The results released on July 10, 2014, by CareFirst of Maryland, a Blue Cross Blue Shield plan, probably had some Maryland hospitals shaking in their boots. It wouldn’t be surprising if hospitals around the country felt the vibrations.

CareFirst was reporting for the first time on the results of its patient-centered medical home (PCMH) program, which the insurer initiated three years ago. The Patient Protection and Affordable Care Act (ACA) established a formal PCMH pilot program within Medicare, and insurers in the commercial market who aren’t part of the pilot, such as CareFirst, have been experimenting with the concept too. A PCMH program pays physicians incentives to monitor the health of their patients more closely, with the objective of minimizing referrals to specialists and hospital admissions. Members seen by medical home physicians participating in the CareFirst program experienced 6% fewer hospital admissions, 11% fewer days in the hospital, and 11% fewer outpatient visits than other CareFirst clients last year.1

The PCMH is just one of the ACA initiatives aimed at reducing hospital admissions and, by extension, hospital revenue. The ACA’s emphasis on primary care as a bulwark against hospitalization, and its endorsement of accountable care organizations (ACOs) and bundled payments, is having, and will continue to have, a major impact on hospital revenue—in some cases not in a good way, speeding hospital consolidations and closures. Stephen Schimpff, MD, retired Chief Executive Officer of the University of Maryland Medical Center, puts it this way:

It is a changing world for hospitals; it is harder to thrive in the way in which it was done in the past. We used to be in the business of disease and pestilence, the more disease and pestilence the better. Now we are in a totally different business, improving the health of your community.

But the ACA has been something of a double-edged sword. While its payment initiatives are staunching the flow of patients to hospitals, its insurance expansion has opened the spigot. The ACA’s Medicaid expansion has sent waves of people through hospital doors in some states. Many of them were previously “self pay”—with some percentage being “no pay”—and hospitals are suddenly being compensated for their care. The health insurance marketplaces have brought eight million customers, not all of them newcomers, to hospital doors. However, hospitals have had to contend with the pricing demands of qualified health plans (QHPs), which sell individual health plans and must comply with federal rules, some of which filter down to hospitals.

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The Revolution Gathers Steam

Just as the application of steam power to manufacturing in Great Britain in the mid-1700s ignited the industrial revolution, the 2010 passage of the ACA has prompted an emerging upheaval in health care. Traditional hospital operations across a broad range of activities have been upended and are being refashioned.

Hospitals are merging at a pace previously unseen, buying insurance companies (and being bought by insurance companies), and piling into “clinically integrated networks” faster than high school seniors jumping into beach-bound cars on the last day of school. Health systems are also buying physician practices to establish PCMHs or ACOs, or simply to have a better footing to contend with insurance companies outside of Medicare that are requiring some form of risk-based “value,” “bundled,” or “capitalized” purchasing contract—terms that are being tossed around with varying meanings.

“At the strategic level, the Affordable Care Act has certainly colored the internal dialog at Catholic Health Initiatives [CHI] around the positioning of our health system and our markets,” says Juan Serrano, Senior Vice President of Payer Strategy and Operations at CHI, which owns about 90 hospitals around the country. CHI has about 15 hospitals participating in the Shared Savings Program at the Centers for Medicare and Medicaid Services (CMS).

The Shared Savings Program is an ACO option, a companion to the smaller, more radical Pioneer ACO program. Both programs promote what has come to be called “value purchasing,” in which Medicare and Medicaid, and an increasing number of commercial insurers, pay hospitals for integrated clinical care. There were 32 Pioneer ACOs and about 350 hospitals in the Shared Savings Program. Only two organizations have terminated Medicare ACOs, while seven have shifted from the Pioneer program (in which they must assume “downside” risk for losses) to the more financially forgiving Shared Savings Program, which permits one-sided (bonus-only) financial arrangements.

About 100 hospitals participate in the Medicare bundled payments pilot program, which is another product of the ACA. Medicare has also begun testing PCMHs, although the CMS had been experimenting with the concept prior to ACA passage. The demonstration program kicked off in 2011. It pays a monthly care management fee for beneficiaries receiving primary care from a designated medical group. The care management fee is intended to cover care coordination, improved access, patient education, and other services to support chronically ill patients. The program is operating in select states, and like other ACA programs it has sent ripples into the commercial marketplace, where companies such as CareFirst have inaugurated their own programs. The idea is
to keep patients from being referred to specialists at hospitals, where care is more expensive.

While “clinical integration” and “value purchasing” have become watchwords in the hospital industry thanks to the ACA, the law has also prompted some hospitals to look outward, beyond their normal operational borders, particularly in terms of capitalizing on the eight million entrants into the federal and state health insurance marketplaces. As a result, hospitals are slowly moving into the health insurance business. CHI recently purchased QualChoice, a health insurance company based in Arkansas. Serrano says the purchase may become a platform for CHI to offer plans in the state and federal marketplaces. “The purchase of QualChoice allows us to accelerate our value delivery to the market; it gives us a distribution channel for our products and new models of care: for example, new disease management programs and narrow networks,” he states.

Some hospitals participate in the ACO and bundled payment programs simultaneously. “We are working with both health systems that have bundles with CMS, and with health systems that have bundles with CMS while at the same time participating in the Medicare Shared Savings Program,” explains Morgan Bridges-Guthrie, a spokeswoman for Premier, Inc., which provides buying, data, and other services to hospitals. “So, ACOs instituting bundled payment programs is a natural fit.”

Hospital executives will need to be even more nimble next year as ACA programs continue to morph. The QHPs that sell individual policies in federal and state insurance marketplaces face new requirements in 2015, some of which affect hospitals. In addition, the CMS will rework its ACO program, both the narrow Pioneer and broader Shared Savings models.

Debate Over ACA Shifts to New Issues

The debate about the ACA seems to have morphed since spring 2014. Then, there were questions about whether the eight million people the Obama administration had forecast would enroll in federal and state marketplaces would actually show up. When they did, the question became whether all of the new entrants would pay their premiums and actually get coverage. Most did. Competing studies by national organizations have offered differing results about what percentage of that eight million (or whatever the final 2014 number turns out to be) were previously uninsured. That was the whole point of the ACA, to insure the uninsured. But even the fire over that question has died down.

Interestingly, no one seems too concerned that 90% of marketplace participants are receiving federal subsidies for their premiums and that those premiums average 75%. Maybe those federal costs are less than what taxpayers were paying for the portion of the eight million who were previously costing hospitals money in the form of uncompensated care. However, a report from the Department of Health and Human Services (HHS) inspector general in July said that at the end of 2013, the federal marketplace (13 states have their own marketplaces) had 2.9 million inconsistencies relating to an applicant’s income status and Social Security number.7

It is probably because of the federal subsidies that QHPs, having offered reasonable premiums for the four plan levels (bronze, silver, gold, and platinum) in 2014 while they got a feel for the costs of covering essential health benefits, now feel free to jack up 2015 premiums. Companies began filing 2015 premiums with HHS this summer; they take effect on January 1, 2015. The Wall Street Journal in June looked at potential 2015 premium increases in 10 states and found that the largest carriers were proposing increases of 8% to 22.8%.8 These proposed increases may not stick: Both the states and HHS have the power to negotiate lower rates. But it seems clear that a certain percentage of marketplace participants will switch to lower-priced plans using more constricted networks. This will put even more pressure on hospitals.

A New World for Hospitals

That uncertainty aside, some trends now seem immutable. In the name of clinical integration, some of the biggest hospital companies, such as CHI and Ascension Health, have been adding hospitals and considering buying insurance companies. The not-for-profit Denver-based CHI system, which provides health care services in 18 states, assumed control of several hospitals and a health system and purchased a majority interest in a physician-owned health plan last year.

In the reverse scenario, health insurers are buying hospitals. Highmark Inc., one of the biggest Blue Cross/Blue Shield plans in the country, in 2013 bought the West Penn Allegheny health system, which boasts eight hospitals in western Pennsylvania. Highmark offers marketplace and nonmarketplace policies in Pennsylvania, Delaware, and West Virginia, and is the only marketplace carrier in the third state. Spokesman Aaron Billger says Highmark’s acquisition of the West Penn hospitals was not done with marketplace leverage in mind. Rather, the hospitals provide Highmark with a platform to create an integrated delivery network—called the Allegheny Health Network—that serves as an ACO/PCMH-type destination for the 218,000 policyholders (marketplace and nonmarketplace) in western Pennsylvania.

Highmark’s ACO program is not a part of either Medicare model, so it illustrates how the commercial insurance marketplace is picking up the ACA ball and running with it. There were 147,000 Highmark-insured individuals whose physician practices were members of the Highmark Accountable Care Alliance between October 2012 and October 2013. In clinical quality performance measures, those practices showed a 26% improvement in quality scores and a reduction in medical costs, with total six-months savings of about $11.5 million.

ACA Impact on Hospital Financial Health Unclear

This scurrying by hospitals to capitalize on the new ACA programs has had an uneven financial impact on them. A June Modern Healthcare analysis of earnings reports for about 200 hospitals and health systems, both not-for-profit and investor-owned, found that hospital margins narrowed significantly last year despite an improving economy.4 The magazine wrote: “Despite a buoyant stock market streak by some publicly traded chains, health care providers as a group continue to operate with slim and shrinking margins. Overall, a smaller percentage of health care providers saw positive operating margins last year compared with the previous two years.”

The Modern Healthcare analysis found that the average operating margin in 2013 was 3.1%, down from 3.6% in 2012 based on data available for 179 health systems, which included acute-care, post-acute-care, rehabilitation, and specialty hos-
valve replacements, congestive heart failure, percutaneous lumbar spinal fusions, coronary artery bypass grafts, heart episodes of care, including hip and knee joint replacements, focus on improving care and reducing costs across multiple modality settings, and haven't shown much progress on the revenue side,” said Diane Huggins, Vice President of Communications at LifePoint, says not all of the gain in net income came from treating new Medicaid recipients. “Clearly, there were a confluence of factors that impacted our Q1 2014 results compared to the same quarter of the prior year in addition to Medicaid expansion,” she states.

There has been little analysis of how ACOs have specifically affected hospitals, which are just one member of an ACO team that depends heavily on physician practices as, for want of a better term, quarterbacks. However, hospitals are the key team member because they drive shared savings via better quality care that results in fewer hospital readmissions. The only financial results issued so far by the CMS were in July 2013 for the 32 Pioneer ACOs. Thirteen of the 32 produced shared savings with CMS, generating a gross savings of $87.6 million in 2012 and saving nearly $33 million for the Medicare Trust Funds. Overall, Pioneer ACOs performed better than published rates in fee-for-service Medicare for all 15 clinical quality measures for which comparable data are available. Medicare has not published any comparable results for the Pioneer programs in 2013 or for the much larger Shared Savings ACO program.

The Pioneer results are partly encouraging and partly not. Some hospitals earned substantial profits. Others turned themselves inside out to no avail. “We’ve spent a lot of money and haven’t shown much progress on the revenue side,” said Richard Barasch, Chairman and CEO of Universal American Corp., at an investor conference in June. “There’s a limit to our public service feelings about this. We are going to scale back some degree.” Universal has 34 ACOs and is one of the biggest players in the ACO world. Most of its ACOs participate in the Shared Savings Program.

The CMS has not published financial results or health outcomes from its Bundled Payments for Care Improvement (BPCI) initiative. Its four bundled payment models allow providers to bid as a team to provide a continuum of services for a predetermined target amount to include physician payment, nursing-home care, surgery, and other care, most commonly for treatments such as heart, colon, and spinal surgery, as well as hip and knee replacements.

The Premier, Inc., Bundled Payment Collaborative includes 17 health care provider systems with more than 45 hospitals across the nation. Members of the collaborative are committed to sharing best practices and data with each other. They focus on improving care and reducing costs across multiple episodes of care, including hip and knee joint replacements, lumbar spinal fusions, coronary artery bypass grafts, heart valve replacements, congestive heart failure, percutaneous coronary interventions, and colon resections.

“We haven’t charted the financial impact yet,” Premier’s Bridges-Guthrie explains when asked how the Premier bundled payments participants have fared so far. “Our Bundled Payment Collaborative members went live beginning of January, so it is a bit too early to tell real results versus estimates. At this time, we only have partial results. Unfortunately, it’s just too early to know performance.”

Changes in ACA Programs on the Way

Even as hospitals try to gain traction in current ACA programs, some of those programs will be changing. The CMS was supposed to publish a proposed rule in May 2014 detailing changes it wants to make in the Shared Savings Program. That proposal had not been issued as of mid-July. But just the prospect of the proposed rule forced the American Hospital Association (AHA) to launch a pre-emptive strike in the form of a long letter to Patrick Conway, MD, Acting Director of the CMS Innovation Center. In that letter, Linda E. Fishman, Senior Vice President of Public Policy Analysis and Development, said the AHA continues to have “significant concerns about the design of the current Pioneer ACO Model and the Medicare Shared Savings Program (MSSP).”

The two programs are similar in many regards, although the Pioneer program offers greater potential rewards to participants for greater savings. Both the Pioneer and Shared Savings ACOs enroll Medicare recipients and accept “risk.” Payment is based on traditional fee-for-service (FFS) in the first two years, but Pioneer ACOs can transition to population-based payment after that if “results” warrant the transition. Population-based payment is per-beneficiary-per-month compensation intended to replace some or all of the ACO’s FFS payments. The CMS also requires that 50% of Pioneer revenue come from participating in “risk” contracts with other payers by the end of the second performance period.

The AHA wants a laundry list of changes, as does the American Medical Group Association (AMGA), whose members—larger physician group practices—typically drive the ACOs, which almost always include hospitals. Fishman’s letter to Dr. Conway complained that the Pioneer ACO and MSSP programs place too much risk and burden on providers with too little opportunity for reward in the form of shared savings. She made a number of suggestions for changes to improve the programs, all of them technical and all of them practically requiring a doctorate in statistics to understand for anyone not steeped in ACO terminology and methodology. Suffice it to say that the AMGA has some of the same concerns about requirements, for example, attached to the minimum savings rate (MSR) for ACOs. The MSR accounts for the potential random variation in savings that may not be linked to improvements in quality and efficiency.

The QHPs already have new rules to follow in 2015, those established by the so-called “2015 Letter to Issuers in the Federally-facilitated Marketplaces.” One change drills down to hospitals and opens up new liability: the first-time imposition of civil money penalties (CMPs) for any breach of federal rules by any party, including consumer assistance entities such as hospitals. When the draft letter was published, the AHA argued that applying CMPs to individual and institutional assisters, especially voluntary certified application counselors (CACs), would have...
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a chilling effect on some hospitals continuing to serve in that role. It wanted the CMS to reconsider the application of CMPs to voluntary assisters, and to limit CMPs in general to egregious violations of selected requirements in which there are no other enforcement mechanisms already in place. Otherwise, hospitals could be penalized for simple human errors of judgment or facts that are unintentional, nonmalicious, and consistent with the purpose of the ACA—to provide coverage to the uninsured.

The CMS seems to have ignored the AHA’s pleas, so hospitals may have to tiptoe around efforts to sign up federal marketplace customers. Some hospitals may trip over sign-ups or other impediments suddenly strewn in their path thanks to the ACA. But some hospitals will prosper, too, as they figure out how to make this revolution work for them.

REFERENCES


