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Managed Care and Accountable Care Organizations

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ABSTRACT

Managed care generally, and more specifically, accountable care organizations (ACOs) have attempted to provide coordination of patient care in order to eliminate or reduce unnecessary procedures and or test redundancy. The purpose of this research was to study the effects of managed care in accountable care organizations by decreasing health care costs by increasing efficiency in health care.

Key Words
Accountable Care Organization, Managed Care, primary care provider, cost, utilization review

1 INTRODUCTION

According to the Centers for Medicare and Medicaid (CMS), in 2011 health care spending in the U.S. was $2.7 trillion, or 17.9% of Gross Domestic Product, and between 2009 and 2011 this spending increased at 3.9% annually (CMS, 2012). One of the proposed ideas to assist in resolving this problem has been Managed Care (MC) via Accountable Care Organizations (ACOs.

Managed care was the idea of creating coordination of care in an attempt to control costs in health care spending. The primary care physician in MC was placed as the major point of control in terms of monitoring utilization throughout the system; i.e., the "gatekeeper" (Mains, Coustasse and Lykens, 2003). The simple idea of an ACO was to formulate a unit consisting of a local health care organization and/or a related set of clinicians that take responsibility for both the cost and quality of care rendered to a defined population (Schoen et al., 2009).

The use of ACOs has been attempted to provide the coordination of patient care to eliminate or reduce unnecessary procedures and/or test redundancy. ACOs have aimed to distribute payment to providers based on the quality of rendered care and not on the incentive of Fee For Service (FFS), which has been the model often used for payment (Correia, 2011).

Capitation is one of the methods in which ACOs have been attempting to introduce cost containment through the concept of a "per member per month" (PMPM) being implemented as a set rate. In allowing the reversal of the traditional financial incentives for providers created by health insurance companies, capitation has been an influential force for cost containment (Hall, Ellman and Orentlicher, 2011).

2 METHODOLOGY

The primary hypothesis of this study was that Primary Care Provider(s) (PCP) will decrease health care expenditures through memberships in ACOs. The secondary hypothesis was: MOCs will curb overspending through utilization reviews and in having a PCP as the gatekeeper.

This study consisted of a literature review of full text articles cited on CINAHL, PubMed and EbscoHost. Google was utilized when articles could not be located through the previously noted databases. Key words used in the search included 'ACO' AND 'PCP', OR 'cost', OR 'MC', OR 'utilization review'. The Kaiser Family Foundation and The New England Journal of Medicine websites; recent textbooks were also utilized. The search was limited to articles published in English from 2000 to June 2013.

Primary and secondary data were included from articles, websites, and textbooks. Relevant articles were selected after the review of abstracts was performed. Following the literature search, all references were independently screened by two reviewers to identify all citations as meeting inclusion criteria.

3 RESULTS

Hospitals Employment Strategy

In response to implementing health care reform, US hospitals have been increasing the hiring of physicians as a key to preparing expected Medicare payment reforms which has included bundled payments, ACOs, and penalties for preventable hospital readmissions (Goldsmith, 2011). Initially hospitals moved to employ physicians focusing on specialists to form specific service lines, by doing so increasing hiring of PCPs has lead to referrals for the hospitals employed specialists (O'Malley, Bond and Berenson, 2011).

Since new physicians today have been more inclined to value better work-life equivalence, physicians have been more willing to trade higher incomes for the lifestyles that are provided by hospital employment (Higgins et al., 2011). Kocher and Sahni (2011) note a 75% increase in the number of active doctors employed by hospitals since 2000; in turn, percentages of US physician practices owned by physicians have decreased from 70% in 2002 to 48% in 2008, while the number of hospital-owned practices have increased from 23% in 2002 to 53% in 2008. More physicians have become employed by hospitals, and as this has been happening, hospitals have been able to reduce excess costs associated with inessential practice alteration and expensive supplies selected by physicians that have not been essential (Kocher and Sahni, 2011).

Hospital employment has been attractive to beginning practice physicians because of the perceived financial security and work-life balance; hospitals have been achieving this by gaining higher rates to offer better compensation than independent physicians could get on their own (O'Malley, Bond and Berenson, 2011). It has been uncertain whether the benefits of improved care coordination, few complications, and bottom dollar savings through ACO-type organizations, that have assimilated physicians and hospitals, have been passed along to patients as decreased prices (Kocher and Sahni, 2011). Under volume-driven Fee For Service (FFS), physician employment has been appealing to both hospitals and physicians; although this trend has grown it does not guarantee improved clinical integration (O'Malley, Bond and Berenson, 2011).

Partnerships between Insurers and Providers

Various organizations have formed ACOs to serve Medicare and commercial consumers with the agreement of certain terms including of meeting certain quality and outcome standards when rendering care to a group of patients. If both partners attain a savings greater than a certain percentage compared with what would have been spent for the same patients in a FFS model, the insurance company rewards both partners with a share of the savings (Beraducci, Langheim and Vars, 2012).

Several providers have teamed up with insurers to set up commercial, non-Medicare ACOs. One such ACO, AdvocateCare, was created in 2012 as an association between Blue Cross Blue Shield of Illinois and Advocate Health Care of Chicago. After six months of providing care to 750,000 members, some successful utilization results were obtained. During the first six months of 2011, hospital admissions decreased 10.6% and emergency department visits by 5.4% in comparison to the same time frame of the previous year (Berarducci, Langheim and Vars, 2012).

Payment Methods and Financial Incentives

Two very different payment methods to support ACOs, a Shared Savings Program (SSP) and partial capitation referred to as Population-Based Payment (PBP), have been implemented (Lieberman and Bertko, 2001).

Under the basic SSP concept, providers are paid on a FFS basis. Yet, Medicare has been responsible for determining the expected total expenditures for patients cared for by the ACO as well as measuring and assessing the quality of care (Berwick, 2011). The ACO awards a bonus if quality care was provided for less than predicted by Medicare. The possibility of an ACO achieving a bonus was

determined by spending targets; a critical issue achieved through various configurations. Many ACOs have found the SSP payment attractive since bonuses have been implemented on a shared savings approach, which did not involve any financial risk taking activity (Berwick, 2011). A disadvantage of the SSP payment method for ACOs has been the FFS incentive of "do more, get paid more" (Lieberman and Bertko, 2011). ACOs have been more likely to not participate in advanced treatment and care services that were not funded by the FFS system since the ACO would have to directly fund these services without the guarantee of being financially rewarded (Rosenthal, Cutler and Feder, 2011). Although the FFS system is not perfect, many have thought the likelihood of a generous bonus to the ACO for achieving overall savings could achieve different referral patterns so that care is conveyed to the clinicians who make valuable use of resources (Rosenthal, Cutler and Feder, 2011).

Alternatively, the partial capitation or PBP system prepays a provider a predetermined amount for services to a specific group of people for a fixed period. With the PBP payment method, providers have to consider all resources needed to care for the patients for whom they are responsible, which involves a greater financial risk (Rosenthal, Cutler and Feder, 2011). The partial capitation has had many advantages over the SSP payment method making it more attractive to this organization. ACOs and affiliated providers have had more incentive and flexibility to implement advanced treatment and care services not funded in the FFS system (Lieberman and Bertko, 2011). ACOs also receive payment upfront, which better allows for capital and other investments. The payment incentives have differed with partial capitation with the hospital being a "cost center"; conversely, with a SSP, the hospitals have been an accounting "profit center" for an ACO (DeVore and Champion, 2011). There has not just been incentive for the ACOs to cut total costs, but continuously maintain the improvements. Overall, the SSP has not limited patient choice in providers or required financial risks for providers (Lieberman and Bertko, 2011).

4 CONCLUSIONS

MC evolved and shows some promising results through the introduction of ACOs. The Affordable Care Act (ACA) has encouraged the use of MC through ACOs to help reduce health care spending in the US. If an ACO achieved improved care while the cost of providing that decreased, it shared in the savings it achieved for Medicare (Berwick, 2011). The majority of the information that was once theoretical in nature has been producing long-term outcomes in reducing health care spending. Berarducci, Langheim and Vars (2012) found success with partnerships between insurers and providers after setting up AdvocateCare, which provided care to 750,000 members. During the first six months of 2011, hospital admissions were decreased to 10.6% and emergency department visits were down 5.4% in comparison to the same timeframe of the year 2010.

However, one has seen the projected effects of future outcomes with MC having been around for a few decades. Concepts such as capitation to replace FFS have never been fully recognized because of the reduced monetary income this had caused with PCPs in the past. Capitation alone has been used by MC organizations to regulate increased spending in health care since the 1990's (Frakt and Mayes, 2012). The thought has been to try a hybrid of capitation and FFS, along with UR to lower health care costs while increasing quality.

PCPs have had the ability to help lower health care spending with more thorough preventative care measures that have been implemented under the ACA, which provides 100% coverage for all preventative services. Since the focus of health care has been geared toward preventative care versus disease treatment, the effect has lowered costs in health care spending. Education has been indicated to assist in decreased spending and assisted in lowered costs. Patients who have an understanding of the system have utilized their PCP to help them make informed decisions. However, ultimately the responsibility lies with the PCP to assist consumers to make informed decisions that may help curb over-spending (O'Malley, Bond and Berenson, 2011) concluded that by US hospitals increasing the hiring of physicians is a key to expected Medicare payment reforms. Subsequently there has been an increase in the number of physicians employed by hospitals, although it is unclear whether ACO-type organizations that have incorporated physicians and hospitals have actually decreased prices on a patient level (Kocher and Sahni, 2011).

Two payment methods that support ACOs included SSP and PBP. Under the SSP concept, incentives were used in that if the ACO provided quality care

for less than predicted, a bonus was awarded. A disadvantage of the SSP payment method for ACOs has been the FFS incentive of "do more, get paid more" (Lieberman and Bertko, 2011). Alternatively, the PBP system has prepaid the provider a predetermined amount for a fixed amount of time to a specific group. This payment method has shown to be a greater financial risk than the SSP concept. Consequently, ACOs have not been a huge game changer in the short run of bending the cost curve and improving quality of care, but have been definitely worth a shot given the history of problems with the FFS (Devers and Berenson, 2011).

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