

Consequences of the Affordable Care Act for Sick Newborns

In the United States, half a million infants annually require care in a NICU, which is often complex and prolonged. To achieve the best possible clinical outcomes, the needs and resources for these fragile infants must be matched appropriately.

Few arenas of modern medicine have been more efficacious than regionalized perinatal and neonatal intensive care. Regionalized health care has been described as a coordinated system of care “to improve patient outcomes by directing patients to facilities with optimal capabilities for a given type of illness or injury.”¹ The most complex infants are ideally born and cared for at regional high-risk perinatal centers, and large-scale regional referral networks have been successful in ensuring access to these facilities for all women and infants in need.^{2,3} However, driven by lucrative reimbursement for high-risk obstetric and neonatal care, the last 2 decades have witnessed an erosion of regionalized referral systems.⁴

In 2013, major parts of the Affordable Care Act (ACA) went into effect. The goals of the ACA mirror the Institute of Healthcare Improvement’s Triple Aim of better care experience, lower cost, and improved population health.⁵ The changes in provider incentives and regulations will provide concrete benefits to women and infants, including better access to health insurance through Medicaid expansion and health exchanges, more comprehensive insurance coverage for pregnant women and newborns, and potentially less fragmented, better coordinated, and higher value care through Accountable Care Organizations (ACOs) and other capitated arrangements. The ACA will exert some of its influence on perinatal care delivery by realigning financial incentives, which could destabilize perinatal regional referral systems, unless carefully monitored and managed.

CONCERNS

The ACA is not primarily concerned with high-risk infants but several of its provisions could have potentially adverse effects on high-risk obstetric and neonatal systems of care. Decades of research have shown that health care providers respond to financial incentives.⁶ In response to the ACA and other market forces, reimbursement will increasingly transition to capitated, global mechanisms in which health insurers will seek broad contracting relationships with provider networks. Under such payment arrangements, providers have an incentive to reduce

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KEY WORDS

Affordable Care Act, neonatal intensive care, quality of care, regionalization

ABBREVIATIONS

ACA—Affordable Care Act

ACO—Accountable Care Organization

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unnecessary but also necessary care.⁷ Under the Accountable Care model, quality surveillance should mitigate the effect of cost-reduction strategies. However, the science of quality measurement is still evolving. Because intelligent data systems to optimize network-level quality of care delivery are lacking for providers, payers, and consumers, providers may implement care strategies based on cost. Services aligned on cost without adequate quality surveillance could seriously compromise payers, providers, and patients' roles as arbiters of quality. Because decision-making about life and death in neonatology is complex and quality information is often unsophisticated, implementation of the ACA may lead to unintended consequences.⁸

Perhaps the most important concern for the ACA's impact is its influence on longstanding, regional perinatal referral systems. A transition of financial risk to providers may destabilize these systems, unless properly managed. The ACA will simultaneously create incentives for regionalization and deregionalization. Both can be desirable, as long as patient needs are met. The intent of ACOs is to optimally match resources with patient need. Deregionalization that is beneficial may result when ACOs pursue high value care by optimizing need and resources. This might include accommodating lower-risk newborns at lower-level, less costly NICUs. Currently, health plans may deny reimbursement for convalescent transfers to NICUs of the same level of care, even though these may provide care at lower cost. Desirable regionalization would also channel high-risk infants to perinatal centers. However, without adequate data to guide decisions about transfer, care for some infants may be suboptimal. Providers may face incentives to keep high-risk newborns at lower-cost community facilities. Although higher-level referral options usually exist within the

networks, incentives may be aligned to make this more difficult.

Of special concern for neonatal intensive care is the impact of the new financing structures on high-risk pregnancies and newborns at the margin of viability. Where the fee-for-service systems rewarded overuse of services, capitation will reward underuse. Providers may have incentives to select healthy patients by avoiding or transferring high-cost admissions, preventing high-risk pregnancies, avoiding resource-intensive births, and limiting care for the sickest infants. Newborns at the margin of gestational viability, who have severe congenital anomalies, and who are socioeconomically disadvantaged may be at risk for reduced care. For some infants, redirection of therapeutic goals to comfort care may be wholly appropriate. In addition, incentives under the current predominantly fee-for-service system may result in harm through overuse of unnecessary tests and procedures. On balance, the best interest and wishes of patients and families, not financial considerations, should guide these complex decisions.

Several countervailing mechanisms exist to mitigate the potential adverse effects of the ACA. Professionalism, best practice standards, and medico-legal pressures provide some, albeit inadequate, protection. More promising is the emergence of a variety of payment models that protect provider networks and health plans from the financial impact of "outlier patients." These include risk-adjusted payments for high complexity patients, carve-outs for high-risk patients from capitation pools, reinsurance, and risk corridors.⁹

SUGGESTIONS

Given the myriad challenges associated with the implementation of the ACA, it is not surprising that its impact on high-risk perinatal and neonatal services has not attracted focused

attention. Nevertheless, continued inattention could have serious consequences for regionalized delivery systems and patients. Several approaches may ensure access to high quality perinatal and neonatal care.

Quality Measurement

Better measurement will be key to achieving the goals of the ACA. Although significant progress has been made,¹⁰ better tools to assess the quality of perinatal and NICU care across multiple clinical and efficiency domains are needed. Assessment should occur within individual NICUs, across provider networks, and even across disciplines (eg, combined measurement of obstetric, neonatal, and early pediatric ambulatory care). Network-level measurement tools should guide strategic planning for care optimization and promote trans-disciplinary collaboration. Seamless delivery of preventive and therapeutic services will require alignment and common measurement of key contributors to overall network performance. These tools should also guide the appropriate regionalization of services.

Quality Improvement

Institutional and network-wide commitment to excellence is the best strategy for optimizing care. Every health care worker will need to have 2 jobs: doing their work, and making it better. Organizations should formalize these principles and align their internal incentives structures (payment and promotion) accordingly.¹¹

Oversight

Some states have adopted regulatory approaches that require that pregnant women and newborns in need of intensive specialty services be cared for in designated specialty centers. Others have less formal regionalized systems. All states will benefit from systematic

monitoring of the ACA's implementation and shared learning.

Regulators often rely on claims data of suspect validity and granularity in trying to judge the quality of large systems of care. Providers may have access to more granular clinical data. Regulators should partner with providers to link clinical, regulatory, and claims data. Linkage could allow for a careful assessment of the risk profiles of patients to ensure that ACA-related financial arrangements do not create distorted patient populations. Insight into quality of care and related outcomes would help identify referral patterns yielding substandard care. The challenge is to create intelligent information systems capable of generating such insights.

Payment and Accountability

Improved regionalized systems will require for provider networks and payers to collaborate in developing ACOs. Initially the level of capitated rates should be generous enough to promote early adoption and experimentation. Insurers could share information, which might help provider networks to optimize care (eg, reduce duplication of diagnostic tests, care use patterns). Nevertheless, provider networks should expect to compete in the marketplace and must be prepared to continuously drive down cost by improving care.

Because payer and provider incentives for cost reduction will be aligned, reporting of quality measures to the

public will be an important balancing mechanism. States could promote the collection and dissemination of data that consumers find meaningful.

Research

Researchers must harness the lessons from this national experiment. The effect of variation in state-level implementation of the ACA, degree of capitation, and regulatory oversight on perinatal referral systems and quality of care will provide valuable health policy insights.

The task lies in developing the tools capable of providing the requisite information to ensure the equitable provision of high-value quality of care, which is of course the primary goal of the ACA.

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