Market Evaluation

Finances, Bundled Payments, and Accountable Care Organizations

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KEYWORDS

• Health care • Health economics • Bundled payments
• Accountable care organizations • Anesthesia

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.

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

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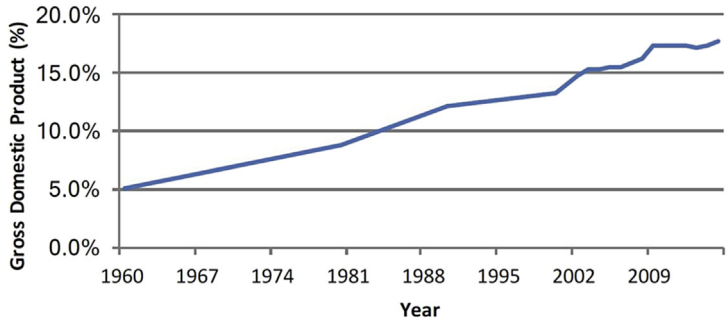

Fig. 1. National health expenditure spending: 1960 to 2015. (*Data from* Centers for Medicare & Medicaid Services. National Health Expenditure Data. NHE Fact Sheet. Available at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.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

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]

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