The Patient Protection and Affordable Care Act has resulted in benefits for North Carolina hospitals and the patients they serve. The impact of the ACA is not as great as it might have been due to lack of Medicaid expansion and exigent challenges at the state and local level.

Introduction

Before there was a global pandemic, people stood around at cocktail parties and made small talk. As you made small talk about your daily travails as a hospital administrator, the conversation would often turn to the impact of the Affordable Care Act (ACA). Folks who leaned liberal usually assumed there had been huge improvements as a result of the ACA. Those of a more conservative bent asked questions that presupposed that “Obamacare” had multiplied the burdens on hospitals. No matter their initial bias, both camps seemed genuinely surprised to learn that the ACA was far down on the list of the things that were either a blessing or a nuisance in the everyday life of a hospital guy.

Hope and Promise

The ACA's stated goals were to 1) make health care insurance available to more people, 2) expand the Medicaid program, and 3) support innovative care delivery methods to lower costs [1]. In 2016, President Barack Obama celebrated the legislation’s wins in JAMA: a 43% decrease in the uninsured rate, improvements in access to care, and 30% of traditional Medicare payments flowing through alternative payment models [2]. Since its enactment, the ACA has been mired in controversy and beset by legal, legislative, and administrative challenges [4]. Although the ACA is now more popular than ever before, this rise in popularity is based on the perceived impacts of the law at a personal level, rather than ongoing political debate [3]. Having already been to the Supreme Court in 2012 [5], oral arguments are scheduled for post-election November to again consider the constitutionality of the individual mandate provision [6].

Failure to Thrive

North Carolina is currently one of 12 states that has not expanded Medicaid under the provisions of the ACA. The failure to expand Medicaid has meant that the benefits of the ACA have not been fully realized in North Carolina. Recent research suggests that Medicaid expansion yielded health benefits for low-income adults in the South, even when those individuals already had access to safety-net care [7]. Safety-net hospitals in states that expanded Medicaid coverage under the ACA also fared better financially than their counterparts in states that did not [8]. Between 2012 and 2015, safety-net hospitals in expansion states saw operating margins improve by 1.1%, versus a decline of .3% in non-expansion states [8]. Likewise, uncompensated care costs as a percent of total hospital operating costs decreased by 47.4% in expansion states versus 7.8% in non-expansion states during the same period [8]. Counterintuitively, between 2014 and 2017 Medicaid expansion was associated with a 4.4%-4.7% reduction in state spending on traditional Medicaid [9]. Even without Medicaid expansion, health care insurance has become available to a greater percentage of North Carolinians since the ACA was passed in 2010. Employer-based insurance increased by 2%, Medicaid by 1%, and Medicare coverage by 3%; of note, North Carolina’s uninsured rate dropped from 16.98% in 2010 to 10.85% in 2018 (Figure 1).

Despite the progress made in securing coverage, it should be noted that not all insurance is created the same. Some insured North Carolinians on high-deductible health plans have insufficient savings to cover the cost of their deductibles [10]. In these cases, hospital patients may be insured, but their balance owed may still end up in bad debt. The impact of bad debt due to high-deductible health plans may be even more severely felt by small, rural hospitals [11].

Paying for Numbers

The ACA also brought different approaches to federal payment methodology. One example of this is the Hospital Value-Based Purchasing (VBP) program. VBP links Medicare

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payments to performance on specific metrics in an effort to reward providers for improved quality of care [12]. In 2020, hospitals’ base operating Medicare payments were reduced by an estimated 2% [12]. The sum total of these reductions is then pooled and redistributed to hospitals as value-based incentive payments depending on their quality measure performance. Under VBP, hospitals may earn less, the same, or more than the 2% reduction. In 2020 these value-based incentive payments were evenly divided between four quality domains: clinical outcomes, person and community engagement, safety, and efficiency and cost reduction. Each domain consists of measures that are compared to a benchmark. Strong performance against these benchmarks results in points for achievement and improvement. These points are factored into an equation that determines whether a hospital is rewarded or penalized by incentive payments.

Examples of clinical outcomes measures include 30-day risk-standardized mortality, 30-day risk-standardized readmissions, and 90-day complications for hip and knee replacement. The person and community engagement domain consists of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. This patient survey inquires into aspects of a patient’s inpatient stay, such as communication with doctors and nurses, cleanliness and quietness of the environment, and care transition. The safety domain measures the incidence of seven different types of health care-associated infections, such as catheter-associated urinary tract infections and certain surgical site infection rates. The efficiency and cost reduction domain is measured by Medicare Spending Per Beneficiary (MSPB).

A great benefit of VBP is that it creates a common and uniform set of metrics against which hospitals can compare themselves. Without such a shared set of metrics, it is tempting for hospitals to grade themselves favorably against internally generated benchmarks and believe their performance to be better than it is. These shared quality metrics have also provided a mechanism for hospitals that truly excel to be recognized for their performance and propagate their best practices.

In addition to providing comparisons for those within the health care industry, these VBP metrics are available to the public via Medicare’s Hospital Compare website [13]. Such data can be used by patients to make decisions about where to seek care, governance boards to understand where their organizations need to improve, and large employers and insurance companies to determine which health systems should be preferred providers. Beyond the specific comparisons available through VBP data, this increase in transparency has accelerated the importance of non-governmental hospital comparison tools, such as rankings by The Leapfrog Group.

Emphasis on VBP metrics, though, has not come without critique. The shift to HCAHPS and other patient experience surveys invites complaint that such surveys are poor tools for measuring whether medical treatment is clinically appropriate and efficiently provided. Over-prescribing of opioids is sometimes blamed on the importance put on such surveys [14], though causation is unproven [15]. Another shortcoming of the VBP methodology is the staleness of the data used for baseline and performance periods in measuring performance. For example, a VBP payment summary report generated for the author’s hospital on August 14, 2020, used the period July 1, 2011, through June 30, 2014, for baseline performance for acute myocardial infarction, heart failure, and chronic obstructive pulmonary disease mortality scoring. The performance period on which incentives payments were awarded was July 1, 2016, through June 30, 2019. The data lag of 13 months presents difficulty in tying timely interventions to scorecard performance. This delay also diminishes the benefit of these data to the public. When a hospital has implemented timely countermeasures to improve quality, but public reporting reflects data that are a year old, the hospital suffers. When stale publicly reported data reflects that high-quality but recent performance by a hospital is poor, the patient loses. Finally, because these metrics impact both patient perception and federal reimbursement, there is concern that hospitals might make clinical decisions that produce favorable metrics even when that outcome doesn’t reflect the most advanced science. An example of this tension is the increasing sensitivity and precision of laboratory testing versus penalties for health care-associated infections, such as Clostridium difficile [16].

Communities with Benefits

Among other wins of the ACA were four new requirements related to the Internal Revenue Service’s community benefit requirement for nonprofit hospitals. These four requirements were: 1) a regular community health needs assessment (CHNA) and implementation strategy, 2) written and posted financial assistance policies, 3) limitations on hospital charges for patients eligible for financial assis-
tance, and 4) specific patient-friendly requirements for billing and collections [17]. One of the benefits of the CHNA is that it creates an occasion for hospitals and health care systems to be conveners of partners to address unfavorable health outcomes in the community. In most North Carolina environments, the local hospital system is the biggest community stakeholder for health concerns. Particularly in rural settings, hospitals often have resources in the form of staff and technology that can be of great benefit to local public health efforts. Because of this, hospitals should be taking the lead in improving the health of their communities. Likewise, the ACA requirements related to financial assistance and collections codified what many forward-thinking health systems had already done. Prior to such requirements, indigent patients with no means to pay could paradoxically be charged more than wealthy patients with very comprehensive insurance. In a similar vein, restrictions on collections forced hospitals to ensure that financial assistance is made available to all patients who qualify before extraordinary collections methods can be employed. These requirements also seem to have had an unofficial impact on organizational views toward collections, resulting in many hospitals taking a more conservative approach to garnishing of wages and liens on assets.

Closer and Scarier

Despite the changes that the ACA has produced, its impact seems muted. Why? One answer is that all health care, like politics, is local. Local market changes, even when the market is a large one, have a greater impact on the annual performance and strategy of hospitals than the expected gradual roll-out of new federal regulations and requirements.
A qualitative study by the North Carolina Rural Research Program underscored the importance of local market and economic conditions, and health system changes more generally, in moderating the effects of the ACA [18]. This is consistent with the author’s experiences. In the past three years in North Carolina there have been merger negotiations between two academic medical centers with a large, non-profit health system (one suspended, one completed); the acquisition of a large community-owned health system by a for-profit system; and plans to sell a robust, county-owned hospital to a multistate health system. In smaller markets, the same level of uncertainty and risk might occur when considering whether to affiliate with a larger system as with the loss of a single highly productive surgeon.

The second answer lies in the other acute and impactful challenges that North Carolina hospitals have faced since the passing of the ACA. At time of writing, North Carolina is five months into the biggest health crisis since the Spanish Flu. The coronavirus pandemic has pushed hospitals in North Carolina to their extremes, where finding adequate supplies, staff, and space is a daily challenge. In the face of such demands, the gradual changes brought about by the ACA pale in comparison. But setting aside COVID-19 as a black swan event, one need only reflect on changes that have been foremost on North Carolina hospital C-suite agendas in the past few years: the projected financial impact of transitioning to Medicaid managed care; contract disputes between health systems and major payors, such as the North Carolina State Employees’ Health Plan; perennial fights over the future of Certificate of Need and the 340B program; nursing and physician shortages; redesign of the Joint Commission’s survey methodology; and rural hospital closures. The lofty
goals of the ACA are aspirational, but these alligators are closest to the boat.

More of the Same?

Such uncertainty about the environments in which hospitals operate will continue. Uncertainty about the future of the ACA will continue as well. Depending on the results of the November election and the Supreme Court’s ruling in this most recent case, the ACA could be significantly strengthened or weakened. Support for a Medicare-for-all proposal has risen to 67%, according to an August 2020 Hill/HarrisX Daily Poll [19]. It is possible that public support for additional expansion of government insurance coverage will increase even more in the aftermath of COVID-19. What remains to be seen is whether supporters of North Carolina Medicaid expansion will be successful. Nevertheless, North Carolina hospitals, out of necessity, will remain focused on the immediate concerns of their local markets. And that’s what will be talked about at cocktail parties if they ever return.

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