

Research Article

Achieving Healthcare Value through Care Plan Accountability

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Abstract

U.S. medical costs continue to outpace the GDP despite the introduction of multiple accountable care efforts established to reduce unnecessary expenditures. These increasing costs have a negative impact on patients who are experiencing increased out-of-pocket expenses as well as employers who must shoulder a large part of the healthcare cost burden. While there are multiple societal factors contributing to the rising medical costs, our healthcare system can play a more effective role in addressing this problem. This role begins with fundamental changes to our reimbursement systems placing an emphasis on individual plans of care and adding greater accountability through free market controls. A comprehensive plan of care lays out the roles of care plan participants across medical, social, and behavioral services with a corresponding budget covering all the services provided as well as the expected outcomes from each service. An initial free market control is patient authority to accept or reject the plan of care with a corresponding financial responsibility for compliance in care plan execution. The elements of provider accountability include a public provider performance reporting system across quality, costs and patient satisfaction factors as well as a reimbursement system that incentivizes effective care planning and execution. This shift in focus from incremental care to care planning and execution combined with the institution of pro-competitive and financial accountability measures is expected to bring greater value to healthcare by improving patient outcomes while reducing medical costs.

Keywords

Accountable Care, Competition, Free-Market Controls, Healthcare Value, Plan of Care, Reimbursement System, Transparent

1. Introduction

The State of US Healthcare: The healthcare industry is experiencing much activity around accountable care to reduce medical costs and add greater value to healthcare. In 2024 CMS announced nearly half the population with traditional Medicare are being served through an accountable care organization [1]. Additionally, Medicare now offers a chronic care management service to recipients with two or more chronic conditions, helping to manage these conditions through the coordination of services within their community

[2].

Despite these efforts spending on healthcare in the U.S. continues to increase. Since the first quarter of 2023 hospital spending alone has increased by more than 10%. [3]. Overall healthcare spending is projected to outpace GDP growth moving from 17% to nearly 20% of the GDP by 2032. [4]. With rising costs, patients are carrying a larger burden of their healthcare expenses increasing out-of-pocket healthcare payments by 11% and 6.6% in 2021 and 2022 respectively [5].

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These healthcare costs represent a major source of bankruptcies in the U.S. with 58.5% of debtors citing medical expenses as contributors to their bankruptcy [6]. Patients are not the only ones impacted by the spending increase. Employer's premium contribution for family coverage has increased by 24% since 2019 with the annual employer contribution in 2024 averaging more than \$19,000 [7]. Totalling over \$12,000, the U.S. per capita healthcare spending in 2022 exceeded the average spending of comparable countries by 89% [8]. Meanwhile, the U.S. population's life expectancy was the lowest among these countries [9].

We cannot attribute all the healthcare spending challenges to the healthcare industry. There are many contributing factors including an aging population, sedentary lifestyles, and unhealthy diets as well as continuing innovations to address the results of these factors. However, we can look to the healthcare system to play a role in addressing the problem. Restructuring the fee for service payment system represents a critical step toward pursuing this role. The current fee for service system has evolved from a government and other third-party payer system which removes the patient from the role of making informed choices based on the perceived value and costs of those choices. The result has been an unaccountable healthcare system as well as unaccountable patients. Current efforts to insert accountability into the healthcare system through big data and sophisticated quality process measures continue to leave patients out of the equation and fail to take advantage of natural free market controls. Rather than continuing to build structures around this flawed system perhaps we should step back and ask what true accountable care should look like and consider supporting an infrastructure which increases the consumer's role in making healthcare decisions.

The following terms come to mind when identifying the characteristics of a truly accountable healthcare system: patient centered, engaged patients, integrated care, health promotion and prevention focused. The system must also offer optimal value for each service provided and corresponding healthcare expenditure. What steps can we take to attain all these characteristics in our health system? It starts with a greater focus on patient care planning and management as well as cost transparency around these plans. In addition, a true accountable care system must insure there are free market controls in place to drive healthcare accountability. These free-market controls must include steps to support informed patient/payer decision making as well as a transparent payment system that increases the emphasis on value while reducing the emphasis on volume.

2. Achieving Patient Centered Care Through Individual Plans of Care

Driven by the fee for service reimbursement system, physicians and hospitals are primarily focused on treating patients

during instances of medical intervention. True patient centered care would transform the reimbursement system to place a greater emphasis on the integrated planning and management of the care for each patient. While these individual plans of care may increase upfront healthcare costs, they will arguably reduce the onset of preventable illnesses as well as much of the redundancy of services to more than offset the additional upfront costs. The level of planning and management as well as the corresponding costs will vary based on each patient's condition.

Annual Plans of care for patients with chronic conditions: Chronic conditions include obesity, hypertension, high cholesterol, coronary heart disease, chronic obstructive pulmonary disease, kidney disease, diabetes, and cancer. This category represents an increasing segment of the US patient base with 42% of the population having two or more chronic conditions [10].

The primary care physician would be expected to provide an annual plan of care for each patient. This plan would take into consideration the patient's conditions and when necessary, involve specialist and community services collaborations. The annual plan of care would include the following:

1. The objectives for the care to be provided with the tangible outcomes for the patient if the objectives are met.
2. An identification of the medical services to be provided to the patient throughout the year with the corresponding costs. These integrated care plans will require active input from all the specialists who care for the patient as well as all the facilities (hospitals, SNFs etc.) needed to deliver the services. All these participants in the episode of care may be considered cost centers who must compete by optimizing the value they deliver in exchange for the payments they receive.
3. An identification of the social and economic needs of the patient throughout the year with references to sources for getting those needs met. Currently, less than half of solo physician practices coordinate care with community social services citing paperwork and inadequate staffing as barriers to serving in this role [11]. The reimbursement system must be updated to provide funding for these services.
4. An identification of the specific duties of the patient in making the annual plan a success with the corresponding financial consequences for the patient should he/she not comply with the plan. (Note: Patient engagement is best achieved with financial incentives).
5. A care management plan which identifies the investment of time and resources to execute the plan of care and detect variations from the plan as soon as possible. For this approach to be successful there must be resources invested in executing the plan of care. Depending on the plan and the health of the patient, this investment could be as little as an annual preventative check-up to daily phone calls and in-home monitors to allow for early detection and interventions. This care

plan implementation service should be included in the plan of care and adjusted as needed throughout the episode based on changes in the patient's condition. These services should be included in the cost of care for each patient.

6. An annual care plan budget with an itemized costing of all the services to be provided to the patient. Once again, the direct impact of increased costs on the non-compliant patient should be emphasized.

The introduction of artificial intelligence to the practice of medicine supports individual care plan development and execution. Precision medicine is expected to improve care plan effectiveness as well as reduce the manual effort required to establish individualized care plans [12]. Meanwhile, "intelligent" telehealth, using wearable sensors will significantly improve care plan tracking capabilities [12].

Surgical Plans of Care: In an analysis of 2014 Medicare claims data researchers found surgical care represented 51% of Medicare program spending [13]. Accordingly, efforts to reduce healthcare spending must include a focus on surgical care.

The surgical plan of care contains the same components as the annual plan for patients with chronic conditions but only covers the surgical global period. This global period consists of the surgical day plus 10 Days post-surgery for outpatient cases or 90 days post-surgery for inpatient cases. In elective cases this plan may include pre-surgery requirements which set certain expectations on the patient for improving their health status prior to surgery to improve the probability of an optimal outcome. In addition, the physician must set clear expectations for the patient during the global period to insure an optimal recovery. Once again, the patient must accept responsibility for extra costs due to patient non-compliance. For emergency surgeries the global period of care plan must be developed after the surgical case is completed and must give greater latitude for variation given the higher level of unknowns and uncertainties in these situations.

Well Patient Plans of Care: Ninety percent of U.S. healthcare expenditures are for those with chronic and mental health conditions [14]. Our healthcare providers must place a strong focus on the healthy segment of the population to prevent the onset of chronic disease and reverse the growth in spending.

The well patient plan of care also contains the same components of the annual plans for chronic patients. However, this plan is much more prevention oriented. These plans will place a much greater emphasis on patient lifestyle responsibilities to promote health and prevent the onset of chronic conditions (ex. heart disease, cancer, obesity, diabetes, respiratory disease, strokes). We would expect these individualized plans to consider patient and family history. Patient non-compliance in these cases should have insurance premium consequences.

3. Establishing an Accountable Care Structure

Front End Competition: The patient and the payer have a pro competition role to play in this equation. If either is not satisfied with the plan – services, costs, patient's role or expected outcome they would be expected to get a second or third opinion. Adding this competitive step into the equation on the front end places a burden on the provider to contain costs, not overstate the patient's role and not understate the expected results. Ultimately the plan of care with the corresponding care plan budget must be agreed to by the patient and payer to move forward.

Performance Reporting on Quality, Service and Cost: Public reporting of physician and health system performance must be instituted to support informed consumer decision making and promote healthy competition for medical services. This reporting system must be designed in a way where patients find it easy to access and understand performance when selecting a physician for their care. A simple system with three sets of measures would serve this purpose. The first measure would be the percentage frequency of adverse events. This measure would cover the quality basics. For example, in surgery cases both unplanned returns to surgery and surgical complications would be considered adverse events. The second measure would consider the average percentage variation between the planned care and actual services provided. This factor would be measured as a percentage of costs and must be identified for each patient. The composite variation in actual to planned costs should be a performance measure reported and made public for every physician. The final set of competitive measures should come from a simple patient survey conducted by the payer at the end of the episode of care. This survey would involve three simple questions with the sole purpose of identifying overall performance. The intent of this survey is not to identify specific areas for improvement. Providers may want to conduct additional, more detailed surveys to help them know where to improve. The three questions will obtain patient feedback on how well the physician and healthcare team did in meeting the following expectations:

1. Service – Responsiveness, courtesy and respect, access and wait times.
2. Quality – Achieving the objectives established in the plan of care.
 - a) Chronic care: improvement in health status, frequency, and duration of illness.
 - b) Surgery: Recovery time, Level of recovery, duration, and level of pain.
 - c) Well care: improvement/maintenance of health status, frequency, and duration of illness.
3. Costs – Costs include total episode of care costs and the patient's portion of the costs. The cost factor will gain increasing importance for patients as they continue to pay a greater portion of the costs out of pocket.

The patient satisfaction survey should include a five-point

response ranging from did not meet to exceeded expectations. Once again, the composite patient satisfaction scores should be a performance measure reported and made public for every physician. These results focused performance measures will put the burden on the physician to ensure cost expectations are not understated while service and quality expectations are not overstated. Public reporting of these easily understood measures is an effective pro-competitive step supporting the free market in healthcare allowing patients and/or payers to make informed decisions.

Reimbursement: The reimbursement structure plays a vital role in aligning the healthcare delivery system with desired results. The current fee for service structure is a primary driver in the volume driven health system we have today. A new structure must be established which rewards productivity, outcomes, and efficiency. As we explore a change in reimbursement to incentivize the effective execution of the bundled care system an immediate question is how we pay for all these additional services. Studies have found 25% to 30% of healthcare costs are wasteful spending [15]. Accordingly, we do not need extra dollars to pay for the bundled care system. We pay for the additional services by redirecting wasteful healthcare spending to services that offer value with the expectation that total spending will drop when the right incentives are established in a pro-competitive free market system. In the current fragmented system, the patient/payer receives bills from many providers during the episode of care. As a result, it is difficult for the patient to monitor their total costs of care. A pro-competitive system must provide the patient with a total cost of care plan with the risk for variation placed on the healthcare providers unless the variation was driven by patient non-compliance with the plan. The most effective reimbursement system should place a large part of the risk and reward on the primary driver of costs and success. Other than the patient, the primary driver in most, if not all medical care, should be the physician providing and directing the care. Incorporating cost risk for the physician will require two steps. First the physician must be able to defend any cost variations. If the extra costs are due to redundant or unnecessary services, they should not be paid. The second step will involve direct payment risk for the physician. In the bundled care approach, the physician planning and directing the management of the episode of care may be offered two times his/her current rate for professional services. However, payment of this fee should be broken into two parts. One half of the total should be paid upon delivery of care while the other half should be paid based on results. Factors having an impact on the second payment are:

1. **Quality and safety:** If certain basic quality and safety levels are not met there is no second payment. In the case of surgical procedures, the exceptions to basic quality include surgical complications, unplanned returns to surgery, and unplanned readmissions within 30 days.
2. **Service and Cost Variation:** By conducting a compari-

son of the actual care delivery with the individualized plan the payer should be able to identify variation from the plan. Any additional costs related to non-value-added variation from the plan should be deducted from the physician's second payment.

3. **Patient Satisfaction:** A true patient centered model must include financial incentives to properly establish and then meet the patients' expectations. As noted above the patient satisfaction survey should include a five-point response ranging from did not meet to exceeded expectations.
4. **Payment on the balance remaining after the service variation deductions may be determined based on the following composite score from the three survey questions.**

Table 1. Satisfaction Survey Scoring.

Score Definition	Composite Score	Percent of Payment
Did not meet expectations	< 2.0	0 %
Most expectations were not met	2.0 – 3.0	50%
Most expectations were met	3.0 – 4.0	90%
Met all expectations	4.0 -5.0	100%
Exceeded expectations	5.0	110%

For surgical care, all claims should be accumulated, and the patient surveys conducted by the payer after the completion of the global period. The results from basic quality measures, variation from the plan and patient expectation scores will determine the amount to be paid to the surgeon. In the case of chronic and well care management, a quarterly claims assessment should be conducted by the payer to determine interim results. These results will be the basis for quarterly outcomes-based payment to the primary care physicians. The payer will conduct an end of the year cost variation assessment as well as a patient satisfaction survey to determine the physician's net payment annually.

4. Conclusion

This true accountable care solution addresses the flaws of the healthcare system by placing an emphasis on care planning and execution for each individual patient, as well as adding free market controls to healthcare decision making. The individualized care plans take advantage of the physicians' knowledge of each patient's condition and circumstances to establish a specific set of services designed to optimize the patient's health. The care plan execution phase manages the delivery of services as planned and assures early intervention when patient conditions change. In addition, this

patient centered planning structure combined with bundled payment-based fee transparency inserts front end competition where patients and/or payers can shop for the highest value care plans. By making healthcare costs transparent to the patient this solution incentivizes the reduction of wastes in healthcare and promotes patient engagement in healthcare decision making. This system also adds public reporting of provider performance, using measures that are easily understood by patients to promote competition and enhance system accountability. Finally, the system adds financial accountability to healthcare by assigning the financial burden of quality and cost variations to those responsible for driving the variation. This financial accountability is expected to generate a significantly higher level of provider team and patient engagement in executing the care plans, leading to improved outcomes and reduced costs.

Abbreviations

CMS	Centers for Medicare and Medicaid Services
GDP	Gross Domestic Product
U.S.	United States
SNF	Skilled Nursing Facility

Author Contributions

John Rezen is the sole author. The author read and approved the final manuscript.

Conflicts of Interest

The author declares no conflicts of interest.

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