Affordable Care Act

Educational Briefing

Executive Summary

The Patient Protection and Affordable Care Act, otherwise known as the ACA, is the comprehensive health care reform bill passed by Congress in March 2010. The law reshapes the way health care is delivered and financed by transitioning providers from a volume-based fee-for-service system toward value-based care. Through a series of new programs, regulations, fees, and subsidies, the ACA seeks to achieve a triple aim of better population health, lower per capita costs, and elevated patient experience.

Why is the ACA a key issue for providers?

The ACA addresses cost, quality, and access problems in the current U.S. health care system. Rapidly growing health costs have strained the abilities of individuals, government, and employers to finance routine coverage. While health care costs continue to escalate, millions of un- and underinsured lack access to preventative care. In addition, the current fee-for-service system is inadequate in delivering high quality care to entire populations. Although the ACA's regulatory requirements will likely add short-term costs, the Congressional Budget Office (CBO) projects that the law's payment and coverage changes will likely lead to lower Medicare spending in the long-term.

How does the ACA work?

The ACA uses a series of incentives, taxes, and payment programs to emphasize payment for quality outcomes and the elimination of unnecessary spending. It also attempts to provide insurance access to more Americans.

The ACA's payment initiatives offer bonuses and penalties to hospitals based on their ability to improve quality and cost of care. These include mandatory quality programs which make a portion of a hospital's Medicare payments contingent on clinical quality. Examples of such programs include **Value-Based Purchasing (VBP)**, the **Hospital Readmissions Reduction Program (RRP),** and the **Hospital-Acquired Conditions Reduction Program (HAC)**. The law also experiments with voluntary payment programs that attempt to align the incentives of providers and payers, such as **Bundled Payments** and **Shared Savings**.

Key Features of the ACA

	Affordable Care Act Program
Payment/ Quality	• Bundled Payments for Care Improvement
	• Shared Savings
	• Value-Based Purchasing
	• Readmissions Reduction Program
	• Hospital-Acquired Condition Reduction
Delivery	• Accountable Care Organizations
Coverage	• Medicaid Expansion
	• Health Insurance Exchanges

Payment and delivery innovation come together in one of the law's key provisions, the creation of **Accountable Care Organizations** (ACOs) under the Medicare Shared Savings Program (MSSP). MSSP ACOs are formed by the union of one or more providers with Medicare. The providers are assigned a population of Medicare beneficiaries and are responsible for managing the cost and quality of those beneficiaries' health care. While they continue to receive payments for each procedure they perform (known as fee-for-service), these ACOs also receive a shared savings bonus based on how effectively they can limit total costs and meet quality metrics. Meanwhile, the ACO model's clinical and financial potential has led many hospitals and physician groups to form private ACOs with commercial insurers.

While transforming standards for health care payment and quality, the ACA also attempts to expand the number of Americans who have insurance. Through **Medicaid Expansion** the law extends federal money to states to encourage them to expand Medicaid eligibility to all individuals and families with incomes up to 138% of the poverty line, a proposal about half of state governments have accepted. In addition, the law contains employer and individual mandates—backed up with small fines—to encourage the purchase of insurance. The tax bill signed into law by President Trump in Dec. 2017 repeals the individual mandate penalty, effective 2019. Under the ACA, eligible individuals are allowed to purchase their insurance through **Health Insurance Exchanges** (also known as “Marketplaces”), selecting from private insurance plans. The government offers many individuals subsidies so they will be able to afford insurance.

Questions That Hospital Executives Should Ask Themselves

1. How have ACA payment initiatives altered my financial imperatives?
2. What steps will I take to transform clinical delivery to prepare for the shift toward value?
3. How will increasing emphasis on quality metrics affect my relationship with vendors?

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Source: Advisory Board Research and Analysis

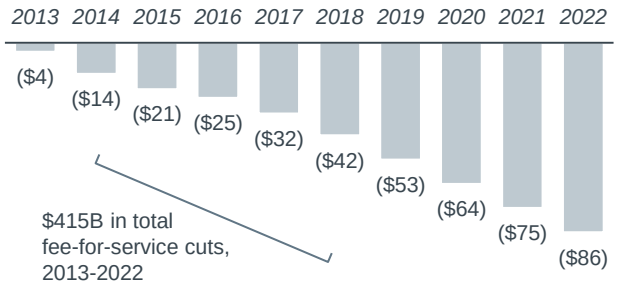
How does the ACA affect providers?

Clinical

The ACA makes providers more financially responsible for the cost and quality of care provided and encourages better coordination among providers. Hospitals face the dual challenge of making their episodic health care more efficient within their institutional walls and also investing in the long-term health of the entire community. This means that providers have to invest in primary care and chronic disease efforts to manage patient health from afar. Providers will need to continue to provide high-quality care, while also reinvesting in the basics of preventative health.

ACA's Medicare Fee-for-Service Payment Cuts

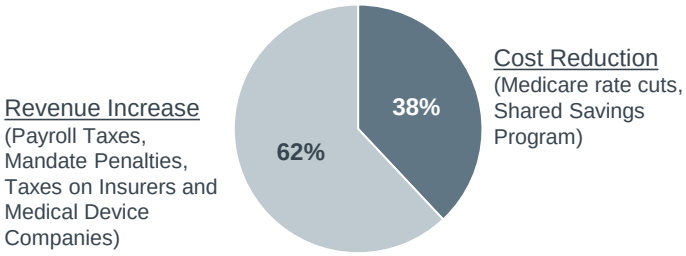
Reductions to Annual Payment Rate[1] (in Billions)



Financial

The shift to risk-based payment makes revenue contingent on value. Relying solely on fee-for-service payments is an increasingly unattractive strategy. The law uses a mixture of cost reductions–such as $415B in cuts to Medicare payments over the next decade–and revenue increases to fund the various tenets of the law. Widespread adoption of new payment models (accountable care organizations, bundled payments, value-based purchasing, etc.) may mitigate some of the negative impact on providers.

Funding for Health Care Reform



Source: US House of Representatives, "Amendment in the Nature of a Substitute to H.R. 4872, as Reported," March 18, 2010.

Operational

A large and complex law, the ACA mainly relies on Health and Human Services (HHS) to monitor and regulate the implementation of the Act's many initiatives. Hospitals administrators will need to overhaul their systems and protocols to effectively record and report the appropriate data to appropriate government agencies. To successfully manage patient health, providers will need to collect, synthesize, and act on patient information beyond what is required. Providers will need to perform the difficult task of segmenting patients based on risk and ensuring they receive the appropriate care.

How might the ACA affect IT?

Managing Chronic Conditions Will Be Key
To keep down costs and improve outcomes, providers will focus on managing long-term health problems such as obesity, diabetes, and hypertension. Hospitals will need innovative technology to help manage these conditions.

Providers Will Look for Cost Savings
The ACA's focus on decreasing per patient cost will inspire hospitals to keep their variable procedural costs low. Hospitals will likely target services, pharmaceuticals, medical devices, and supplies to cut costs. Technology that can drive down hospital costs or expand revenue will be valued.

Hospitals Will Take Divergent Paths
The IT infrastructure must support a variety of payment incentives and models. Some hospitals may enthusiastically become ACOs or participate in Medicare's Bundled Payments for Care Improvement Initiative (BPCI) while others will largely ignore accountable payments in the short-term to maximize fee-for-service revenue. Hospitals will likely use different technologies to achieve population health management goals.

Additional Advisory Board research and support is available

To get key insights on the future of delivery system reform, avenues for radical growth, and how to partner with physicians on enterprise cost control, download our research briefing, "12 Things CEOs Need to Know in 2018."

Source: Advisory Board Research and Analysis