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In the Spotlight: Health Care Reform and Providers

The Affordable Care Act (ACA) will change the way that health care is delivered and will impact physicians, nurses, hospitals, and all other providers. The law includes sweeping provisions that change how people receive their care, while attempting to lower costs, raise quality, enhance efficiency, and achieve overall better outcomes for patients. Medicare and Medicaid reimbursement structure will be altered and there will be an increased focus on quality instead of quantity of care. With an expansion of public health insurance programs and new subsidies to purchase private insurance, there will be a large influx of insured individuals seeking care, causing a possible shortage in available providers. This paper, an overview of provider impacts, is the first in a 4-part series about the ACA and its impact on providers. Other Spotlights will explore the following topics at a deeper level: provider supply, provider quality, and reimbursement reforms.

- The ACA includes policies aimed at preparing for an adequate health care workforce:
  - $320 million in grants to expand health care workforce (2010-2014)
  - Expands scholarships and loan repayments through the National Health Service Corps for doctors, nurses and other health care providers who work in areas with a shortage of health professionals; 5% of North Carolina's population live in these underserved areas (2010-2014)
  - Designates half of the newly established Prevention and Public Health Fund ($250 million) to boost the supply of primary care providers by allocating resources for: State Health Care Workforce Development Grants; Nurse-Managed Health Clinics; Advanced Nursing Education Grants; and Primary Care Training and Enhancement
- The ACA addresses provider quality by including and extending more accountability for patient health outcomes, new quality measures and expanded data collection:
  - Rewards providers for efficiency and quality of care while supporting investment in patient-centered care in a Global Payment Demonstration for Medicaid (2010-2012)
  - Extends current Gainsharing Demonstration in Medicare until September 2011 for organizations who meet certain quality goals are rewarded with bonus payments for staying below CMS spending targets (FY2010)
  - Establishes a private, nonprofit entity – the Patient-Centered Outcomes Research Institute – to identify priorities for and oversee a national program of comparative clinical effectiveness research; helps stakeholders, including patients and their physicians, to make informed choices among treatment alternatives (2010)
  - Establishes health teams of professionals to coordinate care through grants to the states (2010)
  - Creates Center for Medicare and Medicaid Innovation within the Center for Medicare and Medicaid Services, begins full-scale operations in 2011: responsible for developing at least 18 reform programs, including: patient-centered medical homes, promotion of care coordination through salary-based payment; community-based health teams to support small-practice medical homes; use of health information technology to coordinate care for the chronically ill, and salary-based payment for physicians (2011)
  - Community-Based Collaborative Care Network Grants: made up of hospitals, community health centers, and other providers to provide coordinated patient care (2011)

- Demonstration in up to 8 states through Medicaid, provides integrated care for an episode of care ("bundling") based around a beneficiary's hospitalization in order to improve coordination (2012)
- Recognizes qualified pediatric providers, who will receive payments as ACOs as a demonstration for Medicaid and Medicare (2012)
- Independence at Home Primary Care Demonstration for Medicare: payment incentive and service delivery model to coordinate primary care physician or nurse practitioner services to provide at home care (2012)
- Physician and Hospital Compare Websites developed no later than January 1, 2011 (outcome measures will be developed within 3 years)
- Bundling Pilot for Medicare: provides integrated care for an episode of care based around a beneficiary's hospitalization in order to improve coordination (2013)

- The ACA alters the way that providers are reimbursed, further emphasizing patient health results:
  - Hospital Acquired Condition Payment Adjustment for Medicaid: states will no longer be reimbursed for conditions identified by HHS that are acquired at a hospital (2011)
  - Develops a plan for Home Health and Ambulatory Surgical Center Value-Based Purchasing for Medicare (2011)
  - Publishes Value-Based Payment Modifier under Medicare Physician Fee Schedule: adjusts reimbursement to Medicare physicians to base on quality and cost of care (2012)
  - Performance Adjustment and Rebate Phase-In for Medicare Advantage Plans: ties the rebate percentage of the Medicare Advantage plan's quality performance, so that high-performing plans will be reimbursed at a higher rate (2012)
  - Payments based on performance quality measures for acute-care hospitals beginning in October for Medicare (2012)
  - Authorizes adjustments of Medicare hospital payments to encourage hospitals to undertake reforms that would reduce preventable readmissions beginning in October (2012)
  - Hospital Value-Based Purchasing Program, Inclusion of Efficiency Measures for Medicare: will include efficiency measures on which to base payments in acute-care hospitals (2014)
  - Value-Based Payment Modifier under Medicare Physician Fee Schedule (application in 2015, all physicians and physician groups in 2017).
  - Payments to hospitals with high rates of hospital-acquired conditions will be reduced beginning in October for Medicare (2014)
  - Pay for Performance for Select Medicare Providers: payment rewards for providers who meet certain quality and efficiency goals. (2016)

BCBSNC Views

Blue Cross and Blue Shield of North Carolina supports a focus on health care quality and the implementation of care coordination models that ensure patient-centered medical practices. BCBSNC is eager to collaborate with providers to stem the tide of increasing medical costs. Already, we work with providers to develop methods of encouraging high-quality, efficient medical care and with customers to design products that encourage value-based decisions. We welcome the move toward more advanced health information technology and see it as cost-effective for both providers

and insurers, ultimately benefiting the health care consumer. BCBSNC believes that addressing rising medical expenses in order to give customers affordable health options involves all sectors of the medical community, including insurers and providers.

What to expect long-term

According to the Kaiser Family Foundation, public funds accounted for 46% of total health care expenditures in 2008. As the primary funder of health care, the federal government has enormous leverage to affect change in the way healthcare is delivered. Certainly, there will be cost-shifting of the Medicaid and Medicare programs. According to the North Carolina Hospital Association, spending and reimbursement cuts put up to 15% of total inpatient Medicare reimbursement at risk. The Medicaid expansion will increase enrollment and, at lower reimbursement rates than privately insured individuals, hospitals that serve Medicaid patients could face budgetary pressures.

Providers will all face the need to implement new healthcare information technology (HIT). Beginning in 2011, incentives will be made available to all eligible professionals and hospitals that adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health records technology. These incentive programs are designed to support providers in this period of transition and instill the use of electronic health records in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care. Other reforms, such as bundled payments, using best practices as one basis for payments, hospital readmission reimbursement reductions, episodic payments and comparative effectiveness research will also encourage a shift toward financial rewards for care recognized as quality. The coming Spotlights will further explain many of the long term effects of the ACA on provider supply, reimbursement, and quality.

For More Information

Healthcare.gov “In Focus” on Providers: http://www.healthcare.gov/law/infocus/providers/

North Carolina Medical Journal, “Health Reform and Workforce: The North Carolina Connection”: http://www.ncmedicaljournal.com/May-Jun-10/Ricketts.pdf

CMS Hospital Center: https://www.cms.gov/center/hospital.asp

White House ACA Brief on North Carolina Impacts: http://www.whitehouse.gov/files/documents/health-reform-states/affordable-care-act-immediate-benefits-nc.pdf

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