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EDITORIALS

Affordable Care Act Implementation: Implications for Hospital Medicine

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At the Centers for Medicare and Medicaid Services (CMS), we are charged with implementing many of the major provisions of the Affordable Care Act (ACA). Major policies and programs aimed at transforming the way care is delivered and paid for, testing and scaling innovative delivery system reforms, and expanding the number of Americans with health insurance will now move forward. The healthcare system is moving from paying for volume to paying for value. Hospitals and clinicians will need to be able to manage and be accountable for populations of patients and improving health outcomes. In this article, we highlight 4 broad provisions of the ACA that are either already implemented or under development for implementation in 2014, and are anticipated to have widespread impact on our health system. The potential impacts of each provision on hospitals and hospitalists are outlined in Table 1.

EXPANSION OF INSURANCE COVERAGE

The central and perhaps most anticipated provision of the ACA is the expansion of insurance to the currently uninsured through the creation of state-based health insurance exchanges. The exchanges are a competitive marketplace for purchasing private insurance products by individuals and small and large businesses. The individual mandate that accompanies the exchange provision requires that individuals purchase insurance. For those who cannot afford it, the government provides a subsidy. Any health plan that wishes to participate in an exchange marketplace must include at minimum a package of essential health benefits in each of their insurance products, which include benefits such as ambulatory care services, maternal and newborn services, and prescription drugs.[1] Importantly, health plans are required to implement quality improvement strategies and publicly report quality data. The ACA also requires the Secretary of Health and Human Services (HHS) to develop and administer a quality rating system and an enrollee satisfaction survey system, the results of which will be available to exchange consumers. All of these requirements will promote the delivery of high-quality healthcare to millions of previously uninsured Americans.

Implementation of the exchanges in combination with the expansion of Medicaid is expected to provide insurance to approximately 30 million people who currently lack coverage. Prior to the Supreme Court ruling in June of 2012, states were required to expand Medicaid eligibility to a minimum of 133% of the federal poverty level. This expansion is subsidized 100% by the federal government through 2016, dropping to 90% by 2020. The Supreme Court ruled that the federal government could not require states to expand their Medicaid rolls, although it is expected that most states will do so given the generous federal subsidy and the significant cost to states, hospitals, and society to provide healthcare to the uninsured.

TRANSFORMATION OF HEALTHCARE DELIVERY

In addition to the expansion of insurance coverage, the ACA initiates a transformation in the way that healthcare will be delivered through the testing and implementation of innovative payment and care delivery models. The ACA authorized the creation of the Center for Medicare and Medicaid Innovation (CMMI, or The Innovation Center) within CMS. Payment and care delivery demonstrations or pilots that demonstrate a high quality of care at lower costs can be scaled up nationally at the discretion of the Secretary, rather than requiring authorization by Congress. The Innovation Center has already launched initiatives that test a variety of new models of care, all of which incentivize care coordination, provision of team-based care, and use of data and quality metrics to drive systems-based improvement. These programs include pilots that bundle payments to hospitals, physician group practices, and post-acute care facilities for episodes of care across settings. This allows providers to innovate and redesign systems to deliver equivalent or higher quality of care at lower costs. Another CMMI model, called the comprehensive primary care initiative, involves CMS partnering with private insurers to provide payment to primary care practices for the delivery of chronic disease management and coordinated care to their entire population of patients, regardless of payer. Of great relevance to all hospitalists, CMMI and CMS, in partnership with other HHS

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TABLE 1. Potential Impacts of Each Provision on Hospitals and Hospitalists

Affordable Care Act Provision	Example of Potential Impacts on Hospitals and Hospitalists
Expansion of insurance coverage	Care for fewer uninsured patients/fewer unreimbursed services
	Patients have improved access to services after discharge
	Shorter lengths of stay due to better access to outpatient services and care
Delivery system transformation	Financial incentives aligned between inpatient and outpatient providers to better coordinate care
	Payment is at risk if performance rates do not meet benchmarks and if costs are not lowered
	Consolidation of hospitals and health systems within local markets
Value-based purchasing	Medicare FFS reimbursement increased or decreased based on quality and cost measure results
	Opportunity to align incentives between hospitals and hospitalists
Patient-centered outcomes research	Emerging research on delivery system interventions relevant to hospitalists, such as care transitions
	Funding for PCOR available for hospitalist researchers interested in delivery systems and outcomes research

NOTE: **Abbreviations**: FFS, fee for service; PCOR, Patient-Centered Outcomes Research.

agencies, launched the Partnership for Patients program in 2011. To date, approximately 4000 hospitals have signed on to the Partnership in a collective effort to significantly reduce hospital readmissions and hospital-acquired conditions. Hospitalists are leading the charge related to Partnership for Patients in many hospitals. The Innovation Center is concurrently launching and rapidly evaluating current pilots, while considering what other new pilots might be needed to further test models aimed at the delivery of better healthcare and health outcomes at lower costs.

Perhaps the delivery system initiative that has received the most attention is the implementation of the Medicare Shared Savings Program (MSSP), or Accountable Care Organizations (ACO). Under the MSSP, ACOs are groups of providers (which may include hospitals) and suppliers of services who work together to coordinate care for the patients they serve. Participating ACOs must achieve performance benchmarks while lowering costs to share in the cost savings with CMS. Although this program is focused on Medicare fee-for-service (FFS) beneficiaries, it is expected that all patients will benefit from the infrastructure redesign and care coordination that is required under this program. The pioneer ACOs are large integrated health systems or other providers that have higher levels of shared risk in addition to shared savings. Hospitals that are a part of a participating ACO have greater financial incentives to work with their primary care and other outpatient providers to reduce readmissions and other adverse events and achieve quality benchmarks. With the degree of savings as well as financial risk that is on the table, it is possible that over time, hospitals and health systems may consolidate to capture a larger share of the market. Such a consequence could have a parallel effect on job opportunities and financial incentives and risk for hospitalists in local markets.

VALUE-BASED PURCHASING

Improvement in the quality of care delivered to all patients is another central purpose of the Affordable Care Act. The law requires that the Secretary develop a National Quality Strategy that must be updated annually; the first version of this strategy was published in April of 2011.[2] The strategy identifies 3 aims for the nation: better healthcare for individuals, better health for populations and communities, and lower costs for all. One of the levers that CMS uses to achieve these 3 aims is value-based purchasing (VBP). VBP is a way to link the National Quality Strategy with Medicare FFS payments on a national scale by adjusting payments based on performance. VBP rewards providers and health systems that deliver better outcomes in health and healthcare at lower cost to the beneficiaries and communities they serve, rather than rewarding them for the volume of services they provide. The ACA authorizes implementation of the Hospital Value-Based Purchasing (HVBP) program as well as the Physician Value Modifier (PVM). The HVBP program began in 2011, and currently includes process, outcome, and patient experience quality metrics as well as a total cost metric, which includes 30 days postdischarge for beneficiaries admitted to the hospital. Hospitals are rewarded on either their improvement from baseline or achievement of a benchmark, whichever is higher.[3] The PVM program adjusts providers' Medicare FFS payments up or down beginning in 2015, based on quality metrics reported on care provided in 2013. In the first year of the program, groups of 100 or more physicians are eligible for the program, and are given a choice on metrics to report and whether to elect for quality tiering and the potential for payment adjustment[4]; by payment year 2017, all physicians must participate. To participate, physicians must report on quality metrics that they choose through the Physician Quality Reporting System (PQRS) or elect to have their quality assessed based on administrative claim measures. Measures currently in the PQRS program may not always be relevant for hospitalists; CMS is working to define and include metrics that would be most meaningful to hospitalists' scope of practice and is seeking comment on whether to allow hospital-based physicians to align with and accept hospital quality measures to "count" as their performance metrics.

PATIENT-CENTERED OUTCOMES RESEARCH

Building on the down payment on Comparative Effectiveness Research (CER) funded under the American Recovery and Reinvestment Act of 2009, the ACA authorized the creation of the Patient-Centered Outcomes Research Institute (PCORI) and allocated funding for CER over 10 years. Rebranded as Patient-Centered

Outcomes Research (PCOR), CER has the potential to improve quality and reduce costs by identifying what works for different populations of patients (eg, children, elderly, patients with multiple chronic conditions, racial and ethnic minorities) in varied settings (eg, ambulatory, hospital, nursing home) under real-world conditions. The PCORI governance board was created in 2010, and as required by law, developed a national agenda for patient-centered outcomes research, which includes assessment of prevention, diagnosis, and treatment options; improving healthcare systems; communicating and disseminating research; addressing healthcare disparities; and accelerating PCOR and methodological research. The amount of funding available for research and PCOR infrastructure will ramp up over the next several years, eventually reaching approximately $500 million annually, with increasing funding opportunities for comparative research questions related to clinical and delivery system interventions using pragmatic, randomized, controlled trials; implementation science; and other novel research methodologies. Hospitalists have many roles within this realm, whether as researchers comparing delivery system or clinical interventions, as educators of students or healthcare professionals on the results of PCOR and their implications for practice, or as hospital leaders responsible for implementation of evidence-based practices.[5]

CONCLUSION

The Affordable Care Act is a transformative piece of legislation, and our healthcare system is changing rapidly. Many of the ACA's provisions will change how care is delivered in the United States and will have a direct effect on practicing physicians, hospitals, and patients. Although CMS plays a major role in the implementation of the law, the government cannot be, and should not be, the primary force in transforming health care in this country. Through the provisions highlighted here as well as others, CMS can create a supportive environment, be a catalyst, and provide incentives for change; however, true transformation must occur on the front lines. For hospitalists, this means partnering with the hospital administration and other hospital personnel, local providers, and community organizations to drive systems-based improvements that will ultimately achieve higher-quality care at lower costs for all. It also calls for hospitalists to lead change in their local systems focused on better care, better health, and lower costs through improvement.

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