The Affordable Care Act: Quality Improvement Measures and Their Impact on Physicians

Abstract

The Affordable Care Act of 2012 (ACA) created provisions for a broad restructuring of the entire health care system in the United States, which, according to the authors, requires major reorientation by public and private entities, including physicians, clinicians, and health care management professionals. Quality improvement is a major component of the ACA. The legislation included provisions for new types of health care organizations designed to deliver improved primary and preventative care; financial incentives designed to encourage health care providers to adopt Meaningful Use standards as well as stimulate improved overall care; and mandated health care provider reporting on quality improvement in several areas. While the overall effects of these provisions on patient outcomes will be largely longitudinal and therefore difficult to quantify, evidence is nonetheless emerging about the effectiveness of these approaches on the degree of improvement for patient care. It is generally positive, if moderately so. At the same time, it relies on increased involvement by physicians, in terms of playing greater public roles, collaborating with one another to make health decisions for patients, and reporting outcomes in order to receive financial incentives as well as remain compliant with ACA regulations. This review discusses the implications of the ACA on physicians, clinicians, and health care providers in terms of this increased involvement.

Keywords: Affordable Care Act, quality improvement measure, Federally Qualified Health Centers, Patient-Centered Medical Homes, Health Homes, Accountable Care Organizations, Meaningful Use, Quality Improvement Measures
Introduction

The Affordable Care Act of 2012 (ACA) provided for a major shift in how physicians and health care organizations approach the delivery of services and care to patients. While much of the public debate has centered on success of insurance marketplaces, the most profound impacts of the ACA will take place in how patient care is handled. The ACA defined a three-part goal of providing better health care for individuals, better health outcomes in the community, and lower health care costs overall, and outlined an array of strategies health care providers can employ in order to meet them. Quality improvement measures for these goals have included novel approaches to delivering health care, a greater emphasis on primary and preventative care, and increased accountability on the part of health care providers.

Due to the fact that the provisions to ACA’s goals are as yet still being implemented, and the effects of these provisions will be largely longitudinal insofar as patient outcomes are concerned, there is little data on their success. But there are a number of papers already available that discuss the current state of quality improvement measures under the ACA as well as how these measures are affecting physicians and health care providers.

In this review, I will first discuss the new kinds of health care organizations the ACA made provisions for and how they are structured. Next, I will focus on articles that discuss the roles physicians can have in quality improvement in the new health care landscape. Finally, I will examine articles that discuss how quality improvement can be quantified in the future in order to provide the best outcomes for patients and health care providers in terms of providing better health care for individuals, better health outcomes for the community, and lower health care costs.


**Review of Literature**

**Novel approaches to primary and preventative care**

Calman et al. (2012) provided a general overview of the different approaches to achieving the ACA’s three-part goal. The overview discusses how Federally Qualified Health Centers (FQHCs), Patient-Centered Medical Homes (PCMHs), and Accountable Care Organizations (ACOs) are structured.

Calman found that FQHCs, also known as Community Health Centers, have largely been effective in providing improved access to care for underserved demographics, increasing patient utilization of preventative care, and providing management of chronic diseases at or above levels of care provided at other health facilities. Overall, Calman found that patients receiving most of their care at FQHCs had a 24% lower total cost of care than those who do not. PCMHs concentrate on providing primary and preventative care by “primary-care providers” who are assisted by a group of health care professionals. Qualifying as a PCMH under ACA guidelines requires a significant commitment to primary and preventative care, and while Calman did not have data as to their effectiveness, he noted that “provisions in the ACA ensure that this approach will continue to be monitored and evaluated.”

ACOs are established by hospitals, physician groups, or other health care organizations that decide to collaborate in order to provide quality health care more efficiently and effectively. ACOs are motivated by sharing savings and/or risk in order to coordinate care and avoid ER visits, lengthy inpatient stays, and expensive specialist visits. The primary goal of the ACO is to help patients use services appropriately, thus keeping them healthy while reducing costs. As with other models, this goal is best achieved by promoting preventative and primary care. ACOs also have to coordinate specialty services, monitor overall patient experiences, and ensure safety.
Health Homes (or Patient-Centered Medical Homes) are not a physical location; they are groups of providers who have shown they are able to provide coordinated primary and mental health care, substance abuse services and a raft of other support services. They are designed to assist patients with difficult conditions receive care and manage all of their conditions. Essentially, Health Homes are designed to assist high risk individuals with improved care at reduced cost.\(^1\) Approximately half of states were implementing PCMHs for their Medicaid populations as of 2012, which makes them an approach of particular interest in terms of improved outcomes.\(^2\)

In an interview with the Cleveland Clinic Journal of Medicine, Dr. David Longworth discussed the implications ACOs and Patient-Centered Medical Homes (PCMHs) may have on clinical practice.\(^3\) Longworth believes that the effectiveness of ACOs hinges on PCMHs as “the cornerstone of management,” and that home health, as part of the “postacute care continuum,” will also become increasingly important during the shift to PCMHs and ACOs. He recognized the major challenge to ACOs as being communication between primary care providers and home health services during the transition to home health care. And Longworth identified managing home health costs as a secondary challenge to PCMHs and ACOs.\(^3\)

A 2012 study\(^4\) of 669 health centers found that PCMHs consistently received higher ratings from patients than other health care facilities, but that these ratings were correlated with higher operating costs per patient per month. Mean total PCMH ratings were more than ten points higher (on a 100-point scale) than other health centers, and were correlated with a 4.6% higher operating cost per patient per month. For sub-scales, 10-point higher scores for patient tracking and quality improvement were also correlated with higher operating cost per physician full-time equivalent and per patient per month. Meanwhile, a 10-point higher PCMH subscale
score for access and communication was correlated with lower operating cost per physician full-time equivalent.⁴

Lawler and Floyd (2013) described the strategy being employed by Vidant Medical Center to adapt to the ACA’s Hospital Value-Based Purchasing Program (VBP). The VBP is designed to give the health care provider community incentives to minimize the frequency of adverse events that result in harm to patients, adopt care standards that are evidence-based, and redesign hospital processes to enhance the patient experience.⁵ This compensates hospitals based on their performance as compared to other hospitals, and is intended to raise standards across the board. At Vidant Medical Center, the VBP resulted in the facility outlining a set of performance standards in patient experience of care and clinical process of care, and making leadership accountable for them.⁵

**The role of physicians in quality improvement**

As health care providers, physicians will play a major role in ensuring quality improvement in the new health care landscape. Physicians will have a primary responsibility in coordinating patient care in all of the approaches described above, and there is a general consensus in the health care community that their leadership will be crucial to the success of the ACA’s three-part goal. A number of papers have discussed that role, and how to best implement physician leadership in quality improvement.

In the new health care landscape, physicians will be called upon more than ever to play roles outside of the consultation room, and the success of the ACA’s three-part goal will largely be affected by their willingness to take on a more public role. A 2006 paper looked at the level of importance physicians applied to public roles and their degree of participation in those roles.⁶ The authors surveyed 1662 physicians engaged in primary and non-primary care specialties, and
asked them to rate the importance of community participation, political involvement, collective advocacy, and relevant self-reported activities. 90% of respondents rated community participation, political involvement, and collective advocacy as “important.” And more than 2/3 of respondents had participated in at least one of the three in the past three years. This widespread support of public roles bodes well for the success of the ACA’s three-part goal.

Two papers looked at the role of physicians as a source of leadership in attaining quality improvement of health care outcomes. In one, the authors discussed the importance of “supportive medical and managerial leadership” in facilitating care management processes. They outlined a number of recommendations for successful leadership on the part of physicians and health care managers. Among them were the importance of embracing a leadership theory, focusing leadership efforts on important patient outcomes, using available sources of power to implement changes, and developing a team approach to care. This last recommendation dovetails with one made by another group of authors, who examined the role of physicians as leaders in the kind of collaborative setting that PCMHs present. The authors analyzed 8 primary care practices that were enrolled in a three-month facilitated quality improvement intervention. Based on their analysis, the authors identified three behaviors that are particularly important to good leadership by physicians: “explicitly soliciting team input; engaging in participatory decision making; and facilitating the inclusion of non–team members” in the health care process.

Indeed, collaboration among physicians and non-physicians may prove particularly important in the post-ACA environment, as health care professionals must increasingly coordinate their efforts in order to provide patient outcomes that meet the three-part goal for improved patient care. A 2014 study looked at the provision in the ACA to use “shared decision
making [to] ensure that medical care better aligns with patients’ preferences and values.”

The authors enumerate several ways in which shared decision making can affect quality improvement measures, “including increased patient knowledge, less anxiety over the care process, improved health outcomes, reductions in unwarranted variation in care and costs, and greater alignment of care with patients’ values.” It would seem that shared decision making has the potential to be a critical part of meeting many aspects of the ACA’s three-part goal. Yet, as the authors point out, as of 2014 there has not been much done on the part of physicians or health care management to encourage shared decision making. To some extent, the authors point to a lack of mandated requirements around shared decision making on the part of Medicare and Medicaid, which is undoubtedly a factor. But in terms of physician participation in shared decision making, the problem may be due to the professional culture surrounding quality improvement as a whole.

A 2005 study found that “quality improvement still [had not] permeated the professional culture of medicine,” with particular emphasis on the reluctance of physicians to participate in such measures.10 This conclusion was based on a survey the authors conducted in 2003 of more than 3,000 primary and non-primary care specialists; the physicians’ responses indicated low levels of interest in redesigning hospital systems or procedures to better manage patients’ care (34%); and similarly low interest in receiving quality of care data for patient experiences (25%), clinical outcomes (18%), and patients who receive recommended care (20%).10 While these data seem to indicate a lack of interest in quality improvement on the part of physicians, it is important to acknowledge that the study was conducted some nine years before the ACA was passed, and may not reflect the current culture. Still, they cannot be overlooked when it comes to determining the causes of slow implementation of ACA quality improvement measures such as shared decision making.
Ultimately, the health care community has to find ways to engage physicians in quality improvement. A 2013 paper\textsuperscript{11} acknowledged that collaboration by physicians may be hindered by their competing financial interests, and sought to find solutions to that problem. The authors analyzed a system of financial incentivization implemented by a health insurance company in Michigan. They identified five areas that were particularly effective in promoting physician engagement in quality improvement: “(1) developing a vision of improving primary care, (2) deliberately fostering practice–practice partnerships, (3) using existing infrastructure, (4) leveraging resources and market share, and (5) managing program trade-offs.”\textsuperscript{11} A comprehensive program such as this one, in which means of using the existing infrastructure along with financial incentives (such as resources, market share, and program trade-offs) may prove effective in stimulating quality improvement among physicians in other states as well.

Using financial incentives to encourage quality improvement by physicians is by no means a new concept. A 2011 study reviewed the effects of financial incentives on quality improvement.\textsuperscript{12} The researchers looked at studies into single-threshold target payments, fixed fee per patient achieving a specified outcome, payments based on the relative ranking of medical groups’ performance (or tournament-based pay), a mix of tournament-based pay and threshold payments, and changing from a blended payments scheme to salaried payment. Overall, the reviewers found “positive but modest” results across all schemes, and concluded that further research was warranted and that financial incentive programs should be “carefully designed before implementation.”

\textbf{Meaningful Use and Primary Care Outcomes}

The ACA also made provisions for the Meaningful Use (MU) initiative, a three-stage process; Title III of the ACA made nearly $40bn of MU incentivized payments available to
health care providers. The three stages of MU are: Stage I, Data Capture and Sharing, which was slated for 2011-2012; Stage II, Advancing Clinical Processes, which is occurring in 2014; and Stage III, Improved Outcomes, which is scheduled for 2016. The goals of the MU initiative are to “(1) improve the quality, safety, and efficiency of care and to reduce health disparities; (2) engage patients and their families; (3) improve care coordination; (4) improve population and public health; and (5) ensure adequate privacy and security protection for personal health information.”

According to an article published in 2013, the IDC identified the MU incentivized payments as the “primary motivator for small physician practices to adopt electronic health records (EHRs).” However the author of the article contends that meaningful use incentives, and indeed EHRs themselves, “won’t deliver the change we collectively seek.” He suggests that we do not seek EHRs and MU as outcomes in and of themselves, but rather as tools toward achieving “the strategic analysis of data to understand patients, populations, processes and performance” and use the knowledge gained from this analysis as the quality improvement measure that can produce better patient outcomes.

Yet a 2013 study of 14 primary care practices in Connecticut that had achieved Stage I Meaningful Use showed that quality improvement was in fact correlated with MU incentivized adoption of EHRs. While a minority of practices reported improvements in patient care ($n=3$), the researchers nonetheless found that practices that were PCMHs “scored higher on all quality improvement domains and received financial rewards more commonly.” This finding indicates that MU incentivized EHRs may be most effective when they are associated with PCMHs, which has interesting implications for both as the health care landscape continues to evolve to one that is more reliant on the latter for delivery of care.
Quality Improvement Measures

The Affordable Care Act has made quality improvement increasingly important to health care providers, with incentives such as MU and pay for performance, and this presents physicians with a new range of challenges, not least among them determining how to best quantify and implement quality improvement measures.

A 2013 article examined the prerequisites for succeeding in quality improvement in the new health care environment. The authors indicate that meeting these “preconditions for success” will become critical to health care providers, because without them, they contend that even “the best intentioned quality improvement program will fall short.” To prevent this, they outline four general requirements for success: “(1) Governing body support; (2) Management commitment; (3) Meaningful physician engagement; and (4) Effective quality improvement infrastructure.” While these preconditions are geared towards hospitals, they are equally applicable to smaller practices as well. Smaller practices may not have a formal governing body, and may have smaller management teams, but the support and commitment of the physicians in the practice is nonetheless very important to the success of quality measures. And effective quality improvement infrastructure is vital to the success of these measures as well: as the authors point out, “the specific methodology [for quality improvement] is not as important as simply identifying one and adhering to it.”

A “Viewpoint” article from JAMA in June of 2013 discussed the future of quality measurement and its implications for patient care and health care provider accountability. In this article, the authors proposed a roadmap for the ACA’s transitional health care landscape, the chief pillar of which was identified as “ongoing collaboration between the public and private sectors.” Unlike past federal statutes and private initiatives, which have been specific and
discrete, the ACA makes provisions for a broad restructuring of the entire health care system in the United States, which, according to the authors, requires major reorientation by public and private entities, both laterally and vertically. In order to effectively measure quality improvements, data must be captured at all three levels of care: individual physicians; in groups and facilities; and in populations and communities.

This means that physicians will have to adapt to a new system of reporting on quality measures in order to receive incentive payments, meet the ACA’s public reporting requirements and avoid penalties. Physicians and other clinicians have to comply with three mandatory CMS quality measures; “the physician quality reporting system, the physician value-based modifier for Medicare, and the EHR incentive program for Medicare and Medicaid.” The authors suggest that this system may require reduced complexity in order to be effective; furthermore, they argue that the measurement system must support improvement. In particular, they recommend that physicians adopt an EHR system that is “linked to a registry and…used for benchmarking with peers via electronic dashboards, timely feedback of individual and group performance, and decision support to drive improvement.”

**Conclusions**

In spite of the fact that it is less than three years old, the ACA has nonetheless begun to show meaningful, if moderate, outcomes in terms of both patient care and the level of involvement on the part of physicians. Novel health care organizations such as FQHCs, ACOs, and in particular PCMHs appear to be having positive impacts on patient care while at the same time reducing overall health care costs in certain areas. At the same time, the available research tends to indicate that these organizations are not universally reducing costs in all areas, and therefore there may be some room for improvement where it is possible. It may be that these
organizations, being relatively new, have not yet fully realized their potential in terms of efficiency and cost effectiveness. At the same time, there is obviously a limit to the degree to which they will be able to lower costs, and it is not at all certain that this limit is below the one existing health care structures are able to provide. Ultimately, the value of these organizations will be measured in aggregate terms that consider both the degree of improvement to health care outcomes and savings, so the fact that they are not lowering costs in all areas is not necessarily a negative result.

Physicians will undoubtedly play an expanded public role in the new health care environment, regardless of whether they practice in one of the new health care organizations, in a traditional hospital, or maintain a private practice. But research has shown that physicians are generally amenable to this role, or at least have been in the past, and therefore this should not present too great a burden on them.

Adapting to Meaningful Use standards and Quality Improvement Measures may prove more challenging. These provisions of the ACA have mandated requirements that have potential advantages and drawbacks for physicians. For example, MU financial incentives can be attractive to physicians, but at the same time they require significant changes in terms of adopting EHR and reporting on compliance. Similar complexity applies to implementation of and compliance with Quality Improvement Measures. While initial reports suggest that the overall effect has been moderately positive, more research needs to be done in order to determine the real efficacy of the ACA as it relates to Quality Improvement Measures and their impact on physicians and patient care.
References

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