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The Role of the Affordable Care Act in Payment Reform

By Juliet Spector

The Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama on March 23, 2010.[1] The law challenged the existing health care system through sweeping reforms related to making coverage more accessible, expanding covered services and benefits, and reducing costs, along with curbing the high medical cost trend and improving health outcomes. The ACA proposed various changes related to payment reform. These changes were an attempt to not only achieve a lower cost of care, but also to increase both the accessibility and quality of medical care.

Even with these goals, the ACA was not necessarily the catalyst for payment reform, but happened in sync with trends that were already brewing in the provider market. The long-standing provider payment model of fee-for-service (FFS) was losing its effectiveness for some providers. Commercial utilization rates were starting to flatten and reverse, making the FFS model less reliable for assuring providers earned the revenue levels upon which they depended (a provider's FFS revenue decreases with decreasing utilization). In addition, the growing Medicare population (along with the aging of the population) and the expansion of Medicaid[2] to millions of new people due to the ACA also intensified financial pressures on health care providers because both Medicare and Medicaid pay for services at lower rates than commercial plans. These factors are contributing to more providers taking on risk and ultimately influencing the overall treatment patterns of the population. Along with the enactment of the ACA, physician integration, quality improvement and information technology (IT) infrastructure investments are making it easier to design and implement payment models that depart from the standard FFS design to help providers better manage these risks while still maintaining the overall quality of care of the population.

OVERVIEW OF ACA PAYMENT REFORMS

In concert with these changes, the ACA introduced its own payment reforms, including:

Reforms regarding quality improvement

- Establishing the Medicare Hospital Value-Based Purchasing (VBP) program:

  VBP programs allow acute care hospitals to receive rewards, or incentive payments, for providing care that improves the health outcomes for patients (programs like this are also known as "pay-for-performance").

- Strengthening quality for Medicare Advantage:

  The ACA also established incentives for Medicare Advantage programs through several channels: establishing bonus payments for programs that can show increases in managed care, especially for patients with chronic conditions; identifying gaps in coverages for current beneficiaries and non-covered members in surrounding service locations; and improving general quality through educating staff, technological improvements, and providing additional support in the form of nurses, physicians, etc.

Reforms regarding accessibility

- Creating programs that address primary care shortages and support the building of the health care workforce:

  The ACA includes measures to address the accessibility of health care services—for instance by examining the health care workforce and assessing how the government can support its appropriate training.

- Adding a temporary increase in Medicaid payments for primary care doctors (from Jan. 1, 2013, to Dec. 31, 2014):

  To boost the incentive for primary care physicians to better manage care, the ACA established incentive payments of up to 10 percent of the total amount for certain qualified services.

- Increasing payments for rural health care providers:

  The ACA extended the Rural Community Hospital Demonstration Program created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. One of the largest efforts to analyze accessibility in low-utilization, low-access areas was establishing the study by the Medicare Payment Advisory Commission (MedPAC) on adequacy of Medicare payments for health providers in rural areas.

- Requiring commercial health plans to meet specific criteria in terms of distance and mix of specialties in establishing provider networks.

Reforms regarding affordability and cost

- Establishing the Independent Payment Advisory Board (IPAB) to monitor Medicare cost trends
- Addressing the benefit discrepancies between a Medicare FFS beneficiary and a Medicare Advantage beneficiary
- Reducing unnecessary paperwork and administrative costs.

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Reforms regarding affordability and cost and quality improvement

- Establishing the Center for Medicare and Medicaid Innovation (CMMI, or Innovation Center):

  The ACA established the CMMI under the Centers for Medicare and Medicaid Services (CMS) to encourage and promote the development of payment delivery models that attempt to improve patient outcomes through several channels. Examples of the innovations these models promote include: more efficient coordinated care, increased risk sharing among physicians and hospital groups, fostering collaborative institutions that promote best practices for improving the quality and cost of care for beneficiaries, and generally to increase managed care services that monitor and improve patient health status.

Each of these payment reforms targets one or more of the three main problems facing the health care system: achieving a higher quality of health care, increasing or maintaining current levels of accessibility for beneficiaries, and reducing cost by either cutting wasteful expenditures or controlling payment rates. It is difficult to succeed in all three simultaneously because improving quality and access will typically result in increased expenditures from hiring more experienced staff or providing more training and monitoring for quality control. Likewise, reducing costs can potentially lead to less accessibility if high-cost, low-utilization procedures are strategically consolidated or relocated in larger hospital groups—for instance from a rural to a more urban setting.

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The ACA has made substantial headway in the transformation of Medicare and Medicaid programs, one of the driving forces toward payment reform. These changes have created trickle-down effects in the commercial market. Certain programs from the ACA, such as the Medicare Shared Savings Program (MSSP) and the Bundled Payments for Care Improvement (BPCI) pilot, have served as frameworks for programs emerging in the commercial market. However, reduction in payments in the Medicare and Medicaid markets incentivizes some providers to seek other sources for offsetting shortfalls, most typically commercial market reimbursement levels. Effectively, through its dictating public program provider payment levels, the government has apportioned the challenge to control costs to private health insurance plans. ■

This article was prepared on behalf of the Society of Actuaries (SOA) from various published reports, interviews and other sources to provide information on provider payment reform, as well as to stimulate discussion about the ability of the ACA to achieve higher quality and lower costs in our healthcare system. The article is not intended for other purposes and the reader should seek qualified professional advice appropriate to their own specific needs. The statements contained in the report are those of the authors and do not necessarily represent the views of Milliman or its other consultants.

ENDNOTES

1. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).
2. The expansion of Medicaid has resulted in fewer charity cases and higher revenue from people who were previously uninsured. However, the trade-off is that the Department of Health and Human Services (HHS) restructured uncompensated care payment by cutting disproportionate share hospital (DSH) payments and adding a new type of payment *(http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html)*. Fewer charity cases for the hospital could jeopardize its not for-profit status. In addition, some providers and hospitals have invested resources in educating their patients on expanded coverage and helping them enroll. Providers in non Medicaid expansion states had their DSH payments cut without receiving the extra bump from expanded coverage but may have received additional uncompensated care payments. It is difficult to generalize how exactly this will net out.

Juliet Spector, FSA, MAAA, is a consulting actuary at Milliman in Chicago, Ill. She can be reached at *juliet.spector@milliman.com.*