Accountable Care Act
Improving Quality through Delivery System Reforms
Sep. 19, 2012

On June 28, 2012, the U.S. Supreme Court ruled that the Affordable Care Act (ACA) was constitutional. All coverage provisions in the ACA remain.

Several parts of the ACA are intended to move health care toward a patient-centered system that rewards the quality of care delivered, not just the quantity of services provided.

Independent Payment Advisory Board

- The ACA establishes an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. Beginning April 2013, it requires the chief actuary of CMS to project whether Medicare per capita spending exceeds the average of CPI-U and CPI-M, based on a five-year period ending that year. If so, beginning January 15, 2014, the Board will submit recommendations to achieve reductions in Medicare spending. Beginning January 2018, the target is modified such that the board submits recommendations if Medicare per capita spending exceeds GDP per capita plus one percent. The Board will submit proposals to the president and Congress for immediate consideration. **The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D. Hospitals and hospices (through 2019) and clinical labs (for one year) will not be subject to cost reductions proposed by the Board**. The Board must also submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care by Jan. 1, 2015.

Accountable Care Organizations

- The ACA allows providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.

Innovation Center

- The law creates an Innovation Center within the Centers for Medicare & Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and CHIP different payment structures and methodologies to **reduce program expenditures while maintaining or improving quality of care.**

Payment reform models that improve quality and reduce the rate of cost growth could be expanded throughout the Medicare, Medicaid, and CHIP programs.

- It supports **comparative effectiveness** research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be overseen by an appointed multi-stakeholder Board of Governors and will be assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. The law terminates the Federal Coordinating Council for Comparative Effectiveness Research that was founded under the American Recovery and Reinvestment Act.

Bundled payment pilot program

- The ACA establishes a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. The pilot program will cover 10 medical conditions. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, a plan will be developed for expanding the pilot program.

Improving the quality of care

- The ACA establishes a hospital **value-based purchasing program** in Medicare to pay hospitals based on performance on quality measures and extends the Medicare physician quality reporting initiative beyond 2010. Inpatient payments are reduced by 1 percent in 2013, increasing to 2 percent by 2017, and this money is redistributed to hospitals depending on quality scores. The law develops plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.

- Medicare inpatient payments to hospitals are reduced by up to 1 percent, and up to 3 percent in 2015, to account for excess (preventable) hospital readmissions for specific conditions. (Effective Oct. 1, 2012)

- Medicare inpatient payments to hospitals are reduced by 1 percent in the risk-adjusted worst 25th percentile for hospital-acquired conditions. (Effective fiscal year 2015)

- The ACA creates new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective Jan. 1, 2012 through Dec. 31, 2016); makes global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); and allows pediatric medical providers organized as accountable care organizations to share in cost-savings.

Patient Safety Organizations

- Starting Jan. 1, 2015, health plans offered through insurance exchanges may only contract with hospitals of more than 50 beds if such hospitals participate in a PSO.

The Oklahoma Hospital Association has prepared Fact Sheets on numerous topics related to the ACA of interest to hospitals. The Fact Sheets may be accessed at www.okoha.com/aca.