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Accountable Care Organizations vs. Health Maintenance Organizations

Presented by Integrated Healthcare Strategies
as Authored by Bob Erra, President

The new healthcare legislation includes provisions for Accountable Care Organizations that will try to reduce the costs of treating Medicare patients in return for a share of the savings they achieve. ACOs look and smell a lot like the Health Maintenance Organizations that grew out of legislation passed in the late 1960s. So how do HMOs and ACOs differ? What lessons can we learn from the early years of HMOs that will help providers serve their patients better as ACOs?

Health Maintenance Organizations

The HMO legislation was designed to reduce escalating healthcare costs by encouraging preventive care and creating a system to keep people from self-referring to specialists and out of the hospital. Payers (insurance companies) made fixed, capitated payments to physician organizations and medical groups based on the number of patients they enrolled; a portion of premiums were set aside in a pool to pay hospitals. As an incentive to reduce hospital admissions and average length of stay, physicians were paid 50% of any savings from the hospital pool. Hospitals were paid a per diem for patients admitted. In the early years of capitation, well-run physician organizations earned significant incentive payments by managing patient care to avoid unnecessary hospital admissions and to reduce lengths of stay.

HMOs competed for members (patients) with insurance companies that paid providers based on their volume of services (fee-for-service). The insurance companies were able to pass on the cost of increased volume to clients, mostly employers, in the form of higher premiums. HMOs were able to offer lower premiums because their costs were based not on volume, but on managing the patient's care. For several years, this managed care approach mitigated the escalating cost of healthcare.

The HMO system of care is best demonstrated by Kaiser, Intermountain, and Geisinger. These fully-integrated organizations are both insurers and providers of health care, taking the financial risk for setting premiums while owning the hospitals and employing the physicians who manage the care.

901 MARQUETTE AVENUE S., SUITE 2100
MINNEAPOLIS, MN 55402
phone: 612.339.0919
toll free: 800.327.9335
fax: 612.339.2569

700 WEST 47TH STREET, SUITE 400
KANSAS CITY, MO 64112
phone: 816.795.1947
toll free: 800.821.8481
fax: 816.795.0301

Accountable Care Organizations

Accountable Care Organizations are integrated delivery systems that rely on a network of primary care physicians, one or more hospitals, and physician specialists, subspecialists and surgeons. Healthcare reform proposed to implement Medicare ACOs based on a shared savings model to be rolled out in 2012.

To participate, ACO networks must include both hospitals and physicians; their primary care physicians must serve at least 5,000 Medicare beneficiaries (patients); and they must commit to the program for two years. If a participating ACO achieves savings of greater than 2%, these savings are shared 50/50 between the ACO and Medicare.

The ACOs will be managed by insurance exchanges with payments coming from the Medicare program. The insurance exchanges will not bear any insurance risk.

Lessons from the HMO transition

I lived through the transition from fee-for-service to managed care during my tenure at Scripps Clinic. We learned many painful lessons, the most telling being the need to manage patients' expectations as they transitioned to a system of managed care from one where they could self-refer and demand more care, even when it wasn't needed. With the introduction of ACOs, providers will once again be asked to transform the delivery system, and will have to manage patient expectations so they can provide care more cost effectively without compromising quality. Their success in managing expectations will play a big role in determining whether patients are satisfied with the quality and compassion of the care they receive, or whether they will demand access to all levels of care and revolt when it is denied or delayed.

About the Author

Bob Erra is President of Integrated Healthcare Strategies. He can be contacted at Bob.Erra@IHStrategies.com or at 800.327.9335.

About Integrated Healthcare Strategies

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