

HEALTH POLICY REPORT

The Affordable Care Act at 10 Years — Payment and Delivery System Reforms

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Among the provisions of the Affordable Care Act (ACA), its coverage and access provisions have attracted by far the most attention and controversy. However, as health professionals are well aware, the ACA also launched potentially groundbreaking changes in how health care is paid for and delivered in the United States (see Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org). The aim was to reduce the cost and improve the quality of services and thus, in the prevailing jargon of health reform, to improve their value.

In another Health Policy Report now published in the *Journal*,¹ we address the coverage and access provisions of the ACA. This Health Policy Report reviews the major reforms in payment and delivery systems under the law as well as data on the results of some of its notable undertakings.

At the outset, a few introductory comments are pertinent. First, the number and variety of reforms set in motion by the ACA amount, in retrospect, to a major national experiment that reflects the widespread uncertainty that existed in 2010 about how precisely to improve health services in the United States. Second, the profusion of ACA initiatives and changes that were launched all at once, layered on a dynamic health care system, makes it difficult to isolate their independent effects. Third, in any set of experiments, both successes and failures should be expected. However, even unsuccessful initiatives can instruct future efforts to improve our health care system. Fourth, as compared with the coverage and access provisions of the ACA, those affecting the payment and delivery of health services have had a remarkable level of bipartisan support.

Given space limitations, our review of the payment and delivery system reforms under the ACA is selective. We cover three general areas

— changes in payment, initiatives for primary care enhancement, and the creation of the Center for Medicare and Medicaid Innovation (CMMI).

CHANGES IN PAYMENT

Payment reforms under the ACA include both straightforward reductions in how much providers or plans are paid and a variety of experiments with value-based payment. Value-based payment systems link providers' compensation to their performance with respect to the cost and quality of care.

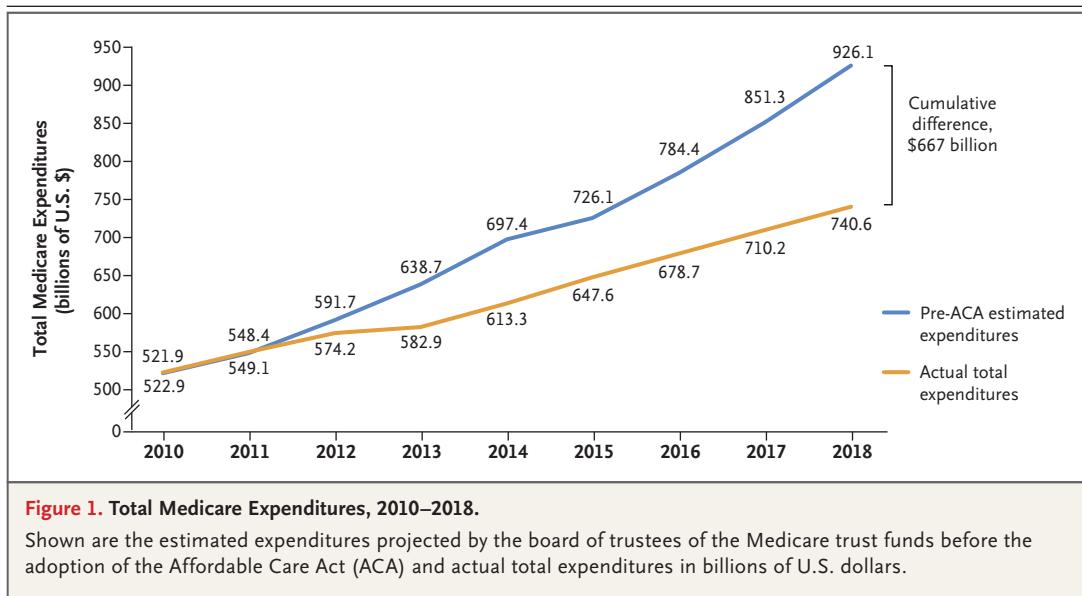
PAYMENT REDUCTIONS

To save money for its expansions in access, the ACA reduces the annual increases in payments to hospitals under the traditional Medicare program. Hospitals agreed to these reductions in anticipation of increased numbers of paying patients and reduced levels of uncompensated care. When the law was passed in 2010, the Congressional Budget Office (CBO) estimated that these reductions would save the federal government \$196 billion over 10 years.²

The ACA also reduces payments to Medicare Advantage plans, the private insurers that cover all or most services for enrolled Medicare patients, in return for an annual, fixed federal payment or premium. The CBO predicted that these reductions would save the Medicare program \$507 billion from 2012 to 2021.³ Partly as a result of these measures, over the 10 years since the enactment of the ACA, increases in Medicare expenditures have been 20% lower than the projections of the increases by the board of trustees of the Medicare trust funds (Fig. 1).^{4,5}

VALUE-BASED PAYMENT — A VARIED AGENDA

There are two categories of ACA experiments with value-based payment under Medicare and



Medicaid. The first category involves efforts to reward or penalize certain specific behaviors by providers or results within the traditional fee-for-service system (often called pay for performance [P4P]). This category includes programs such as the Hospital Readmission Reduction Program (HRRP), the Hospital-Acquired Condition Reduction Program (HACRP), and the Hospital Value-Based Purchasing (HVBP) program.

The second category involves departures from classic fee-for-service programs that held providers globally accountable for the cost and quality of health care offered to their patients. This category includes programs such as accountable care organizations (ACOs) and the Bundled Payments for Care Improvement (BPCI) program.

Hospital Readmission Reduction Program

Before the passage of the ACA, research showed wide variation in Medicare readmissions across procedures and diagnoses, with 30-day readmission rates as high as 24.7% among patients with certain conditions such as congestive heart failure.⁶ Policymakers hoped that by taking better care of patients during and immediately after their hospital stays, providers could reduce these rates, thereby improving the quality of care and reducing Medicare expenditures. The HRRP specified that any hospital with an above-average, risk-adjusted rate of readmissions within 30 days among patients with one or more of six clinical conditions would incur a financial penalty.⁷

Initial studies indicated that the program was having a positive effect.⁸ Readmission rates among patients with targeted conditions decreased from 21.5% in 2007 to 17.8% in 2015.⁹ However, later studies suggested that changes in risk classification for patients, rather than changes in actual readmission rates, were responsible for much of the apparent reduction in readmissions. Other researchers have found that the decrease in readmissions was actually outpaced by simultaneous increases in observation stays and visits to the emergency department, and the decrease occurred during a time when admissions overall were decreasing.¹⁰⁻¹³ Critics have also noted that methods of risk adjustment did not account for social and economic factors affecting patients in safety-net hospitals, which appeared to be disproportionately penalized.¹⁴ In response, the 21st Century Cures Act, which was signed in 2016, requires that the HRRP include adjustments for socioeconomic factors. In addition, conflicting results of studies have called into question whether fewer readmissions under the HRRP were associated with increased mortality among Medicare beneficiaries.¹⁵⁻¹⁷ On the whole, the results of this initially promising P4P initiative remain uncertain.

Hospital-Acquired Condition Reduction Program

The ACA sought to reduce medical errors by cutting Medicare payments by 1% to hospitals that perform in the lowest quartile of U.S. hospitals

with respect to rates of preventable hospital-acquired conditions. As with the HRRP, the HACRP showed initially promising results that have subsequently been questioned.

The federal Agency for Health Research and Quality (AHRQ) reported a cumulative reduction of 21% in hospital-acquired conditions from 2010 to 2015.¹⁸ A more recent analysis showed a 4.5% annual reduction in hospital-acquired conditions from 2010 to 2017.¹⁹ However, skeptics have noted that the decrease in hospital-acquired conditions actually began before the reduction program took effect. Sankaran et al. raised questions about the efficacy and fairness of the program because they found that low-performing hospitals generally did not improve despite being penalized and that they tended to be large academic hospitals with disproportionate numbers of disadvantaged patients.²⁰ All in all, it appears likely that hospital safety has improved since the enactment of the ACA, but the role of the law in explaining this improvement remains uncertain.

Hospital Value-Based Purchasing Program

Starting in 2013, the HVBP created financial incentives for hospitals to improve on multiple measures of quality involving clinical processes and patient experience. Hospitals stand to gain or lose Medicare payments, depending on how their performance compares with that of other hospitals. Researchers have evaluated the effects of the program on hospital quality of care and mortality in participating facilities as compared with critical access hospitals, which are exempt from the program. They found no significant difference in rates of improvement in quality metrics or in mortality.^{21,22}

Accountable Care Organizations

The ACO program has been by far the most visible innovation initiated by the ACA in payment and delivery systems. An ACO is an entity formed by health care providers who agree to take responsibility for the quality and costs of care for a population of patients. If the spending of an organization for its assigned patients is lower than expected (the benchmark), the ACO shares in savings. In some types of ACOs, providers accept risk (so-called downside risk) for costs exceeding benchmarks. In these cases, the ACO may be required to make a payment to the

Centers for Medicare and Medicaid Services (CMS). Participation in ACOs is voluntary.

As of early 2019, there were more than 1500 public and private ACOs covering 44 million patients. Almost 600 of these ACOs have contracts with Medicare, and they provide care for nearly one third of all Medicare beneficiaries.²³ Multiple studies suggest that ACOs have generated modest net savings of up to 2% for Medicare while maintaining or improving quality. Reductions in the use of post-acute care have played an important role in these savings.²⁴

Design features that are integral to the program may have contributed to the modest effect of ACOs. When an ACO produces savings, the benchmark is adjusted to reflect lower spending. This process has the unintended effect of demotivating participants, since savings in 1 year make it more difficult to achieve savings in the following year.²⁵ A continuing source of savings may also be necessary for the infrastructure investments needed to improve care management, such as information technology and staffing. New CMS regulations in 2018 sought to address this design problem.

CMS has concluded that ACOs that accept downside risk perform better than others.²⁶ Chernew et al. questioned this conclusion, arguing that only organizations that are likely to benefit choose to accept such risk.²⁷ There is some evidence that ACOs led by physicians have tended to perform better than those led by hospitals.²⁸⁻³⁰ Still another observation has been that the performance of ACOs tends to improve over time.²⁸

Bundled Payments for Care Improvement

Although there have been several BPCI variants, all have given providers a single, prospective payment for treatment of a surgical or medical condition. Providers retain any savings, may absorb excess costs, and have to meet quality criteria. More than 1025 hospitals, physician groups, and post-acute care organizations have participated.³¹

The most popular type of bundled payment — with approximately 400 participants — was model 2, which began with hospital admission and covered all Medicare charges for both hospitalization and post-acute care for the following 30, 60, or 90 days. BPCI participants selected the surgical procedures or medical conditions to bundle from a list designated by CMS. Hip and

knee replacements were the most commonly selected surgical procedures, and congestive heart failure was the most commonly selected medical condition. CMS has experimented with making bundled payments mandatory for joint replacements in certain geographic areas.

The BPCI program appeared to have reduced expenditures for surgical procedures such as hip and knee replacements, but savings may not have exceeded the costs of administering the reform.³² The program was less promising with respect to medical conditions such as congestive heart failure, pneumonia, and chronic obstructive pulmonary disease.³³ CMS discontinued the original BPCI program in 2018, but in October 2018 it launched a new iteration, BPCI Advanced, which is scheduled to run through at least 2023. Ongoing evaluations have met technical challenges such as small sample sizes.

PRIMARY CARE ENHANCEMENT

The ACA launched a number of experiments designed to improve health system performance by strengthening the nation's primary care infrastructure. These experiments have produced mixed results.

The ACA launched three primary care medical home experiments involving 1850 sites. The evaluations showed largely equivocal results with respect to quality and costs.³⁴ The Comprehensive Primary Care Initiative attempted to coordinate increased payment from private and public sources to promote improved primary care outcomes. It was associated with a 2% reduction in visits to the emergency department but no net savings after the costs of the program were taken into account.³⁵ Claims-based quality measures were largely unchanged except for more timely follow-up care after hospital stays or visits to the emergency department.

Building on the lessons of the Comprehensive Primary Care Initiative, the CMMI launched the Comprehensive Primary Care Initiative Plus, which involves 14,810 primary care practitioners in 2851 practices serving 15 million patients in 18 different markets across the country.³⁶ The final results of this recent experiment remain to be determined.³⁷

One primary care program with more promising results has been the Independence at

Home Demonstration, which provides intensive home-based primary care for homebound patients. Evaluations have shown a significant decrease in visits to the emergency department and hospitalizations, as well as increased beneficiary and caregiver satisfaction.³⁸ The program was associated with a decrease of \$25 million in Medicare expenditures, although this reduction does not take into account incentive payments made to practices.³⁸ The Bipartisan Budget Act of 2018 extended the Independence at Home Demonstration for 2 years.

CENTER FOR MEDICARE AND MEDICAID INNOVATION

The ACA created the CMMI, a new agency within the CMS. With funding of \$10 billion over 10 years, the CMMI has the mandate to conduct research and development that can improve the quality of Medicare and Medicaid services, reduce their costs, or both. The ACA also granted the secretary of health and human services the unprecedented authority to implement CMMI reforms throughout the Medicare and Medicaid programs (without the usual congressional approval) if, on review by the Office of the Actuary of CMS, they are deemed to increase the value of services. Two programs that have met this test are the Pioneer ACO model and a diabetes prevention program.³⁹

CMMI experiments have included bundled payments, the Pioneer ACO model, and the Comprehensive Primary Care Initiative programs mentioned previously. Both the Government Accountability Office (GAO) and the CBO have issued positive reviews of the CMMI, which currently has bipartisan support.^{39,40}

TRENDS IN THE COST AND QUALITY OF CARE

The ultimate test of the payment and delivery system reforms under the ACA is whether they have reduced the cost of care, improved the quality of care, or both in the United States. From 2010 to 2017, the annual average national per capita health care spending increased by 3.6%, a relatively modest increase by historical standards and one that is closer to the per capita growth in the gross domestic product than pre-

viously observed (Fig. 2).⁴¹ This is striking given the concurrent extension of new health insurance benefits to more than 20 million Americans.⁴² From 2010 to 2018, the average annual increase in Medicare spending was 4.4%, less than half the rate from 2000 to 2010.⁴³ Although the ACA did not specifically target private sector spending, premiums for employer-sponsored insurance also increased at a relatively modest annual average rate of approximately 4% from 2010 to 2017.⁴⁴

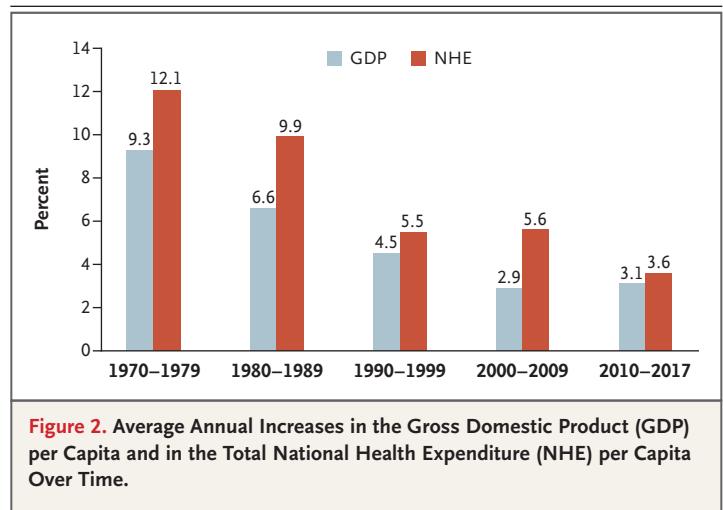
With respect to the quality of care in the United States, AHRQ data show continued slow gains after the enactment of the ACA, with improvement observed in more than half the 147 measures that were tracked. Only 8 measures showed deterioration.⁴⁵

Linking these overarching developments in the cost and quality of care to the specific provisions of the ACA is challenging. The clearest causal relationship concerns decreases in Medicare payments under the ACA; these decreases helped to moderate growth in Medicare spending. Other evidence suggests that reductions in the utilization of hospital services may also be playing a part in moderating Medicare expenditures. Some observers hypothesize that the reforms in payment and delivery systems under the ACA — especially in global value-based payment experiments, such as ACOs — may have contributed to these reductions in Medicare utilization as providers have changed behavior in anticipation of broad adoption of value-based payment among both public and private payers. However, beyond its effect on Medicare prices, the role of the ACA in moderating health care costs remains to be definitively established.

With regard to trends in quality, observed improvements began before the enactment of the ACA. Thus, the effect of the law on global quality of care in the United States remains uncertain.

CONCLUSIONS

Data on the effects of the profusion of ACA interventions and their implications for health system reform going forward remain far from robust. Perhaps the best evidence concerns the relationship between prices and costs throughout the health care system. The efficacy of the



payment reductions in Medicare suggests that private payers may achieve similar savings if they are able to reduce the prices they pay; these prices generally far exceed those of Medicare.⁴⁶

Some of the most important lessons of the ACA experience may pertain to the future design of value-based payment programs. As currently configured, P4P programs lack clear efficacy. Any future experiments of this type should be significantly redesigned, perhaps to better reflect insights from behavioral economics.⁴⁷ Such reconfigurations may include imposing larger penalties, shortening the time between behaviors and their financial consequences, and reducing the number of concomitant interventions.

In contrast, the ACO program has had some modest success. This may have resulted in part from participants' ability to find savings in post-acute care and thus to avoid difficult changes in their own clinical practice patterns. Alternatively, holding providers broadly accountable for the cost and quality of patients' care, rather than incentivizing very specific behaviors, may be more effective in increasing the value of services, perhaps because provider flexibility encourages innovation in care delivery.

The ACO experience further suggests that future experiments with accountability for cost and quality should encourage physician accountability for and control of such initiatives. Since the supply of physicians with the necessary skills to lead such experiments may be limited, training programs to prepare physicians for ac-

countability for health care outcomes may prove useful.

CMS has concluded that there should be greater emphasis on downside risk in the design of ACOs, but this proposal remains controversial.²⁷ Behavioral economic theory indicates that the prospect of loss is more motivating than the opportunity for gain, which would be consistent with the way in which CMS interprets the ACO experience. However, downside risk may also discourage provider participation because of risk aversion. Intensive experimentation with greater downside risk within the value-based payment movement appears to be warranted. The tendency of ACOs to perform better over time further suggests the wisdom of allowing these and other payment and delivery system reforms to mature before judging their success.

Pham and Ginsburg have commented that value-based payment programs may have relied too much on incentivizing primary care physicians to improve health care value and too little on incentivizing specialists, whose services account for the overwhelming majority of health care costs.⁴⁸ This observation suggests the need for more value-based payment programs aimed at specialists, such as the BPCI program, in which surgical bundles showed some modest promise. The comparatively favorable record of the Independence at Home Demonstration suggests that home-based primary care for the nation's most vulnerable patients warrants greater exploration.

The institutionalization of research and development at CMS through the CMMI is another generally positive outcome of the ACA. With its bipartisan support and positive evaluations from the GAO and the CBO, the program offers hope that CMS will be able to continue to learn from experiments in payment and delivery system reform.

It is also very clear that designing and evaluating such experiments is challenging and that enduring improvements in payment and delivery systems will require long, patient effort on the part of public and private stakeholders in our health care system. It is tempting to conclude that the very number and variety of ACA experiments should serve as a cautionary tale, and that future policies should concentrate on a few powerful interventions. However, the ACA experience has yet to identify any such magic remedies for the high costs and quality deficiencies of our huge, underperforming health care system.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

We thank Corinne Lewis, M.S.W., and Shanoor Seervai, M.P.P., for their research support and comments that greatly improved an earlier version of the manuscript.

From the Commonwealth Fund, New York.

This article was published on February 26, 2020, at NEJM.org.

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DOI: 10.1056/NEJMhpr1916092

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