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The Impact of Health Reform on Health Care Providers

The 2010 Patient Protection and Affordable Care Act (Health Reform) has the potential to dramatically change the way health care services are financed and delivered. This policy brief, the fourth in a series, summarizes the impact health reform may have on health care providers (physicians, physician assistants, nurse practitioners, allied health workers, hospitals, nursing homes, etc.). Previous briefs addressed an overview of health reform, state implications, and community implications.

CHANGES IN THE NUMBER OF GEORGIANS SERVED

The health reform law includes changes to eligibility for public insurance programs and credits to employers and individuals for offering or purchasing private coverage. Over time, those who choose not to purchase health insurance of some kind will be penalized through the tax code, the goal being to have the maximum number of people covered by health insurance. Recent analyses estimate that, with full implementation of health reform, approximately 75% of non-elderly Georgians will have private coverage through their employer, the new health insurance exchanges, or individual plans. About 19% will have coverage through Medicaid or PeachCare for Kids, the state's Children's Health Insurance Program (CHIP), and roughly 6% will remain uninsured.

The impact on individual providers will depend on their payer mix prior to reform. Providers who previously saw only private pay patients may see an increase in their overall practice volume. Those providers who previously served a high proportion of uninsured Georgians will likely see a reduction in uncompensated care as individuals gain private or public coverage. Providers who accept public coverage may see that proportion of their business increase as the percentage of Georgians with public coverage increases.

CHANGES IN WORKFORCE

Because many Georgians will be newly covered, the state will likely need more providers, especially primary

care providers. The health reform law addresses workforce issues in a number of ways. The law allocates \$11 billion to create and expand federally qualified health centers (FQHCs) and provides additional

HEALTH REFORM: Rx FOR PROVIDERS

POTENTIAL OPPORTUNITIES:

- Market expansion
- Support for primary care workforce
- Funding for FQHCs
- Two-year increase in Medicaid primary care rates
- Gainsharing demonstrations
- Bundled payments for coordinated care
- Quality reporting incentives
- Accountable Care Organizations
- Home-based care teams

POTENTIAL CONCERNS:

- DSH payments reduced
- Reporting penalties
- Penalties for hospital-acquired conditions and readmissions
- Stringent waste, fraud, and abuse provisions
- Financial risk under global payment methodology

funding for health center-based residencies to train physicians in primary care. Unused medical residency slots from hospitals nationwide will be redistributed according to a formula that apportions 70% of the slots to states with the lowest medical resident-to-population ratio. Georgia is one of these states and will be eligible for additional funding to support graduate medical education. Seventy-five percent of the newly apportioned slots must be for primary care (family practice, internal medicine, geriatric medicine, or pediatric medicine) or general surgery. A number of programs will be created to increase the health care workforce, such as state workforce planning grants, establishment of a public health workforce loan repayment program, state and local grants for mid-career professional training, public health training fellowships, a graduate nurse education demonstration project, and the establishment of a primary care extension program similar to the agricultural extension service. Most of the federal funds appropriated for these programs will be available beginning in fiscal year (FY)10.

CHANGES IN PAYMENT

The law implements several changes in payments to providers. Some payments increase, some decrease, some are extended, new methods of payment are created, and some payment mechanisms must undergo assessment.

Payments for public coverage will be temporarily changed by increasing the reimbursement rates for Medicaid and CHIP. This will include a two-year increase of Medicaid rates with a federal match for primary care services to equal the higher Medicare rates. While the entire cost of the increase will be borne by the federal government, states will have to pick up the additional cost or lower the rates after two years.

Payments for the Disproportionate Share Hospital (DSH) program will be reduced over time. DSH awards payments to hospitals that serve high proportions of Medicaid, Medicare, and uninsured patients. It is expected that large numbers of previously uninsured individuals will gain coverage, thus reducing the financial burden on DSH hospitals. In Georgia, net DSH payments totaled approximately \$282 million in 2009.

Some payment systems will be extended. Payments for Gainsharing Demonstration Projects will be extended through FY11. The Gainsharing Demonstration Projects were included in the 2005 Deficit Reduction Act to align financial incentives with enhanced quality and efficiency. Critical access hospitals will also be allowed to continue receiving enhanced payments. These payments will cover 101% of reasonable costs for providing outpatient care and qualifying ambulance services.

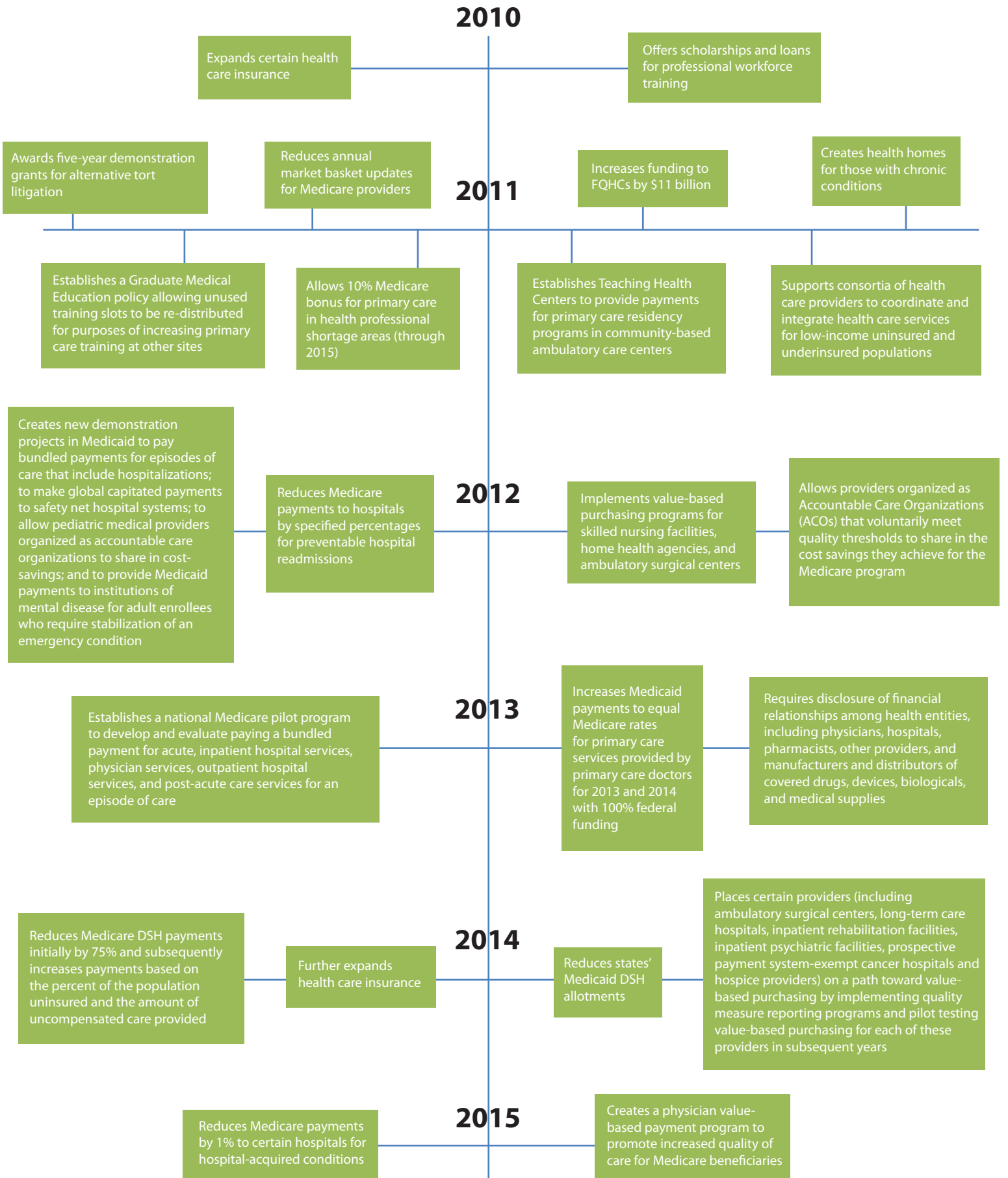
New payment mechanisms will be created. One new payment mechanism will be established through a demonstration project to pay for concurrent hospice and Medicare services. Another new payment mechanism will involve global capitated payments for states to pay hospitals. Global payments are fixed-dollar payments for the care that patients may receive in a given time period, such as a month or year. Providers that receive these payments assume a financial risk for both the occurrence and management of medical conditions. Demonstration projects will transition participating states from paying hospitals through fee-for-service rates to paying hospitals with global capitated payments.

Some payment mechanisms will undergo assessment. The law establishes a demonstration project to evaluate the use of bundled payments for the delivery of integrated care to Medicaid beneficiaries. In addition, the Medicare Payment Advisory Commission (MedPAC) will assess the adequacy of Medicare payments to rural providers. MedPAC must also assess the need for additional Medicare payments to urban hospitals for inpatient services.

CHANGES IN ACCOUNTABILITY

The new law addresses quality by tying payment incentives and penalties to expanded reporting requirements. Value-based purchasing programs will be implemented for hospitals. Incentive payments will be made to participating hospitals that meet performance standards for a specific period. Critical access hospitals will be eligible first. Georgia has 34 certified critical access hospitals and an additional 33 that are eligible for critical access status. Value-based purchasing programs under Medicare will also be

SIGNIFICANT IMPLICATIONS FOR HEALTH CARE PROVIDERS



extended to skilled nursing facilities, home health agencies, and ambulatory surgery centers. Incentive payments will be extended to physicians who satisfactorily report quality measures through 2013, and in 2015 penalties will be levied on physicians who do not report. A value-based payment modifier will be added under the physician fee schedule. To reduce duplication, quality reporting will be integrated with requirements for meaningful use of electronic records.

Although short on detail, the law includes language to require new quality reports and data analysis under the physician feedback program. Long-term care hospitals, inpatient rehabilitation hospitals, and hospices must report on quality measures beginning in 2014. Also in 2014, new quality reporting programs will be required for inpatient cancer hospitals exempt from the prospective payment system. Hospitals will also be subject to a penalty adjustment for high rates of hospital-acquired conditions; and a hospital readmission reduction program will target potentially preventable Medicare hospital readmissions.

The law also addresses accountability for waste, fraud, and abuse unrelated to quality initiatives. The number of years providers have to file claims will be reduced from three to one. New monetary penalties will be imposed for false claims and for false or delayed access to information for investigations. Providers must return overpayments within 60 days or be subject to potential penalties under the False Claims Act. Certification for home health services or durable medical equipment benefits will be dependent on a face-to-face encounter. Under the Medicare hospice benefit, beneficiaries will be required to have a face-to-face encounter with a hospice physician or nurse practitioner regarding eligibility and recertification, and stays exceeding 180 days will require a medical review. Medicaid providers will be automatically terminated if they were terminated from Medicare or another state program. The required structure and activities of compliance programs for certain, yet-to-be determined, providers will be explicitly defined.

CHANGES IN ORGANIZATION

The health reform law promotes new types of provider organization through a variety of incentives, programs, and projects. Accountable care organizations (ACOs),

consisting of groups of providers that agree to be held accountable for the overall quality, cost, and coordination of patient care in return for a share of potential savings, will be created. A Pediatric ACO Demonstration Project will be established so participating states can allow pediatric providers meeting certain requirements to receive incentive payments. Under Medicare, the law allows groups of other providers (in addition to pediatricians) to form ACOs beginning no later than January 2012. ACOs that meet quality performance standards will be eligible for incentive payments.

A new model of physician and nurse practitioner home-based primary care teams will be tested to assess its ability to reduce expenses and improve health outcomes. Another team model will establish community-based interdisciplinary teams to support primary care practices, including obstetrics and gynecology practices, within hospital service areas. Funding will also be provided for projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems.

CONCLUSION

Health care providers are at the center of changes due to health reform. Most providers will be affected by changes in the insurance status of the population and in the way they are reimbursed for services from government payers. Almost all will be affected by the law's efforts to increase quality. Only some will be affected by other portions of the law. Over the next two years, much more will be known as administrative regulations are written and published. Health care providers will need to stay up-to-date on those regulations in order to be strategically positioned when health reform is fully implemented in 2014.