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Market Evaluation:

Finances, Bundled Payments, and Accountable Care Organizations

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INTRODUCTION

Health care spending in the United States has been under scrutiny during the past few decades, with rates of spending increasing at a substantial rate. In 2015, national health expenditures grew to \$3.2 trillion, accounting for 17.8% of the nation's gross domestic product (Fig. 1).¹ In an effort to control costs and improve quality, changes in health care delivery and financing have emerged to improve this fragmented health care system. This trend has resulted in shifting of financial risk to providers for both the quality and cost of care, including the emergence of accountable care organizations (ACOs) and bundled payment models. This article discusses financing and delivery models in the context of procedures and surgeries that happen outside of the traditional operating room setting. It describes the history of health insurance, trends in ambulatory surgery centers, and new payment models that have emerged from the Affordable Care Act (ACA) and the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA).

EVOLUTION OF HEALTH INSURANCE IN THE UNITED STATES

Historically, health insurance in the United States has been primarily through a fee-for-service model, in which providers are paid individually for each service. This started with Blue Cross and Blue Shield plans and Medicare, which paid separately for hospital and physician services. Not surprisingly, this payment model encouraged the delivery of more services because hospitals and physicians were paid for more care. A combination of the fee-for-service payment system, the third-party insurance system, and advances in technology resulted in increasing health care costs.²

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It became evident by the 1980s that this payment model alone was financially unsustainable. Between 1965 and 1984, there was a 1400% increase in overall Medicare costs, compared with a 242% growth in the consumer price index.³ Such a large and disproportionate increase placed financial pressure on employers, payers, the government, and patients. Inpatient care, which has historically made up the bulk of health care delivery, has also been the most costly for the Medicare system, with 73% of Medicare expenditures in 1980.³

Efforts for cost-containment emerged, leading to Medicare's first major effort to control inpatient spending. Medicare's Inpatient Prospective Payment System (IPPS) was launched in 1983 as an attempt to limit unnecessary utilization of inpatient services because hospitals were historically paid retrospectively based on charges. With IPPS, hospitals were prospectively paid a certain amount based on clinical conditions, or diagnosis-related groups (DRGs). Because hospitals were getting paid the same amount regardless of resource utilization, it encouraged shorter length of stay and a reduction in the increase of inpatient costs, with no measurable impact on quality.⁴ These factors contributed to a profound change in economic incentives for hospitals, also encouraging a shift of care to outpatient settings, including ambulatory surgical centers.

As economic incentives changed for hospitals, there was also an evolution in reimbursement for physician services. Historically, medical insurance companies would pay physicians based on a "usual, customary, and reasonable rate." Based on research done by Hsiao and colleagues,⁵ there was a transition from charges to the resources needed to provide services, which was called the resource-based relative value scale, which included physician work, practice expense (when performed in a physician office setting), and professional liability costs. Relative value units (RVUs) were used to compare the time and intensity of physician services, and actual payment from Medicare and many commercial payers is based on a conversion factor of RVU.

TRANSITION FROM HOSPITAL-BASED SURGERIES TO AMBULATORY SURGICAL CENTERS

In 1966, Drs David Cohen and John Dillon⁶ published a study entitled "Anesthesia for Outpatient Surgery" in JAMA, describing an outpatient surgery pilot program at the University of California, Los Angeles. Motivated by increasing bed shortages, unnecessarily long hospitalizations, and associated high costs for inpatient surgeries, surgeons selected specific operations to occur as outpatient rather than inpatient operations during this pilot. Selection criteria of cases included a maximum predicted postoperative observation time of 3 hours and no evidence of infection. In a sample of 804 subjects, only 4.1% of cases resulted in inpatient admission postoperatively, indicating the feasibility of this pilot. During a 2-year study period (1963–1964), they reported a total estimated savings of \$28,000 to patients or insurance companies, and approximately 1000 hospital-days were saved during the study period.

Encouraged by this pilot, Drs. Wallace Reed and John Ford^{7,8} opened the first ambulatory surgical center in February 1970, in Phoenix, Arizona, investing in the concept that low-risk surgeries could move away from a complex hospital system and into a lower cost, higher

efficiency model. Throughout the 1970s, Drs. Reed and Ford published their findings from their successful Surgicenter to serve as a guide for fellow physicians. They described the provisions necessary to formally establish such a center and to ensure high quality of care for patients, including the regulatory approvals required, the types of equipment stocked, thresholds for deferring surgeries in sicker patients, and postoperative discharge protocols. The initial Surgicenter model continued to primarily use general anesthesia (90% of cases), and the most common operation was diagnostic dilation and curettage, with gynecologic surgeries comprising most cases. They documented the benefits to surgeons, anesthesiologists, and patients, including higher production of surgical cases, ability to stock the latest technology and equipment, and easier facilitation of quality improvement and patient safety efforts.

By the 1980s, health care delivery notably shifted out of the inpatient arena and into outpatient facilities, including physician offices and ambulatory surgical centers. Two major contributors to this shift were newer payment arrangements and technologic and medical advances. Specifically, improved anesthetics and analgesics, alongside newer minimally invasive surgical approaches, allowed for patients to be safely cared for in an outpatient setting, with same-day discharges postoperatively.⁹ In 1980, about 3 million operations were done in an ambulatory setting, which grew to 27 million by 1995.¹⁰ Interestingly, during the same period, there was not a notable change in rates of inpatient operations, indicating the expanding utilization of surgeries and procedures in this health care environment. This expansion led to a substantial growth in the health care provider workforce, including anesthesiology. In 1967, there were 8800 anesthesiologists and 13,400 certified registered nurse anesthetists (CRNAs), increasing to 19,000 anesthesiologists and 22,500 CRNAs by 1986. During this 20-year period, the number of anesthesiologists increased by 116%, compared with a 68% increase for CRNAs.¹¹

Recent data show that outpatient surgeries made up nearly half of the 19 million surgeries performed in 2012 in community hospitals across 28 states.¹² Many specialties moved a large percentage of their total procedures to ambulatory surgery centers, including gastroenterology and ophthalmology (Fig. 2).¹³

However, as the health care system expanded, it also became more fragmented and there were concerns about quality. The fee-for-service model continued to reward the quantity of services rather than the quality of patient care. Problems with care coordination and integration emerged because patients now had multiple sites of care, including urgent care centers, hospitals, outpatient providers, and specialty services.¹⁴ Concern arose that, although the United States had the largest health care spending of all countries, measures of population health and quality lagged behind, such as high infant mortality rates and low life expectancy rates compared with other OECD (Organisation for Economic Cooperation and Development) countries. For example, 2 Institute of Medicine (IOM) reports in 1999 and 2001 addressed patient safety and quality improvement, and issues that required large-scale changes in the health care delivery system.^{15,16} Specifically, “To Err is Human” highlighted that tens of thousands Americans die each year from medical errors and, therefore, effectively made patient safety and quality a priority for policymakers. The “Crossing the Quality Chasm” IOM report described broader quality issues and defined 6 aims: care

should be safe, effective, patient-centered, timely, efficient, and equitable. The report also recommended that common conditions serve as a starting point for restructuring health care delivery, with an emphasis on decreasing waste, making evidence-based decisions, ensuring transparency, and customizing care according to patient needs and values. These reports shifted the framework for health care delivery, prompting a greater need for multidisciplinary care coordination.

OUTPATIENT CARE COORDINATION

Focus subsequently shifted toward outpatient care coordination and management. In the 1980s and 1990s, the increase of health maintenance organizations emphasized the shift in philosophy toward establishing primary care providers serving as central gatekeepers to specialty services. Although many models allowed for more of an open access model, these health organizations were an attempt at cost containment with a focus on care integration and capitation, or providers taking on more financial risk. The Balanced Budget Act (BBA) of 1997 introduced Part C of Medicare, or Medicare Advantage, which allowed for the administration of Medicare by private insurers, typically through managed care plans. BBA also created the Outpatient Prospective Payment System (OPPS) in 2000 by the Centers for Medicaid and Medicare Services (CMS), which prospectively paid fixed amounts for outpatient facility and skilled nursing facility fees. Throughout the 2000s, several other legislative efforts included revisions to the OPPS, which ultimately established a new payment rate system for medical and surgical services, and created the Hospital Outpatient Quality Reporting (OQR) program.¹⁷ Both the OPPS and OQR encourage financial planning in outpatient care, while meeting quality metrics for outpatients. Some models, such as pay-for-performance, additionally link financial incentives to outcome metrics and have been shown to improve quality of care in some domains.¹⁸

PATIENT-CENTERED MEDICAL AND SURGICAL HOMES

The concept of a medical home model first emerged in pediatrics in 1967 but began to spread throughout the United States in a variety of disciplines in the late 1980s to 1990s. The patient-centered medical home (PCMH) is a model of primary care management that seeks to meet the health care needs of patients through team-based care, and to improve efficiency through care coordination and a system-based approach to quality and safety.¹⁹

From an anesthesia perspective, the perioperative surgical home (PSH) is the primary practice model that has been proposed to improve the fragmented and expensive perioperative system. Similar to the medical home, the PSH is a patient-centered and physician-led multidisciplinary team that aims to guide patients throughout the entire surgical experience. A recent review identified key elements that have been applied to this model, including preoperative triage systems with innovation programs for select patients, intraoperative pain and fluid management, integrated scheduling with outpatient and inpatient electronic health record (EHR) systems, and postoperative efforts such as early mobilization with coordination of rehabilitation services and improved patient and caretaker education on perioperative pain and postdischarge care.²⁰ The concept of medical and surgical homes holds promise for cost reduction and quality improvement within health care.

BUNDLED PAYMENTS

The ACA, enacted in 2010, included the development of the Center for Medicare and Medicaid Innovation (CMMI), which aimed to test innovative payment and delivery models that could reduce costs while maintaining or improving health care quality. CMMI launched the Bundled Payments for Care Improvement (BPCI) initiative in 2013. The concept of bundled payments holds hospitals accountable for all care during the hospital stay, as well as the 90-day period after discharge. Therefore, bundled payments simply refer to the grouping of different medical services across a prespecified episode of care. BPCI includes 4 broadly defined models of care that link payments for multiple services during a defined episode of care, as specified by 48 different DRGs (Table 1).²¹

Although the expression bundled payments is a newer terminology, the concept is similar to the original 1983 Medicare IPPS, which is evident in Model 1, as well as the OPSS, as previously described. Models 2 and 3 are retrospective with different definitions of episodes of care, whereas Model 4 is a prospective payment for an inpatient admission. Also, bundled payments have been shown to have a beneficial impact in the private sector, before BPCI creation. For example, among the most well-known performance-based bundled payments is the Prometheus payment model, developed in 2006.²² This model assigns evidence-based case reimbursement rates (ECRs) to common conditions such as diabetes and heart failure, as well as common procedures such as joint replacements. A single ECR covers all inpatient and outpatient care associated with a given condition, but these episodes do not necessarily need to be anchored by an inpatient stay; they can relate to a disease condition or outpatient procedure. The Blue Cross and Blue Shield of North Carolina knee replacement bundled-payment includes the presurgical period of 30 days before hospitalization, the surgery, and most follow-up care within 180 days postdischarge, and saved about 8% to 10% on average per-episode cost in a 1-year pilot.²³

ACCOUNTABLE CARE ORGANIZATIONS

ACOs are groups of hospitals, physicians, and other health care providers who voluntarily work together to improve the value of care for a defined population. The ultimate goal is to ensure patients receive care in a timely fashion while avoiding unnecessary duplication of services and medical errors.²⁴ The push toward ACOs has come from payers' goal to emphasize the role of primary care provider in care coordination, with a component of payment directly to the quality of care provided. In ACOs, providers take on more risk along the spectrum of provider payment models (Fig. 3).

The ACA established the Medicare Shared Savings Program, intended to encourage the development of ACOs in Medicare. Under this program, a Medicare ACO is formed by a group of providers and suppliers of services, such as hospitals and physicians. Eligibility requirements include a minimum of 5000 Medicare fee-for-service beneficiaries, the establishment of an ACO governing body that is responsible for routine self-assessment, monitoring, and quality of care reporting, and a commitment of at least 3 years in the program.²⁵ If these requirements are met, an ACO application will be reviewed by the Shared Savings Program. Under this program, CMS will initially continue to pay providers

and suppliers using the fee-for-service model. Then, using a financial benchmark based on historical expenditures for beneficiaries assigned to that ACO, CMS will retrospectively determine if an ACO will receive shared savings or owes money due to losses. This amount is also tied to performance on 34 quality metrics, which include measures such as patient survey data via Consumer Assessment of Health Care Providers and Systems, risk-standardized readmission rates, and certain preventive care such as colorectal cancer screening.

The Pioneer ACO model was subsequently launched in 2012, with greater potential savings or losses, focused on organizations that already have experience with care coordination.²⁶ Between 2012 and 2013, Pioneer ACOs generated approximately \$183 million in savings to the Medicare program, compared with the relative projected spending levels, while improving mean quality scores from 70.8% to 84.0%.²⁶ Although initial reviews of ACOs are overall promising, there have been some concerns. One-third of Pioneer ACOs did not generate lower expenditure growth relative to their comparison populations during the first 2 years and 2 ACOs generated significantly higher expenditure growth during their second year. However, multiple factors may contribute, including variation in time necessary for an ACO to redesign care delivery and adverse selection of high-cost patients. Further research is needed to determine how ACOs in different markets will function, and CMS is currently working to redesign certain elements, such as newer benchmarking methodologies, through their Next Generation ACO model, which opened for application in December 2016.²⁷ The Next Generation ACO model allows providers to assume higher levels of financial risk and reward, alongside tools to support patient engagement and care management.

THE MEDICARE ACCESS AND CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

In 2015, MACRA became law with bipartisan support, replacing the sustainable growth rate (SGR) for physician reimbursement.²⁸ The prior SGR was part of BBA in 1997 as a way to control costs related to physician reimbursement from Medicare. However, temporary measures to override the SGR formula had dominated public policy discussions due to payment cliffs that required legislation to override.

Through MACRA, health care professionals are provided with stable fees for 5 years. The Quality Payment Program was launched and included 2 tracks for providers to choose from: the advanced alternative payment models (APMs) or the merit-based incentive payment system (MIPS). The APMs include ACOs, medical homes, and bundled payment arrangements, among others. In terms of MIPS, the plan is to replace and consolidate 3 current existing payment programs: the Physician Quality Reporting System, the meaningful use of EHRs, and the value-based payment modifier. In 2019, providers who participated in MIPS and submitted 2017 data can earn a positive MIPS payment adjustment. Participants in an advanced APM in 2017 may earn a 5% incentive payment in 2019. These provisions within MACRA pave the way for value-based payment models to dominate physician reimbursement.

PROLIFERATION OF NEW PAYMENT MODELS

In 2016, CMS launched the first mandatory postacute bundled payment, the Comprehensive Care for Joint Replacement (CJR) model, which aims to improve the value of care for Medicare beneficiaries undergoing hip and knee replacement surgery. Similar to the previously described bundled payment models, the episode includes an inpatient stay and a 90-day postdischarge period. The CJR model requires participation from IPPS hospitals in 67 metropolitan areas throughout the country, which will be accountable for the cost and quality of care during the episode.²⁹ This model set a strong precedent for future financial models tied to episodes of care and is an indication of the shift toward value-based payments.

Not only has CMS developed the models described, state Medicaid and commercial insurance companies have also adopted similar models, which reflect payer goals of providing higher quality, lower cost care. Some bundled payment models have naturally followed into the private insurance setting. In other instances, CMS has engaged with multiple other payers for their proposed models, including in an all-payer payment reform initiative in Maryland.³⁰ The Department of Health and Human Services has set target goals to have 90% of all Medicare fee-for-service payments tied to quality or value by 2018 and, more specifically, 50% of all Medicare payments through alternative payment models by the end of 2018.³¹ The passage of MACRA proves also that there is strong bipartisan support to shift toward value-based payment in the current health care system with its increasing costs.

FUTURE DIRECTIONS

Despite uncertainty about the ACA, change in payment and delivery models have actually been evolving over decades. This has been a response to the consistent increasing cost of care, and questions about quality and value. The ACA has accelerated new payment models, particularly in Medicare through the formation of CMMI. Many of these models, such as bundled payments, PCMH, and some forms of ACOs have been proliferating in the commercial insurance market because these payers have similar concerns about cost and quality. Additionally, many of the pay-for-performance mechanisms are independent of ACA. Finally, independent of politics, the economy and health care system will continue to be tasked with finding ways to reduce the increase in health care costs while maintaining quality and access. As with all other specialties and clinical settings, nonoperative anesthesia will have to demonstrate the quality and value of care provided to payers and patients. This includes measuring the quality and outcomes of care, and identifying ways to better coordinate care and reduce variations of care to minimize unnecessary utilization.

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KEY POINTS

- Increasing health care costs in the United States have resulted in a shift of financial risk to providers for the coordination, quality, and cost of care.
- Although fee-for-service has historically dominated provider payments, newer models, such as pay-for-performance, bundled payments, and accountable care organizations, have the potential for cost savings and quality improvement.
- Regardless of specific policies and payment models, physicians and health systems will need to demonstrate the quality and value of the care they provide.

Fig. 1. National health expenditure spending: 1960 to 2015. (Data from Centers for Medicare & Medicaid Services. National Health Expenditure Data. NHE Fact Sheet. Available at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>. Accessed January 13, 2017.)

Fig. 2. Specialty category by volume, CY 2009 ASC claims. ASC, ambulatory surgical center; CY, calendar year. (Data from U.S. Department of Health and Human Services. Report to Congress: Medicare Ambulatory Surgical Center Value-Based Purchasing Implementation Plan. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/Downloads/C_ASC_RTC-2011.pdf. Accessed January 26, 2017.)

Fig. 3.
Spectrum of provider payment models.

Table 1**Bundled payment models**

	Model 1	Model 2	Model 3	Model 4
Episode	All DRGs: all acute patients	Selected DRGs: hospital plus postacute period	Selected DRGs; postacute period only	Selected DRGs hospital plus readmissions
Services included	All Part A services paid as part of the DRG payment	All nonhospice Part A and B services during the initial inpatient stay, postacute period, and readmissions	All nonhospice Part A and B services during the postacute period and readmissions	All nonhospice Part A and B services (eg, hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

From Centers for Medicare & Medicaid Services. Bundled Payments for Care Improvement Initiative (BPCI). Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-04-18.html>. Accessed January 18 2017; with permission.