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HEALTH CARE INSIDER

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RECENT OBSERVATIONS BY THE GOVERNMENT ACCOUNTABILITY OFFICE ON MEDICAID MANAGED CARE

A few months ago, we spoke about the proliferation of Medicaid managed care across the United States. A majority of states had or were planning to implement managed care payment systems for Medicaid enrollees. As you may recall, the overriding reasons for the changes were cost savings and moving patients into the lowest level of care as quickly as possible. In addition, managed care is attractive to states because it provides greater predictability of costs. But some recent studies performed by the Government Accountability Office (GAO) seem to suggest that those expectations for lowering costs may be optimistic.

One of the studies looked at Medicaid payments to physicians under Medicaid fee-for-service and Medicaid managed care for certain evaluation and management services, such as office visits and emergency care. Although Medicaid payments under both payment schemes were lower than payments under private insurance, Medicaid managed care payments were equal to or higher than Medicaid fee-for-service payments. This suggests that shifting beneficiaries from fee-for-service to managed care may have actually increased Medicaid spending on average.

The other study looked at the integration of Medicare and Medicaid benefits for disabled dual eligible beneficiaries. Disabled dual eligible beneficiaries are those individuals who are disabled, under age 65, and qualify for both Medicare and Medicaid benefits. Recently, both Congress and the Centers for Medicare and Medicaid Services (CMS) have been emphasizing benefit integration for all dual eligible beneficiaries whether disabled or elderly. CMS has started a financial alignment demonstration project which is expected to improve care and reduce program spending.

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IT IS CLEAR THAT MORE RESEARCH IS NEEDED BEFORE CLAIMS CAN BE SUBSTANTIATED ON A NATIONWIDE BASIS.

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The GAO examined (1) spending, utilization and health status, (2) the extent to which integrated dual eligible special needs plans (D-SNP) provided high quality of care while controlling costs and (3) D-SNP and traditional Medicare Advantage plans' performance based on quality and resource use measures. Dual eligible beneficiaries accounted for less than 20 percent of each program's population but greater than 33 percent of each program's spending. Overall spending was driven largely by Medicaid spending. States with high Medicaid spending often had lower Medicare spending but almost always had greater total spending for these beneficiaries.

Because Medicare and Medicaid programs are separately responsible for covering certain services for dual eligible beneficiaries, there may not be an incentive for one program to help control the costs in the other program. For example, Medicaid programs do not pay for most of the cost of acute care so there is little incentive for states to ensure that nursing facilities provide a level of care that will avoid unnecessary hospitalizations. In contrast, in order for a patient/resident to be covered by Medicare in a nursing facility, they must have been a patient in a hospital for three days or more prior to their admission to the nursing facility. Medicare typically pays more than Medicaid, therefore the nursing facility benefits financially if the resident was hospitalized prior to admittance. Does this mean the hospitalization was unnecessary? If so, then this can have an effect on quality of care as well as increasing Medicare costs.

In this study of disabled dual eligible beneficiaries, the GAO found that these disabled beneficiaries were less likely to live in an institution than aged dual eligible beneficiaries. However, among those that did, Medicaid spending was significantly higher for the disabled than for the aged. Despite some better performance on health outcomes for both disabled and aged beneficiaries, the D-SNP had similar costly Medicare services as traditional fee-for-service Medicare plans, thus calling into question whether program costs can be reduced significantly.

In 2011, CMS announced a financial demonstration program that is intended to align Medicare and Medicaid services and funding to reduce costs and improve quality of care for dual eligible beneficiaries. Most states participating will use a capitated model. Under this model, CMS and states will pay health plans a single capitated payment to provide all Medicare and Medicaid benefits to enrolled dual eligible beneficiaries. It is expected to result in savings in the Medicare program by reducing hospital admissions, emergency room visits and skilled nursing care, and in the Medicaid program by reducing costly long term nursing home care.

Some states report they are saving money through managed care plans, some of which limit patients to a specific network of medical providers. Generally, states that paid medical providers high rates were able to save money, while those states that reimbursed providers on the low end ended up with higher costs in the program. Over time, Medicaid managed care may save money through preventative care and managing patients' conditions, but are not likely to save in the short term. In addition, no state implemented Medicaid managed care in the same way, thereby making it difficult to draw broad conclusions about the state's overall success in reducing costs.

It is clear that more research is needed before these claims can be substantiated on a nationwide basis. We cannot rush to any conclusions just yet. These were two studies that looked at very limited services or populations.

By Richard Lipman, CPA
National Health Care Practice Leader

ACCOUNTABLE CARE ORGANIZATIONS

With the signing of the Patient Protection and Affordable Care Act in March 2010, one area of the law that was not greatly discussed at the time was a new health care organization known as an Accountable Care Organization (ACO).

WHAT'S AN ACO?

Accountable Care Organizations (ACOs) are groups of providers (doctors, hospitals, and other health care providers), who coordinate care and accept responsibility for the care of a population of patients.

The goals of an ACO are to:

- Improve the health of the population using evidence-based medicine
- Enhance the patient experience of care (including quality, access and reliability), while encouraging patient engagement
- Reduce, or at least control, the per capita cost of care

The objective of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

When an ACO succeeds in both delivering high quality care and spending health care dollars more wisely, it will share in the savings it achieves for the program. This is also known as value based pricing or risk sharing.

One of the driving reasons for creating ACOs was that the cost of the traditional Preferred Provider Organizations (PPO), Point of Service (POS) plans, Exclusive Provider Organizations (EPO) and some types of HMOs costs were increasing due to the fee-for-service payment system. There was a general consensus among insurance companies and medical providers that a more efficient system could be developed that would limit the drastic increases in cost that healthcare has experienced over the last number of years.

FOCUS OF ACOs

Doctors have traditionally treated each patient on the basis of need. In many cases the doctors are at a disadvantage because many patients don't see a doctor on a regular basis. Serious conditions go undetected that otherwise could have been negated if treated earlier. The main focus of the ACO model is to have medical providers interact on a regular basis with their patients in order to eliminate serious and costly future medical conditions.

ACOs focus on primary care which would include internal medicine, family medicine, general practice and pediatrics. Specialty physicians participate in the following areas: cardiology, endocrinology, oncology, pulmonology, gastroenterology, rheumatology, nephrology, and OB/GYN. The ACO will enter into a contract with an insurance company and together they will develop a set of matrices based upon evidence-based medicine as a means to improve the population health of the ACO patients. Some of those matrices are as follows:

- Outpatient surgeries/procedures performed at preferred (ambulatory) facilities
- Reduction in avoidable hospital readmissions for medical and behavioral health
- Avoidable emergency room utilization
- Ambulatory condition admissions
- Non-trauma admissions
- 30-day readmissions
- Outpatient laboratory tests/services
- Radiology services at preferred (freestanding) facilities
- Generic prescribing rate
- Improvement in breast cancer screening
- Improvement in colorectal screening
- Improvement in cervical cancer screening
- Improvement in diabetes Hba1c screening
- Higher flu vaccination rates
- Higher pneumonia vaccination rates
- Improved diabetes/lipid screening
- Other preventive care measures

The ACO will be judged on the basis of how well it succeeds in having patients comply with the matrix. It is believed that if these matrices are followed by the population that costs will be reduced and the overall population will be healthier.

ACO PAYMENTS

The ACOs compensation from the insurance company will work in the following manner. At the time the service is performed by the ACO, they will receive a payment for the service. However, at the end of the contract year that the ACO has with the insurance company, a complete analysis will be done to determine if the ACO successfully achieved their matrix. If this is the case, the ACO then receives additional compensation because of the matrices' success. Some ACOs have had early success in both controlling the health of the population and receiving their additional compensation. As an example, AETNA's Medicare Advantage Program reduced hospital admissions by 45 percent and hospital days by 50 percent and have stated that this produced an annual savings per ACO patient of $600.

PROPONENTS/DETRACTORS

As with other aspects of the Affordable Care Act, the ACO has its detractors as well as proponents. Proponents of ACOs state that additional payments will have to be paid by the plan sponsor whether fully-insured or self-funded. These additional payments would only be made if the ACO achieved success with their matrices. It is anticipated that medical cost should be reduced by 5 percent to 8 percent. Generally, most insurance companies collect the additional premium in the course of the year. If, as an example, the ACO does not successfully manage their matrix, then the ACO will not receive additional payment. However, fully-insured plan sponsors will not receive a refund of the additional premium paid. Self-funded

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plan sponsors will receive all or a portion of the additional premium that they paid if the ACO is unsuccessful. Detractors state that the matrices that have been developed should be a part of the normal routine of a competent medical provider. Medical providers state that they do not have the staff to treat patients in this manner due to the current fee structures they work under. However, the key complaint that detractors have is that there is no way to measure the claims of reduced cost. As an example, if an individual is told to have a colonoscopy and receives negative results, how is the cost savings determined? There is no way to measure if this action reduced cost.

ACOs recognize in order to have negotiation power with insurance companies – they need to have critical mass. Over the last four years, ACOs have been buying physicians' practices and hospitals in order to gain this critical mass. Clearly, if an ACO is a major player in a geographic region, they will be able to negotiate enhanced terms with insurance companies. Some detractors state that "bigger is better" really doesn't serve the patient. It also must be stated that if the ACO doesn't achieve matrix success, then they will not receive additional payment no matter how large or small they are.

CONCLUSION

Blue Cross, AETNA, United HealthCare and CIGNA are all heavily involved in developing ACO relationships. Additionally, Medicare and Medicaid will be adopting ACOs as their primary delivery system. As is the case with most of the Patient Protection and Affordable Care Act, only time will tell how effective this new delivery system will be in delivering cost efficient and competent health care.

By John DePalma, MPH
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PROVIDING VALUE TO THE HEALTH CARE INDUSTRY

Today's growing and advanced health care industry is a fast-paced environment where regulatory issues, competition, and rapidly changing consumer expectations converge. Managing risks and realizing opportunities becomes a more important focus as health care organizations decide how they will adapt and evolve their business models for long-term survival.

Ensuring today's actions will lead to achieving long-term goals can be a major challenge for anyone. Many health care organizations are unable to address the issues at hand and consider the "big picture" because they are overwhelmed with urgent matters and patient care. UHY LLP's National Health Care Practice brings an understanding of the industry together with innovative solutions that have a positive impact on bottom line. We understand the challenges facing health care providers and facilities.

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