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In the Spotlight: Health Care Reform and Provider Reimbursement

The Affordable Care Act (ACA) seeks to improve health care delivery in many ways, from access to quality to cost. Providers play a major role in these changes; we have already explored the ways that provider supply and quality of care will be affected. This paper will dig in to the way that reimbursement will change for providers. Reimbursement is the payment for services administered, that health care providers receive from payers, which include both private and public insurance programs. Changing the reimbursement structure for providers has the potential to alter the entire health care system. Most of the payment reforms began in 2011 and 2012; however, the changes will continue through 2016. The ACA alters the way that providers are reimbursed from government insurance programs, as specified below. These reimbursement changes will likely also influence the reimbursement methods of private insurers over the long term, as well. The ACA includes:

- 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)
- Disproportionate Share Hospital payment program to reimburse hospitals for care for uninsured will be cut by 25 percent (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)

These payment reforms will have reverberating affects across the industry on payment issues, as well as consolidation.

What to expect

Changing the way providers are reimbursed certainly has implications beyond the Medicaid, Medicare, and CHIP programs. Cuts to the Disproportionate Share Hospital program, as well as the public insurance programs, may result in some cost shifting to private insured individuals. Clearly, this is not the result that supporters of payment reform hope to have. ACA's goal is to create a movement of payment reforms, in which private insurance companies

will follow the lead of successful government payment reforms, for example in bundled payments, and create system-wide changes for reimbursement. Aligning the payment structure across public and private insurance would have a more complete impact on the cost issues of the health care industry. Many private insurance companies, including Blue Cross and Blue Shield of North Carolina, have taken steps toward payment reform ahead of the changes dictated by ACA. Some other examples from a 2011 Commonwealth Fund report are below:

Exhibit ES-1. Shared Risk Payment: Four Approaches

Risk Model	Definition	Examples
Bonus Payment at Risk	Provider is at risk of not receiving a bonus payment based on quality and/or efficiency performance	Blue Cross Blue Shield of Minnesota Preferred One
Market Share Risk	Patients are incentivized by lower copays or premiums to select certain providers so providers are at risk of loss of market share	Buyers Health Care Action Group
Risk of Baseline Revenue Loss	Built on a fee-for-service "chassis"; providers face a financial or payment loss if they fail to meet certain cost or quality thresholds, and/or if actual costs exceed a target cost	Blue Cross Blue Shield of Massachusetts AQC Blue Cross Blue Shield of Illinois–Advocate Health Care
Financial Risk for Patient Population (Whole or Partial)	Providers manage patient treatment costs for all or a designated set of services within a predetermined payment stream and are at risk for costs that exceed payments (e.g., partial/full capitation, global budget)	State Employees Health Commission (State of Maine) *(planned)* Anthem/WellPoint *(planned)*

Some providers may also see benefits in consolidating their practice with larger provider groups or hospitals to help lower overhead costs. As one Milliman study points out, as reimbursements for public programs are lowered, providers feel increased pressure to become more efficient, which often leads to further consolidation. Unfortunately, consolidation often leads to *higher* prices because a larger hospital's more powerful market share gives them an advantage in reimbursement negotiations with insurers. Of course, higher reimbursements from insurers means that premiums increase for the health care consumer.

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 controlling cost while ensuring that consumers still receive quality services.

BCBSNC Views

Blue Cross and Blue Shield of North Carolina 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. In April of 2011, BCBSNC partnered with Caromont Health System to create a bundled payment arrangement for knee replacement surgery. As a part of this program, BCBSNC covers the entire knee replacement, including the pre-surgical period of 30 days prior to hospitalization, the surgery itself, and follow-up care related to the knee replacement within 180 days after discharge from the hospital. This new partnership exemplifies BCBSNC's priority of collaborating with providers. We have concerns about the cost shifting that may occur as a result of lower reimbursement rates and caution against consolidation that often leads to higher medical costs. 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. Initiatives like partnering with CaroMont are key to promoting health care quality and holding down costs.

For More Information:

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