the full continuum of care to an identified population over an episode or a lifetime of care while assuming [limited] risk and accountability for outcomes

Provider risk can be essentially non-existent (quality performance bonuses) to more fully assumed.

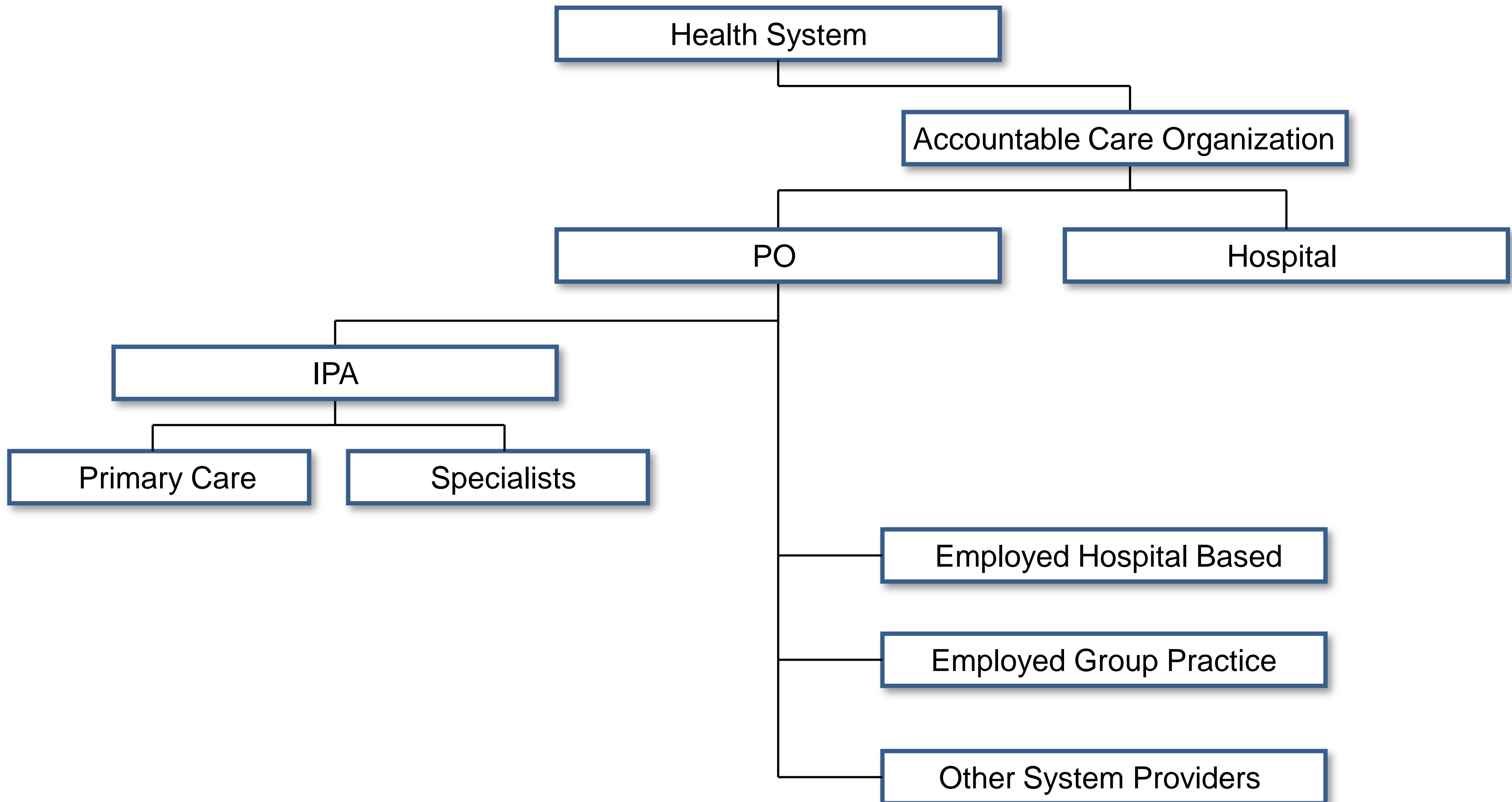
Accountable Care Organizations

- Includes Physicians and ***may*** include Hospitals
- Locally based and operated within a community or region
- *Agrees to data collection and reporting*
- Providers agree to follow care guideline benchmarks based upon evidence
- In exchange for reporting and guideline compliance, *ACO* is paid a Global Fee or Bundled Payment based upon Episodes of Care (ETG)
- Cost benchmark is spending in the three most recent years plus an adjustment for expenditure growth nationally

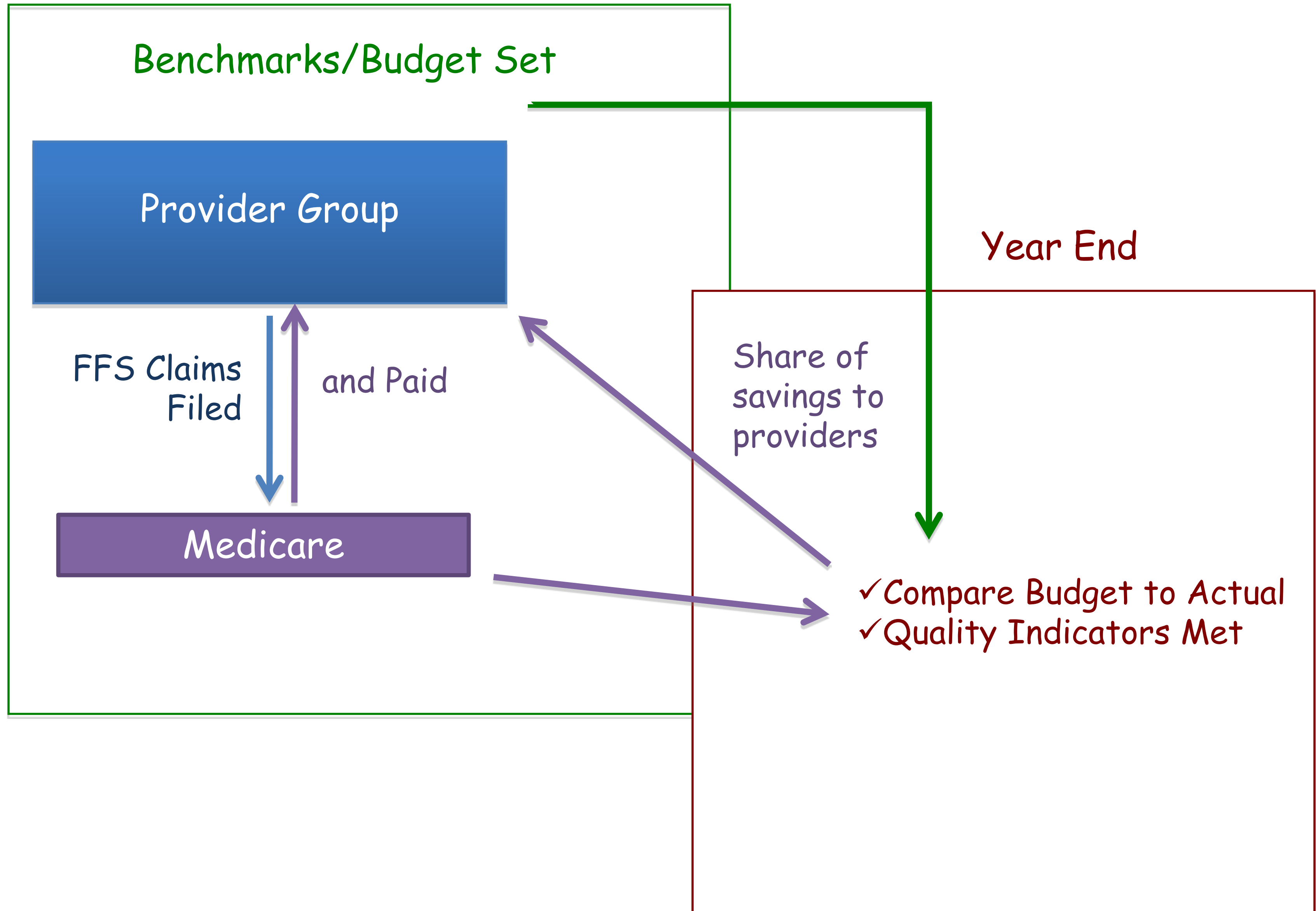


Physician Component:
-Group practice
-IPA
-Hospital employed providers
-MD/Hospital joint venture
-PHO
-Virtual Network

Accountable Care Organization
Organizational Design - Hospital Driven Plan



Pre-Risk Payment Methodology



Why an Accountable Care Organization?

ACOs are one proposed "solution" to the following identified problems

1. Improve integration and with it, quality
2. Improve integration and with it, efficiency
3. Improve access and with it, overall health management

- Therefore, ACOs are one strategy for value purchasing in health care to share the savings among patients, purchasers, payers, and providers

Accountable Care Organizations unknowns??

- What are the benchmarks?
- What are the costs to develop an ACO with the associated infrastructure?
- How will the risk adjustment work?
- What is the potential risk sharing?
- What does the data say about population use?
- Is all the change worth it?

Accountable Care System Models and Core Capabilities

Accountable Care System Models	Redesign Care Processes	Teamwork	Care Coordination	Core Capabilities Performance Accountability	Information Technology	Knowledge Management	Change Management
(1) Multi-Specialty Group Practice (MSGP)[a]	High	High	High	High	High	High	Medium
(2) Hospital Medical Staff Organization (HMSO)[b]	Medium	Medium	High	High	High	Low to Medium	Low to Medium
(3) Physician Hospital Organization (PHO)[c]	Medium	Medium	Medium	High	High	Medium	Medium
(4) Interdependent Provider Organization (IPO)[d]	Low	Low	Low to Medium	Medium	Low	Low	Low
(5) Health Plan Provider Organization/Network (HPPO/HPPN)[e]	Medium	Low to Medium	Low to Medium	Medium to High	Low to Medium	Low to Medium	Low to Medium

[a] 17-26 percent of practicing physicians in groups of 100 plus including institutionally based; 35 percent in groups of 20 plus

[b] Almost all 718,000 practicing physicians

[c] Estimated 37 percent of practicing physicians; see text

[d] 48% of office-based in solo or 2 person partnership; 89% in arrangements of 10 physicians or less; 38% members of IPA's

[e] 38% members of IPA's

Source: *A Guide to Accountable Care Organizations, and Their Role in the Senate's Health Reform Bill*, Health Reform Watch, March 11, 2010 by Jordan T. Cohen

ACO Models and Characteristics for Success

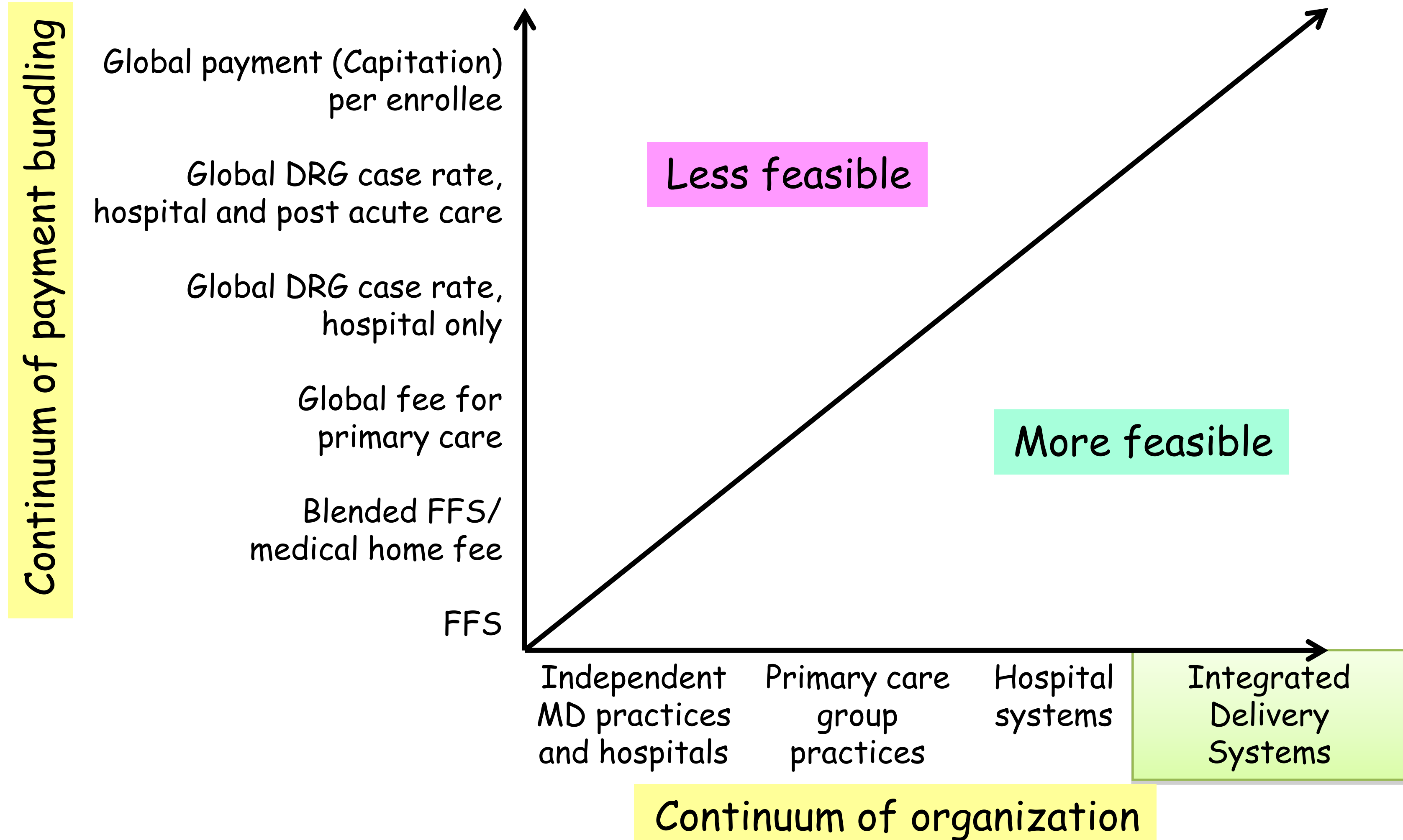
Provider Type	Ability to Manage across the Continuum	Ability to Plan Budgets & Resource Needs	Provider Inclusiveness	Level of Performance Accountability
IPA	Low/Medium	Low/Medium	Medium/High	Medium
Multi-Spec Group	Medium/High	Medium	Low/Medium	Medium/High
Hosp. Med Staff Org	Medium	Low/Medium	Medium	Low/Medium
PHO	Medium/High	Medium/High	Low/Medium	Medium/High
IDS	Medium/High	Medium/High	Medium	Medium/High
Virtual	Medium	Low/Medium	High	Low

Devers K, Berenson R (2009) "Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandries? Urban Institute, October 2009

Notes: Sufficient Size not addressed here
Those that do not include Hospital, Subacute, would need to contract for those services if applicable

Accountable Care Organizations

Medicare Payment Reform Framework: Organization and Payment Methods



Source: S. Guterman, K. Davis, S. C. Schoenbaum, and A. Shih. "Using Medicare Payment Policy to Transform the Health System: Framework for Improving Performance," *Health Affairs*, January 27, 2009; Pages 238-250.

Patient Centered Medical Home (PCMH)

The Patient Centered Medical Home (PCMH) and the Accountable Care Organization (ACO) are two widely discussed models for delivery-system reform that take complementary approaches to achieving these goals. The PCMH model emphasizes the creation of a strong primary care foundation for the health care system, and the ACO model emphasizes the alignment of incentives and accountability for providers across the continuum of care.

Source: Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform

Model Comparisons

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
General strengths and weaknesses	Makes providers accountable for total per-capita costs and does not require patient "lock-in." Reinforced by other reforms that promote coordinated, lower-cost care	Supports new efforts by primary-care physicians to coordinate care, but does not provide accountability for total per-capita costs	Promotes efficiency and care coordination within an episode, but does not provide accountability for total per-capita costs	Provides "upfront" payments that can be used to improve infrastructure and process, but provides accountability only for services/providers that fall under partial capitation, and may be viewed as too risky by many providers/patients	Provides "upfront" payments for infrastructure and process improvement and makes providers accountable for per-capita costs, but requires patient "lock-in" and may be viewed as too risky by many providers/patients
Strengthens primary care directly or indirectly	Yes – incentive to focus on disease management within primary care. Can be strengthened by medical home or partial capitation to primary-care physicians	Yes – Changes care delivery model for primary-care physicians allowing for better care coordination and disease management	Yes/No – Only for bundled payments that result in greater support for primary-care physicians	Yes – If PC included allows for infrastructure, process improvement, and a new model for care delivery	Yes – Gives providers "upfront" payments and changes the care delivery model for primary-care physicians
Fosters coordination among all participating providers	Yes – Significant incentive to coordinate among participating providers	No – Specialists, hospitals and other providers are not incentivized to participate in care coordination	Yes – Depending on how the payment is structured, can improve care coordination	Yes – Strong incentive to coordinate and take other steps to reduce overall costs	Yes – Strong incentive to coordinate and take other steps to reduce overall costs

Source: Health Reform Watch, "A Guide to Accountable Care Organizations, and Their Role in the Senate's Health Reform Bill", March 11, 2010, Jordan T. Cohen

Model Comparisons, continued

	Accountable Care Organization (Shared Savings)	Primary Care Medical Home	Bundled Payments	Partial Capitation	Full Capitation
Removes payment incentives to increase volume	Yes – Adds an incentive based on value, not volume	No – There is no incentive in the medical home to decrease volume	No, outside the bundle – There are strong incentives to increase the number of bundles and to shift costs outside	Yes/No – Strong efficiency incentive for services that fall within the partial capitation model	Yes – Very strong efficiency incentive
Fosters accountability for total per-capita costs	Yes – In the form of shared savings based on total per-capita costs	No – Incentives are not aligned across provider, no global accountability	No, outside the bundle, no accountability for total per-capita cost	Yes/No – Strong efficiency incentive for services that fall within partial capitation	Yes – Very strong accountability for per-capita costs
Requires providers to bear risk for excess costs	No – While there might be risk-sharing in some models, the model does not have to include provider risk	No – No risk for providers continuing to increase volume and intensity	Yes, within episode – Providers are given a fixed payment per episode and bear the risk of costs within the episode being higher than the payment	Yes – Only for services inside the partial capitation model	Yes – Providers are responsible for costs that are greater than the payment
Requires "lock-in" of patients to specific providers	No – Patients can be assigned based on previous care patterns, but includes incentives to provide services within participating providers	Yes – To give providers a PMPM payment, patients must be assigned	No – Bundled payments are for a specific duration or procedure ad do not require patient "lock-in" outside of the episode	Yes (for some) – Depending on the model, patients might need to be assigned to a primary-care physician	Yes – To calculate appropriate payments, patients must be assigned

Accountable Care Organization
Criteria to Qualify

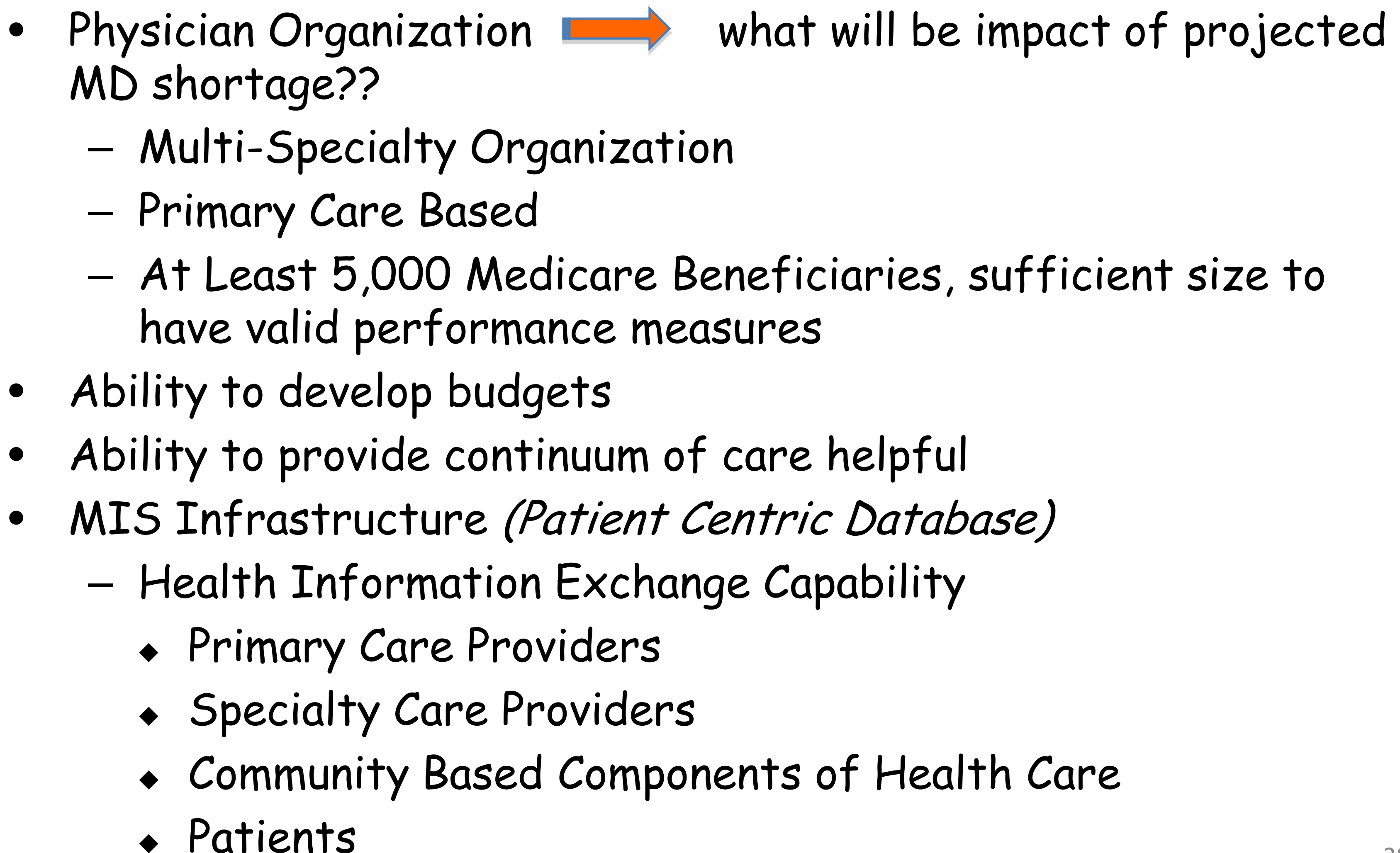
- Agree to a minimum two-year participation
- Develop a formal legal structure that would allow the organization to receive/distribute bonuses to participating providers
- Include the primary care providers of *at least 5,000 Medicare beneficiaries*
- Have contracts in place with a core group of specialist physicians
- Provide CMS the list of primary care and specialty providers participating
- Have a management and leadership structure in place that allows for joint decision making (e.g., for capital purchases)
- Define processes to promote evidence-based medicine, report on quality and costs measures, and coordinate care.

Source: Senate Finance Committee Report

Accountable Care Organization Core Blocks

1. Collection of physicians operating as a group practice
   - Clinical leadership
   - Operational/business management
2. Facility-based care (hospital, SNF, LTAC, health center, etc.)
3. *Advanced medical home model for primary care (Not Required)*
4. Financial and risk management strategy and capabilities
5. Comprehensive IT framework
6. Medical management system
   - Ability to Report on Performance Data
7. Buyers and aggregators who see value in the offering
8. Engaged, informed patients
9. Committed leadership, supportive culture and collegiality among sectors

Accountable Care Organization
Some Requirements



ACO: Organizational Design

- **ACO Configuration Has Multiple Options**
  - Integrated Delivery System
  - Physician Hospital Organization (HPNH)
  - Multi-Specialty Group Practice
  - Other Physician / Hospital Relationships. Can they be collegial?
- **Organization Requirements**
  - Physician Leadership
  - Professionally Staffed
  - IT/Data Capabilities for improving and coordinating care with feedback to providers
  - Cooperative Decision Making
  - Locally Operated
- **Organizational Goals**
  - Compete on Quality and Cost
  - Remove Unnecessary Utilization
  - Improve Care Outcomes
  - How involve patients/insurance plan members?

Accountable Care Organization Incentive Bonus (5.0%) - Quality Thresholds

- ACO must report to CMS on specified quality indicators *(At Present it is approximately 20)*
  - Clinical Processes and Outcomes
  - Patient Perspectives on care
  - Utilization and Costs
- CMS would assign beneficiaries to ACO's based upon the physician from whom the beneficiary had the most primary care services in the preceding year.
- ***ACO would be paid bonus based upon ETG's or Global Payment Definitions to be established by CMS***
- ACO's would be paid based upon FFS Transitioning to Global / Bundled Payment.

Accountable Care Organization Clinical and Cost Benchmarks Established

- **Clinical Benchmarks**
  - CAHPS, HEDIS, Hospital Data, NCQA AHRQ NQF
- **Cost Benchmarks**
  - ETG's – Episodes Treatment Group **(Symmetry/Ingenix)**
  - MEG's – Medical Episode Group **(Thompson Reuters)(3M)**
  - Severity Adjusted Measures
- **Actual Payments**
  - Medicare Payments
  - Health Plan / Employer Payments

Accountable Care Organization What are the "New" Metrics?

- Measuring Performance
  - Per Member Per Month (Population Profiling)
    - PCP Measured
    - Benchmark (Standard)(Panel Size; Use Rate; Cost Per Unit)
- Measuring Quality *(As defined by CMS: 20 at present)*
- Measuring Efficiency
  - ETG's (Physician with Most Cost – Generally PCP)
  - Measures Episode of Care *(Case Mix Adjusted)*
- Measuring Payment
  - FFS, Global Payment

Accountable Care Organizations
New Metrics
Activity Based Costing & Economic Chain Costing - Population Profiling

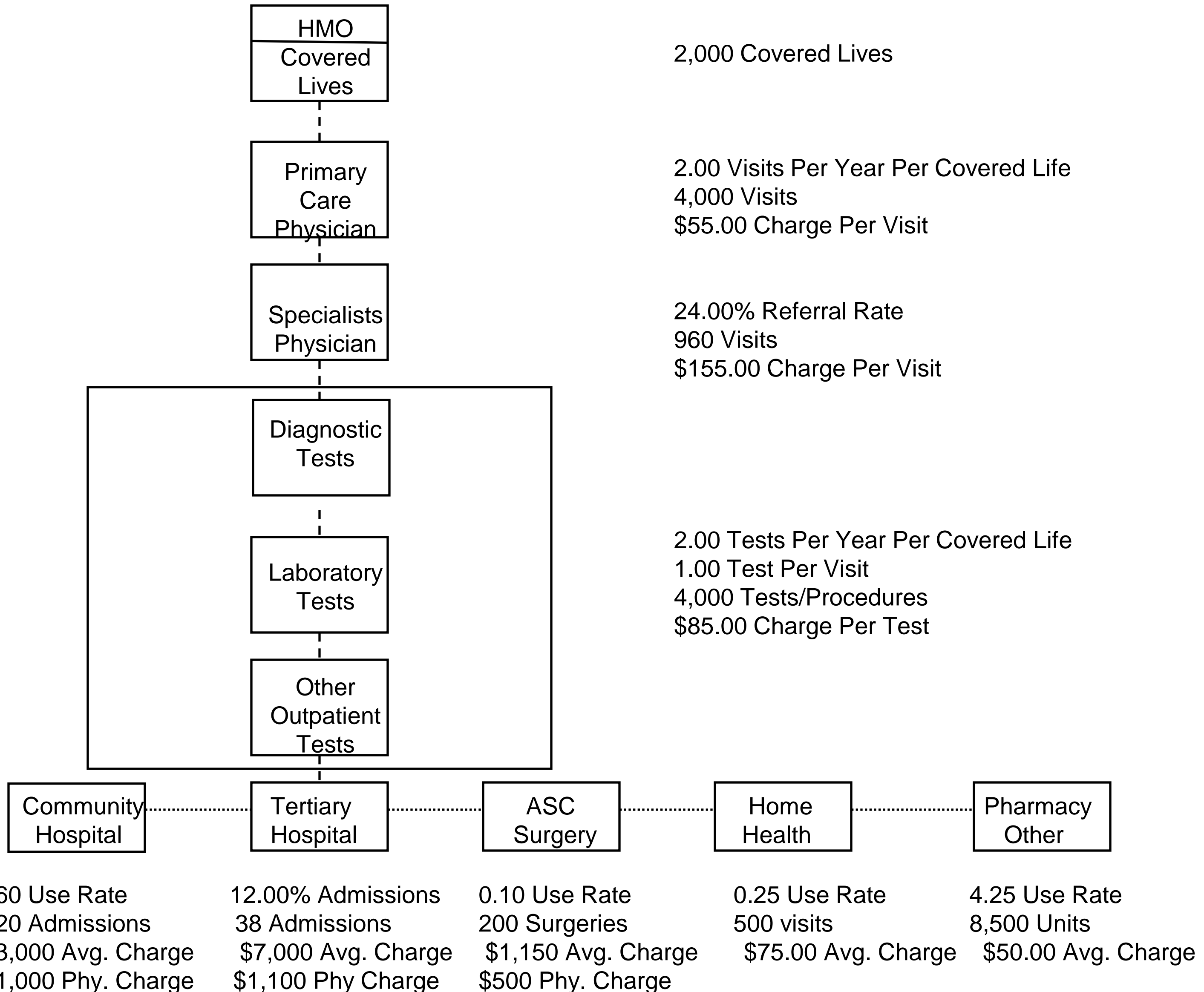


Exhibit VI

Activity Based Costing & Economic Chain Costing
Cost of the Entire Economic Process

Healthcare Organization	Use Rate	Units	Cost or Price Per Unit	Total Cost or Price	Total Cost or Price PMPM	% Cost or Price PMPM
Subscriber Premium		2,000		$3,720,000	$155.00	100.00%
HMO / Insurer				**$631,500**	**$26.31**	**16.98%**
Medical Providers;						
Primary Care Physician	2 visits per member	4,000	$55.00	$220,000	$9.17	5.91%
Specialist Physician	24% Referral Rate	960	$155.00	148,800	6.20	4.00%
Outpatient Diagnostic/Other	2 Tests per member	4,000	$85.00	340,000	14.17	9.14%
Outpatient Surgery	.10 per member	200	$1,150.00	230,000	9.58	6.18%
Outpatient Surgery - Physician		200	$500.00	100,000	4.17	2.69%
Community Hospital	160 Admits/1,000	320	**$3,000.00**	**960,000**	**40.00**	**25.81%**
Community Hospital - Physician		320	$1,000.00	320,000	13.33	8.60%
Tertiary Hospital	12% of Admits	38	$7,000.00	268,800	11.20	7.23%
Tertiary Hospital - Physician		38	$1,000.00	38,400	1.60	1.03%
Home Health	.25 per member	500	$75.00	37,500	1.56	1.01%
Pharmacy/Other	4.25 per member	8,500	**$50.00**	**425,000**	**17.71**	**11.42%**
Total Medical Costs				$3,088,500	$128.69	83.02%
Panel Size		2,000				

Accountable Care Organizations

PCP Physician – New Metrics (Panel Size = 1,000)

Service	PCP Units Per 1,000	Peer Group Units Per 1,000	Percent Diff.	PCP Cost Per Unit	Peer Group Cost Per Unit	PCP Cost Per Member Per Month (PMPM)	Peer Group Cost Per Member Per Month
Laboratory	1.50	1.75	-14.29%	$55.00	$65.00	$6.88	$9.48
Office Visits	3.30	4.00	-17.50%	$80.00	$75.00	$22.00	$25.00
Radiology	.03	.05	-50.00%	$110.00	$125.00	$.23	$.52
Surgery	.70	.60	16.67%	$14.00	$12.00	$.82	$.60
Other	.50	.60	-16.67%	$14.00	$15.00	$.58	$.75
Total	6.03	7.00	-13.93%	$273.00	$292.00	$30.50	$36.35
Percent Diff.					-6.51%		-16.08%

Accountable Care Organizations

Development of Global Payment (Capitation) Rates

I. Determine Delivery System Cost Base For Population Covered

- Statistics By Payer
- Develop Cost Base By Payer
  - **Fixed Cost**
  - **Variable Cost**
- Case Mix Adjustment
- Cost Allocation By Delivery Site:
  - Inpatient
  - Outpatient
  - Home Care

II. Develop Use Rate Assumptions By Major Service

- ***Population Covered (Inpatient/Outpatient/Physician)***
- Use Rate by Service (Inpatient/Outpatient/Physician)
- Use Rate by DRG (Inpatient)
- Use Rate by Payer by Age (Inpatient/Outpatient/Physician)
- Use Rate by Site of Service

Accountable Care Organizations

Development of Global Payment (Capitation) Rates

III. Develop Global Payment (Capitation) Rates

- Subscribers by Insurer (Inpatient/Outpatient)
- HMO's (Inpatient/Outpatient)
- Commercial Insurer (Inpatient/Outpatient)

IV. Identify Risks (Risk is Transferred to Provider)

- Population Covered (Demographics too Small to Develop Use Rate)
- Out of Plan Services/Provider control
- Strength of Plan
- Re-Insurance
- Catastrophic Loss
- Loss of Subscribers
- Loss of Physicians
- Risk Sharing (Stop Loss)
- Operational Issues (Utilization Review)

Accountable Care Organizations

Development of Global Payment (Capitation) Rates

V. Develop Negotiation Strategies (Except for Medicare)

- Patient Incentives
- Termination Clause
- Inflation Indices
- Implications of Not Negotiating
- Initial Settlement Process (First & Second Year)
- Risk Sharing
- Volume Adjustment
- Case Mix Adjustment
- Operational Issues

Accountable Care Organization
What is needed to transition to an ACO?

- What does the Organizational Structure look like?
  - What does the "Medical Management" organization look like?
  - What type of management personnel will be needed?
- What information and data is required to evaluate the feasibility of an ACO?
  - Business Plan in Place
  - Organizational Structure In Place
  - Contracts with Physicians In Place
  - MIS in Place
  - Reporting Capabilities in Place
- What is the financial feasibility of an ACO?
  - What does it cost to establish an ACO?
  - $250,000 to $1,000,000

Accountable Care Organization
What is needed to transition to an ACO?

- How long will it take to become an ACO?
  - ACO's are Expected to be in Place by 2012 / 2013.
  - To be Approved All the Requirements must be in place.
- What are the *Information Technology* Requirements?
  - ETG Software is Available only to Insurance Companies
  - EMR and ETG should be linked
- What are the Management Information Requirements?
  - Clinical and spending benchmarks and metric analysis
  - Can you re-engineer an ETG to make it higher/more consistent quality and lower cost?
  - Care management processes
  - Understanding of spending. Cost Accounting System?
- How will the ACO be paid?
  - FFS, ETG and Global/Bundled Payment ("Capitation")
  - Global / Bundled Payment Based Upon Episode (ETG) are the Intention
  - Not Full Risk initially……??? Medicare is taking Risk
  - Ultimately Global Payment (Capitation) will be the form of payment.

Accountable Care Organization
What is needed to transition to an ACO?

- Innovators (Geisinger; Cleveland Clinic; Baylor etc.)
  - Exploring innovative payment strategies while focusing on delivery efficiency
- Early Provider Acceptance (PCP's can only be in one ACO)
  - Organizing physicians into coherent delivery systems
  - Designing and experimenting with "medical home" model
  - Reorganizing physician-hospital "operating systems"
  - Developing IT platforms
  - Focusing on innovative payer strategies
- Late Provider Acceptance
  - Watching and waiting
- No Acceptance

Options for Physicians

- Organize into an accountable health organization
- Medical group without walls
- Coordinate services virtually
- Position to directly contract as a local network
- Building and reporting against guidelines
- Aggressively negotiate fees based on quality outcomes
- Work with health plans or become one
- Adopt EMR
- Implement other processes and interventions designed to improve quality and efficiency
- Develop stronger patient education programs
- Create disease registries to provide reminders for physicians and patients
- Develop programs to remind healthy patients about preventive care for which they are due (e.g., mammograms, pap smears, colon cancer screening)
- Use nurse care management for patients with serious chronic illness

Massachusetts Initiatives

BXBS "Alternative Quality Contract" – AQC Contract

- *Development of Alternative Quality Contract Based Upon Global Payment and Risk Sharing*
  - ***9 Hospitals Have Signed QEC Contract***
  - ***Only 1 or 2 have been on long enough to see impact!***
- A health care system that provides safe, timely, effective, affordable, patient-centered care for everyone in Massachusetts.
- Five System Elements for Transformation:
  - Payment Reform
  - Administrative Simplification
  - Product Development
  - Engagement: Trustee, Member/Patient, Legislative
  - ***AQC Support (Global Payment and Risk Contract)***

Massachusetts Initiatives

BXBS "Alternative Quality Contract" – AQC Contract

- Contract Participants ***(Effectively an ACO Organization)***
  - *Hospital*
  - *Primary Care Physician Groups*
  - *Specialty Physician Groups*
- Efficiency Arrangement Built Into Contract
- Quality Standards Built Into Contract
- Global Payment
  - Risk Based Contract
  - Risk Mitigated By:
    - *Stop Loss Provisions*
    - *Re-insurance*