

Academic Articles & Reports Round Up: March 2016

Happy Spring! A common theme among the healthcare articles and reports, published in March, was payment reimbursement systems (fee-for-service versus value-based systems) and Accountable Care Organizations (“ACOs”). In addition, typical healthcare topics were also reported on. These include healthcare cost|insurance cost|healthcare competition|and suggested improvements for the United States healthcare system. As a bonus, a few articles and reports focused on healthcare cost and competition issues in other countries.

FEE-FOR-SERVICE REIMBURSEMENT MODEL

Health Affairs posted an article entitled [Fee-For-Service, While Much Maligned, Remains the Dominant Payment Method for Physician Visits](#). The article’s authors found that, despite the recent reform to shift provider reimbursement from fee-for-service to a risk-based alternative, fee-for-service remains the dominant reimbursement method. The authors further point out that, not only does fee-for-service remain the dominant system, it has also continued to grow in recent years.

Then, The Business of Geriatrics journal published an article that poses the question, [Fee for Service: Will It Ever Die?](#) In this article, the author explains why he doesn’t think the Medicare fee-for-service reimbursement system will be replaced by an alternate method in the near future. Given his prediction, the author goes on to explain how clinicians who service geriatric patients can continue to care for their patients while bringing in an “adequate revenue stream” and how clinicians can leverage fee-for-service payments in managed care environments.

ACOs

Health Affairs published an article entitled [Hospitals Participating in ACOs Tend to Be Large and Urban, Allowing Access to Capital and Data](#). The article's authors analyzed ACO composition and found that 20% of hospitals, in the United States, were part of an ACO, in 2014. They also found that hospitals that were most likely to participate in ACOs were those: in urban areas (versus rural areas)|that were non-profit (versus for-profit or government owned)|or that had a small number of Medicare patients, respectively. The authors also found that the ACOs that included hospitals offered more comprehensive patient services, but the authors did *not* find that ACOs were any more able, than a non-ACO hospital, to manage patient care.

Health Affairs also published an article entitled [Variation In Accountable Care Organization Spending and Sensitivity to Risk Adjustment: Implications for Benchmarking](#) that analyzes spending targets ("benchmarks") for ACOs. The authors explain that ACOs vary widely in the amounts they spend on healthcare, as compared to non-ACO providers. As such, the authors concluded that ACOs should implement measures to "equilibrate benchmarks between high- and low-spending ACOs" to maintain participation by ACOs with high spending and to mitigate patient risk selection (e.g., choosing to service healthy patients over sicker patients) and upcoding.

HEALTHCARE COST

The American Journal of Managed Care published an article on [National Estimates of Price Variation by Site of Care](#). The study's authors analyzed insurance claims data, for upwards of 53 million individuals who were covered by employer-sponsored health insurance, between 2008 and 2013. In line with other research, the authors found statistically significant differences in payments among care sites.

The New England Journal of Medicine published an article entitled [Toward Lower Costs and Better Care-Averting a Collision Between Consumer- and Provider-Focused Reforms](#). The article's authors explain that two major healthcare cost reforms have arisen—one that targets providers and one that targets consumers—and that these reforms are on a “crash course” with each other. The authors classify provider-focused reforms as those seeking value-based payment models (e.g., patient-centered medical homes (“PCMHs”) and ACOs). They classify consumer-focused reforms as those that seek cost-sharing and reduced healthcare utilization (e.g., high deductible health plans (“HDHPs”)). The issue lies in the notion that provider-focused reforms rely on patients engaging with their providers (usually through a primary care practice), whereas consumer-focused reforms incentivize patients to limit healthcare services. The authors are convinced, however, that state healthcare marketplace models that standardize health benefits and incentivize the utilization of high-quality, accessible primary care (like that of California, Connecticut, Oregon, and Massachusetts), may be the key to avoiding a collision of reforms.

INSURANCE COST

The Urban Institute published a report entitled [Marketplace Plan Choice: How Important Is Price? An Analysis of Experiences in Five States](#). In its study, the Institute sought to determine which marketplace plans consumers were purchasing most. The Urban Institute analyzed marketplace enrollment data from five states (California, Rhode Island, New York, Maryland, and Connecticut). It found, in line with previously cited anecdotal evidence that marketplace consumers are “extremely sensitive” to premium price, that low-cost insurers enroll the most consumers. The authors concluded that consumers are most drawn to the lowest-priced plans, but noted, too, that a large number of consumers do choose higher-priced plans.

In addition, JAMA Internal Medicine published an article entitled [Cost-Sharing Obligations, High-Deductible Health Plan Growth, and Shopping for Health Care](#) that explores whether HDHPs lower healthcare spending (1) because patients are incentivized to switch to lower cost providers or (2) because patients are foregoing healthcare services.

HOSPITAL COMPETITION

Manhattan Institute published a report entitled [Keeping Score: How New York Can Encourage Value-Based Health Care Competition](#). The article presents the findings of the Manhattan Institute's case study of New York hospital competition and its effects on commercial payers and patients. After analyzing hospital competition within the state, the Manhattan Institute found three main results: (1) hospital mergers typically result in higher healthcare prices and little improvement in overall quality|(2) those in favor of greater hospital size ignore the fact that many benefits of hospital mergers are actually due to managerial quality and not hospital size|and (3) regulators should employ various methods of competition enforcement—and antitrust litigation should only be one of these tools. The authors urge New York policymakers to consider these findings as they continue to reform New York's healthcare system.

U.S. HEALTHCARE SYSTEM, GENERALLY

The Commonwealth Fund published an article entitled [Better Health Care: A Way Forward](#) wherein David Blumenthal, M.D., President of the Commonwealth Fund, identifies and explains three ways in which he thinks the United States can improve its healthcare system. First, he argues for the broadening of Medicaid to additional states, diversifying the Medicaid population, and maintaining individual mandates. Second, he posits, that the United States must move from a fee-for-service reimbursement system to an ACO and bundled care system. He also argues that this will include finding a way to

“control” prescription drug cost. Finally, he argues, that improved quality (e.g., simplified ways to measure healthcare quality, electronic medical records, etc.) is necessary.

MISCELLANEOUS

The New England Journal of Medicine published an article detailing and analyzing Open Payments Data, from 2013 and 2014, in its article entitled [The Physician Payments Sunshine Act-Two Years of the Open Payments Program](#).

The Italian Antitrust Review published an article on [Competition in Procurement Markets: The Case of Medical Devices in Europe](#). This article analyzes aspects of the European Union’s (EU) Procurement Directives system (which is premised on bidding), its effect on competition in the EU, and its application to the EU’s medical device industry.

PLoS One published an article on the [Impact of Market Competition on Continuity of Care and Hospital Admissions for Asthmatic Children: A Longitudinal Analysis of Nationwide Health Insurance Data 2009-2013](#) in South Korea. The authors concluded that market competition reduces continuity of care and that decreased continuity of care, in South Korea’s healthcare system, was associated with higher odds ratio for hospital admissions. Then, the Asia Pacific Journal of Social Work and Development published an article entitled [Does market competition facilitate resident-centered care among nursing home? A comparative analysis](#)—another healthcare study carried out in South Korea. In this article, the authors examined the impact of competition on both non-profit and for-profit, resident-centered nursing homes. They found that competition is positively associated with non-profit resident-centered care but *not* with for-profit homes.

See you next month!