An In-depth Look at Six Cost Containment Programs in the Affordable Care Act

May 2014

This paper describes six cost containment policies or initiatives included in the Affordable Care Act (ACA) that target how health care is delivered and the growth of health care costs. A summary of the implementation occurring in Michigan is also provided.

The policies or initiatives explored in depth here are:

1. *Accountable Care Organizations*
2. *Hospital-Acquired Conditions*
3. *Value-Based Purchasing*
4. *Hospital Readmission Reductions Program*
5. *Center for Medicare and Medicaid Innovation*
6. *Program Integrity*

1. Accountable Care Organizations (ACA §3021, 3022)

Description of Policy. An accountable care organization (ACO) is a network of providers clinically and financially responsible for the entire continuum of care for a group of patients. Depending on the arrangement, providers, hospitals, and health insurers may share responsibility for the patient's care.[1] Following the passage of the ACA, the Centers for Medicare & Medicaid Services (CMS) began developing programs for Medicare providers using the ACO model, including:

- ***Medicare Shared Savings Program (MSSP)*** The MSSP is Medicare's basic ACO model.[2] In this model, participating ACOs receive Medicare fee-for-service payments and can share in savings realized through better coordination of care. ACOs are responsible for quality of care as measured by 33 cost and quality goals related to patient and caregiver experience, care coordination, patient safety, preventive health, and at-risk populations,[3] as well as for cost relative to a benchmark patient population.[4] ACOs must achieve target savings of at least 2 percent in order to share in the savings.[5,6] MSSP participants may elect to transition to sharing in both savings and risks.[7]

- ***Advance Payment Model*** The Advance Payment Model is a supplementary incentive program for select MSSP participants, such as small and rural providers, who may require additional resources to establish an ACO. Advance payments are received through a combination of upfront and monthly disbursements and invested in care coordination infrastructure projects described in the ACO's application. The advance payments are repaid with the shared savings produced by the ACO. ACOs that do not achieve enough savings to repay CMS at the end of a performance period have future payments offset until the shortfall is paid in its entirety.[8]

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- ***Pioneer ACO Model*** Pioneer ACOs, designed for rapid implementation by providers experienced in coordinating care, can benefit from higher levels of shared savings compared to the MSSP, but also face risks, or "downside payments," if saving are not achieved.[9]

Implementation. Over 360 Medicare ACOs formed from March of 2010 to January 2014, serving about 5.3 million beneficiaries.[10] The majority of the ACOs (341)[11,12] participate in the MSSP; among these, 35 are enrolled in the Advance Payment program. In January 2014, preliminary outcome data was released for 114 MSSP ACOs that began participating in 2012. CMS reported that 29 ACOs reduced spending enough to achieve shared savings, generating more than $126 million in savings.[13]

In 2012, 32 provider organizations began participating in the Pioneer ACO model. In July 2013, CMS reported that each ACO performed well on the reported quality measures during the first year and 13 had reduced costs enough to achieve shared savings. Together, the 32 ACO generated $87.6 million in gross savings.[14] CMS also reported that nine ACOs decided to leave the Pioneer ACO program after one year. Seven ACOs departing the program joined the MSSP, while two left the Medicare ACO initiatives entirely. When examined separately by an independent firm, the first year performance of the remaining 23 Pioneer ACOs generated $147 million in gross savings.[15]

2. Hospital-Acquired Conditions (ACA §3008 and 2702)

Description of Policy. Hospital-acquired conditions (HACs) are high-cost and/or high-volume conditions, not present on admission to the hospital but rather acquired during the hospital stay, and deemed to have been preventable through application of evidence-based guidelines. Examples of HACs include foreign object retained after surgery, blood incompatibility, falls, and trauma.[16] The average incremental cost per episode of a HAC to Medicare Part A ranges from $2,860 to $12,378.[17] HACs have long been identified as a major financial burden for payers, with an estimated incremental cost of $170–$205 million per year. To address both increased expenditures and the poorer quality of care that HACs may indicate, Medicare began reducing payments for reasonably preventable complications that occurred during a hospitalization, and ceased payment for select conditions acquired during the hospitalization that could have reasonably been prevented.[18] Building on this, the ACA prohibits Medicaid reimbursements for HACs, as identified by individual states, effective as of July 1, 2011. Additionally, beginning in 2015, hospitals scoring in the top quartile for the rate of certain risk-adjusted HACs (compared to the national average) will see Medicare payments reduced by 1 percent. In 2012, CMS calculated net savings of current HACs for 2011 to be $19.4 million and estimated total savings from HACs for 2013 at $24 million.[19]

Implementation. Although the ACA does not mandate states to report HACs, the legislation provides a strong incentive for states to establish reporting systems. As of May 2012, 27 states and the District of Columbia had enacted legislation to establish adverse event reporting systems.[20] Current federal initiatives (including mandatory federal HAC reporting since 2011 for certain infections) have bolstered HAC reporting activities at the state level. Nevertheless, no federal standards cover state reporting systems, and there is still significant variability among such reporting systems.[21]

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3. Value-Based Purchasing

Value-based purchasing (VBP) enables purchasers of health care to hold providers accountable for both cost and quality. VBP aims to align incentives between purchasers and providers to reduce inappropriate care and identify and reward the best-performing providers.[22] The ACA requires reporting of quality measures and/or VBP across nearly all providers, building on existing quality reporting requirements and demonstration projects.

Hospitals (ACA §3001)

Description of Policy. Since the mid-2000s, Congress has explored how to implement value-based purchasing in hospitals.[23] Building on this work and existing quality reporting requirements, the ACA enacted a budget-neutral VBP program for hospitals. This program withholds Medicare reimbursement to hospitals—increasing from 1 percent in 2013 to 2 percent by 2017—and redistributes this aggregate withheld amount to hospitals based on performance achievement and improvement. Performance is evaluated using clinical processes of care, patient experience, and mortality outcome measures (see Figure 1). Beginning in FY 2015, a measure of efficiency—Medicare spending per beneficiary—will be incorporated into performance assessment. Measures and hospitals for which the reporting data is below a minimum threshold will be excluded from VBP.[24,25]

FIGURE 1: Quality Measures Used in Calculation of Value-Based Purchasing Bonuses & Penalties

Process of Care Measures—FY 2013 and Beyond	
Percentage of heart attack patients given medication to avert blood clots within 30 minutes of arrival at the hospital.	Percentage of surgical patients that received the correct kind of antibiotic.
Percentage of heart attack patients given percutaneous coronary interventions within 90 minutes of arrival.	Percentage of patients who had their antibiotics stopped within 24 hours of surgery.
Percentage of heart failure patients given instructions upon discharge about how to take care of themselves.	Percentage of heart surgery patients who had their blood sugar kept under control after an operation.
Percentage of pneumonia patients who had a blood culture taken before they were given antibiotics.	Percentage of heart surgery patients already taking beta blockers who were given a beta blocker just before and after surgery.
Percentage of pneumonia patients that received the correct kind of antibiotics.	Percentage of surgery patients who received an appropriate treatment to prevent blood clots.
Percentage of patients that received an antibiotic within an hour of surgery.	Percentage of surgery patients who received anti-blood clot treatment within 24 hours before to 24 hours after the operation.

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Process of Care Measures—FY 2014 and Beyond	
Percentage of patients with postoperative urinary catheter removal on postoperative day 1 or 2.	
Patient Experience of Care Measures—FY 2013 and Beyond	
How well nurses communicated with patients.	How well caregivers explained medication to patients before giving it to them.
How well doctors communicated with patients.	How clean and quiet the hospital room and hall were.
How responsive hospital staff were to patients' needs.	How often caregivers explained to patients how to take care of themselves after discharge.
How well caregivers managed patients' pain.	How the hospital stay rated overall.
Mortality Outcome Measures—FY 2014 and Beyond	
Acute myocardial infarction 30-day mortality rate.	Heart failure 30-day mortality rate
Pneumonia 30-day mortality rate	

Source: Kaiser Health News, "How Hospitals' Quality Bonuses and Penalties Were Determined and How to Use the Data," December 20, 2012, http://www.kaiserhealthnews.org/Stories/2012/December/21/value-based-purchasing-methodology.aspx (accessed 2/24/13).

Implementation. In November 2013, CMS announced the bonuses and penalties that individual hospitals will receive during FY 2014.[26] This is the second year CMS will withhold and redistribute millions to hospitals based on quality measure performance.[27] Hospital VBP payment incentives for FY 2014 range from +0.88 percent to –1.14 percent, with almost half (45 percent) of participating hospitals receiving bonuses. The average bonus is 0.24 percent, while the average penalty is 0.26 percent (up from 0.21 percent in FY 2013).[28]

Physicians (ACA §3002, 3007)

Description of Policy. Since at least 2000, Congress has explored financial incentives for physicians to improve quality and efficiency of care through various demonstration and reporting systems, including the Physician Group Practice Demonstration ("PGP demo")[29] and the Physician Quality Reporting System (PQRS). CMS currently uses data from the PQRS to populate the *Physician Compare* website where physicians and patients can view quality performance by individual physicians or group practices. CMS also provides feedback reports to physicians on their quality and resource use relative to other physicians. The ACA built on PQRS and the PGP demo to enact the budget-neutral Physician Feedback/Value-Based Payment Modifier Program. These programs require physicians to report quality

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measures to CMS or face financial penalties, and link physician payment to performance on quality and cost measures through a value-based payment modifier.

Implementation. Physicians who do not report quality measures will face a payment penalty of 1.5 percent in 2015, increasing to 2 percent in 2016.[30] CMS will also implement a value-based payment modifier in 2015, beginning with large physician groups (100 or more eligible professionals) that are not ACOs, and expanding to all physicians and groups by 2017. To do so, CMS will calculate quality and cost composite scores and organize physicians into tiers, based on performance relative to the national mean. Quality measures include clinical care, patient experience and safety, care coordination, efficiency, and population health; cost measures include total costs and costs for beneficiaries with specific conditions.[31] High-quality, low-cost physicians will receive bonuses, while low-quality, high-cost physicians will be penalized up to 1 percent.

4. Hospital Readmission Reduction Program (ACA §3025)

Description of Policy. In June 2007, a Congressional advisory panel described the extent to which inpatient hospital admissions were resulting in readmissions, estimating that over 13 percent of readmissions within 30 days were potentially preventable, and were costing the Medicare program $12 billion annually.[32] Based on this finding, Congress enacted the Hospital Readmissions Reduction Program in the ACA. As of 2013, hospitals face a penalty of up to 1 percent of payments for excess readmissions for acute myocardial infarction, heart failure, and pneumonia. CMS defines “excess” readmissions as readmissions that surpass a hospital’s expected readmission rate: the national mean readmission rate, adjusted for demographic and severity factors of the hospitals’ patients.[33] CMS measures hospitals’ rate of readmissions and compare it to a national average to calculate a risk-adjusted excess readmissions ratio. The penalty amount increases gradually to a maximum of 3 percent in 2015, and the conditions on which a hospital’s excess readmissions are calculated will be expanded as well.

Implementation. In FY 2013, penalties for excess readmissions were approximately $280 million, distributed across 2,217 hospitals and ranging from 0.01 percent to –1 percent (see Figure 2). This included over 300 hospitals that lost the maximum 1 percent of payment.[34] Penalties for the second year of the program, FY 2014, total $227 million among 2,225 hospitals. A little less than half of the penalized hospitals will have their penalties increased from FY 2013, with 18 losing the increased maximum penalty of 2 percent of payment.[35]

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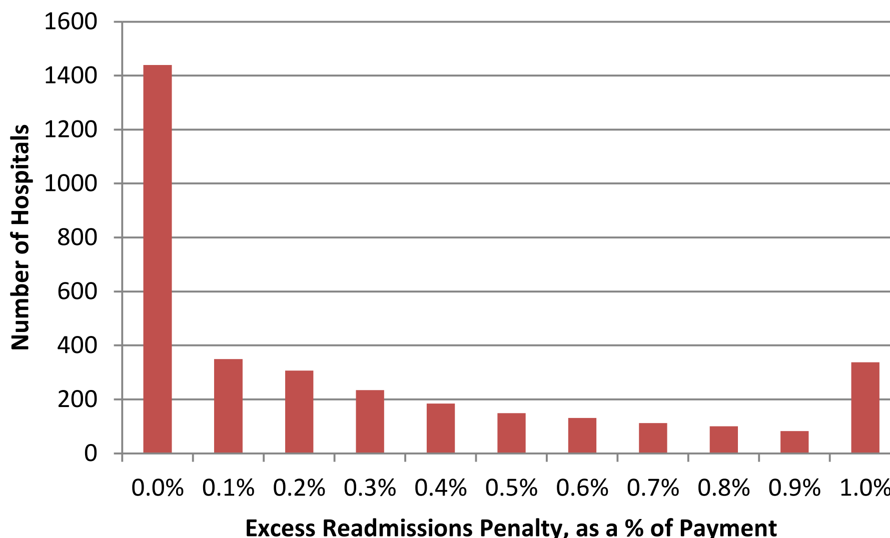
FIGURE 2: FY 2013 Hospital Readmission Reductions Program Results



In the FY 2014 Inpatient Prospective Payment System (IPPS) Final Rule, CMS included an algorithm to account for planned readmissions for acute myocardial infarction, heart failure, and pneumonia.[36] In FY 2015, CMS will expand the applicable conditions to include patients admitted for congestive obstructive disease (COPD) and elective hip or knee replacement.[37]

5. Center for Medicare and Medicaid Innovation (ACA §3021)

Description of Policy. To encourage innovative delivery system reforms, the ACA created the Center for Medicare and Medicaid Innovation (CMMI) to facilitate the implementation of new models that reduce spending while preserving or enhancing quality of care to health care enrollees in Medicare, Medicaid, and the State Children's Health Insurance Program (CHIP). The CMMI was allocated $10 billion in direct funding from 2011 to 2019, and operates several innovation models in the following seven categories:[38]

- ***Accountable Care:*** Projects aimed at providing incentives to providers to improve the quality and efficiency of care delivered to patients
- ***Bundled Payment for Care Improvement Initiative:*** Models that are based on the concept of bundling all services related to a single illness or course of treatment into a single payment to encourage care coordination and more efficient use of services
- ***Primary Care Transformation:*** Demonstration projects based on the Patient Centered Medical Home (PCMH), a model of care designed to strengthen the primary care system
- ***Initiatives focused on the Medicaid and CHIP population:*** Initiatives that test new care delivery models and reimbursement methods to increase quality and reducing costs for care delivered to Medicaid and CHIP beneficiaries
- ***Initiatives focused on the Medicare-Medicaid enrollees:*** Initiatives that are designed to better coordinate and enhance the quality of care delivered to beneficiaries who are enrolled in both Medicare and Medicaid
- ***Initiatives to speed the adoption of best practices:*** Programs that disseminate information on evidence-based clinical practices

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- ***Initiatives to accelerate the development and testing of new payment and service delivery models:*** Initiatives that encourage providers and states to develop, test, and implement systems that improve performance and benefit patients

Implementation. While the CMMI continues to introduce new initiatives, many of its early demonstration projects will reach their expected end dates in 2014. The ACA requires the CMMI to conduct an evaluation of each new model tested. The CMMI has established a Rapid Cycle Evaluation Group to regularly and frequently evaluate each model.[39] As of April 2014, the CMMI has released nearly 20 reports on programs and demonstrations.

6. Program Integrity (ACA §6401, 6402, 6405–6408, 6411)

Description of Policy. CMS estimates that in 2010, Medicare and Medicaid paid more than $65 billion (nearly 7 percent of total program costs) that it should not have. Other researchers estimate this amount to be much higher, and the Government Accountability Office (GAO) has designated Medicare and Medicaid as high-risk programs for fraud, abuse, and improper payments.[40] Although battling fraud and abuse is a longstanding effort, the ACA empowered CMS with new tools and mandates, including enhanced screening procedures for new providers and an optional provisional period during which a provider would be subject to enhanced scrutiny. The ACA created an integrated data repository with claims and payment data across many government programs, and coordinates data sharing for the purpose of identifying potential waste, fraud, and abuse. CMS has new authority to suspend provider payments pending investigation of credible allegations of fraud, and can require surety bonds for certain high-risk providers.

The ACA also targets high-risk services (such as home health services and durable medical equipment) by requiring that referring providers are enrolled in Medicare, giving CMS new authority to revoke enrollment if the provider fails to maintain adequate access to documentation of their practice, and requiring face-to-face visits before providers refer for these services. The ACA took steps to enhance civil monetary penalties, where applicable, and expands Recovery Audit Contractor (RAC) authority to help identify and collect over-payments across Medicare and Medicaid. Finally, the ACA invests $350 million in new resources to bolster anti-fraud activity.

Implementation. Many program integrity provisions in the ACA have been implemented, in part due to strict timelines or expedited regulatory processes mandated by the law. For instance, in 2011, CMS implemented an automated provider screening program that sorts providers into different risk levels based on historically high incidences of fraud, and incorporates new data such as loss of a medical license and Social Security death information. This system is also developing individual risk scores for fraudulent activity for individual providers.[41] RAC authority was extended to the Medicaid program beginning on January 1, 2012. CMS also created the Center for Program Integrity in 2010 to better coordinate fraud, waste, and abuse efforts. All together, these activities are aimed at helping CMS to move from "paying-and-chasing" fraudulent health care claims to a "prevention and detection" model.[42]

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An example of CMS' preventative approach is the agency's temporary blocks on new provider enrollments and supplier applications for home health agencies and medical device suppliers in areas with disproportionally high utilization and questionable billing practices to Medicare, Medicaid, and Children's Health Insurance (CHIP) programs. The most recent moratorium for home health agencies began July 2013 in Chicago, Illinois, and Miami, Florida, and expanded in January 2014 to include four more metropolitan areas (Fort Lauderdale, Florida; Detroit, Michigan; Dallas, Texas; and Houston, Texas). It is expected to last until July 2014.[43]

As for claims already paid, CMS reported record-breaking recoveries in recent years. From FY 2009 to FY 2013, the federal government recovered $19.2 billion. This was an increase from the $9.4 billion recovered during the previous five-year time period.[44]

Implementation in Michigan

Many providers and organizations in Michigan, including the State of Michigan, are participating in initiatives established by the ACA. Figure 3 provides a brief summary of implementation occurring in Michigan, including the Michigan-based participants.

Figure 3. Implementation of ACA Cost Containment Policies and Initiatives in Michigan

Policy/ Initiative	Number of Participants	Participants and Description
ACCOUNTABLE CARE		
Medicare Shared Savings Program	17 ACOs	The following ACOs, some of which cross state lines, are part of the Medicare Shared Savings Program and serve patients in Michigan: Started July 2012 – Accountable Healthcare Alliance, PC Oakwood Accountable Care Organization, LLC ProMedica Physician Group, Inc. Southeast Michigan Accountable Care, Inc. Started January 2013 – Northwest Ohio ACO Physician Organization of Michigan ACO St. John Providence Partners in Care, LLC Started January 2014 – CHA ACO, LLC Franciscan Select Health Network ACO, LLC GGC ACO, LLC National Rural ACO Northern Michigan Health Network Physician Direct Accountable Care Organization PMC ACO Reliance ACO, LLC South Bend Clinic Accountable Care The Accountable Care Organization, Ltd.

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Policy/ Initiative	Number of Participants	Participants and Description
ACCOUNTABLE CARE (cont.)		
Pioneer Accountable Care Organizations	2 ACOs	The following two ACOs in Michigan are participating in the Pioneer ACO model: Genesys PHO – *Flint* Michigan Pioneer ACO – *Detroit* The University of Michigan (Ann Arbor, MI) also participated in the Pioneer ACO model; however, its participation ended in July 2013 and moved to the MSSP.
Hospital Value-Based Purchasing	88 Hospitals	Michigan fared slightly better than the national average in 2014, with bonuses received by 49 percent of eligible hospitals; 48 percent of hospitals in the state faced a 0.27% penalty, on average. Nationwide, Oaklawn Hospital of Marshall, Michigan improved the most from FY 2013, moving from a 0.26 percent penalty to a 0.65 percent bonus in FY 2014.
Hospital Readmission Reductions Program	95 Hospitals	Of the applicable Michigan hospitals in FY 2014, almost 58 percent face a penalty of 0.39%, on average, up from the average penalty of 0.24% in FY 2013. The national average for FY 2013 penalties was 0.38%.
CENTER FOR MEDICARE AND MEDICAID INNOVATION		
Bundled Payment for Care Improvement (BPCI) Initiative	63 Providers	The BPCI initiative, which began in 2013, tests four models based on the concept of bundling all services related to a single illness or course of treatment into a single payment to encourage care coordination and more efficient use of services. The models are: Model 1: Tests retrospective payments for acute care hospital stays Model 2: Tests retrospective payments for acute and post-acute care Model 3: Tests retrospective payments for post-acute care Model 4: Tests prospective payments for acute hospital stays There are 63 providers in Michigan participating in the initiative; 22 providers are testing Model 2, 40 providers are testing Model 3, and one provider is testing Model 4.
Independence at Home	2 Providers	The Independence at Home initiative started June 2012 and is designed to test the effectiveness of delivering comprehensive primary care services at home, in coordination with medical practices in the community. The following Michigan providers are participating in the demonstration: Visiting Physicians Association, PC – Flint *Operating in the Counties of: Arenac, Bay, Genesee, Gladwin, Lapeer, Livingston, Midland, Oakland, Ogemaw, Saginaw, Shiawassee, and Tuscola* Visiting Physicians Association, PC – Okemos *Operating in the Counties of: Calhoun, Clinton, Eaton, Gratiot, Ingham, Ionia, Isabela, Jackson, Livingston, Montcalm, Shiawassee, and Wayne*

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Policy/ Initiative	Number of Participants	Participants and Description
CENTER FOR MEDICARE AND MEDICAID INNOVATION (cont.)		
Multipayer Advanced Primary Care Practice Demonstration	Approximately 400 Practices	Michigan was one of eight states selected by CMS to participate in the three-year demonstration. The Michigan demonstration is called the Michigan Primary Care Transformation (MiPCT) Project. MiPCT began operating in 2012 and is the largest Patient-Centered Medical Home project in the nation. The program is designed to promote alignment of public and commercial payers to improve care coordination for beneficiaries.
Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration	14 FQHC Sites	The FQHC Advanced Primary Care Practice Demonstration is a three-year project that started November 2011and is testing effectiveness of the patient-centered medical home, a model of care designed to strengthen the primary care system, in providing care for Medicare beneficiaries. The following FQHC sites in Michigan are currently participating in the demonstration: Baldwin Family Health Care, Inc. – *Grant* Bellaire Family Health Center – *Bellaire* Sparrow Health Center (County of Ingham) – *Lansing* St. Lawrence Community Health Center (County of Ingham) – *Lansing* Algonac Medical Center (Downriver Community Services) – *Algonac* New Haven Medical Center (Downriver Community Services) – *New Haven* East Jordan Family Health Center – *East Jordan* Family Medical Center of Michigan – *Temperance* Hackley Community Care Center – *Muskegon* InterCare Community Health Network – *Bangor* InterCare Community Health Network – *Holland* InterCare Community Health Network – *Pullman* Lakeland Immediate Care Center – *Cassopolis** MidMichigan Medical Offices – *Roscommon*
Strong Start for Mothers and Newborns Initiative	3 Providers	The Strong Start for Mothers and Newborns is a four-year initiative that started in 2013, testing enhanced prenatal care interventions for women who are at risk for having a pre-term birth and are enrolled in Medicaid or Children's Health Insurance Program (CHIP). The following Michigan providers are participating in the program: Allegiance Health – *Jackson* Providence Hospital – *Southfield* St. John Hospital and Medical Center – *Detroit*
Financial Alignment Initiative for Medicare-Medicaid Enrollees	N/A	In April 2014, Michigan finalized a Memorandum of Understanding with CMS that allows the state to conduct a three-year demonstration project aimed at aligning the health care benefits of Michigan residents who are enrolled in both Medicare and Medicaid. The demonstration will begin in 2015.

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Policy/ Initiative	Number of Participants	Participants and Description
CENTER FOR MEDICARE AND MEDICAID INNOVATION (cont.)		
State Innovation Models Initiative	N/A	Michigan received a Model Design Award totaling $1,653,705 to develop a State Health Care Innovation Plan that focuses on transforming the payment and care delivery system in the state. The plan, which the state submitted to CMS in January 2014, will be used to apply for a second round of funding.
Community-based Care Transition Program	5 Organizations	The Community-based Care Transition Program is aimed at improving care transitions from the hospital to other settings in order to reduce hospital readmissions for Medicare beneficiaries. The following organizations in Michigan are participating in the program: Michigan Area Agency on Aging 1-B *Macomb and Oakland Counties* St. John Providence Health System *Macomb, Oakland, and Wayne Counties* The Senior Alliance, Area Agency on Aging 1-C *Wayne County* Tri-County Aging Consortium *Clinton, Eaton, and Ingham Counties* Valley Area Agency on Aging *Genesee, Lapeer, and Shiawassee Counties*

Sources: Center for Medicare and Medicaid Innovation; J. Rau. November 14, 2013. Nearly 1,500 Hospitals Penalized Under Medicare Program Rating Quality. *Kaiser Health News.* http://www.kaiserhealthnews.org/stories/2013/november/14/value-based-purchasing-medicare.aspx.

* Doing business as Cassopolis Family Clinic

Conclusion

There has been much discussion of the coverage provisions of the ACA but the law also includes robust cost containment provisions. Although each of the policies highlighted here is in nascent stages of implementation, all are premised on prior demonstration programs or experiments in the public and private sectors. Evidence currently available for these policies and initiatives, such as the ACOs discussed earlier, currently points to moderate effectiveness in reducing costs, and at least some successes in improving quality. Many of these initiatives may be synergistic, together creating a more significant effect on the delivery system than each individually.

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