

# The ACA and Changes to Provider Reimbursement

*Produced by Health Resources in Action of Boston  
for the Maricopa County Department of Public Health*

The Patient Protection and Affordable Care Act (ACA) changes provider reimbursements to reward the Triple Aim: improving quality of care and population health outcomes, as well as lowering costs. There are also Medicare-specific cost containment reforms focused on reducing waste and fraud. Our current health care reimbursement systems tend to support volume of care, rather than value based care. Thus, payment systems linked to provider accountability and patient outcomes create new motivation for health care systems to partner with public health departments on prevention strategies that are demonstrated to reduce costs and improve health outcomes. This brief describes these changes in reimbursements to facilitate productive conversations between Arizona health departments and health care providers and systems for the purposes of promoting mutual goals and leveraging resources.

## 1. Incentivizing Primary Care

**Medicaid.** In order to enhance primary care capacity for the previously uninsured, the ACA establishes federal Medicaid primary care provider payment enhancements to bring rates for primary care providers equal to Medicare rates for a two-year period, beginning January 2013 through December 2014 (1). The increase applies to 150 different primary care services provided to Medicaid enrollees by family medicine, general internal medicine, and pediatric physicians. The Medicaid fee increases apply in managed care organizations as well as fee-for-service programs, and the health reform law requires that qualified physicians in Medicaid plans directly receive the enhanced rates (2).

**Medicare.** Between 2011-2016, Medicare physicians who prove that they are Board certified will receive a 10% bonus for office, nursing facility and home visits if, in the previous year, at least 60% of the Medicare services provided were considered eligible primary care services. The bonus also applies to services

provided by nurse practitioners and physician assistants under the personal supervision of a qualified physician.

## 2. Medicare Hospital Value-based Purchasing Program (VBP)

Beginning 2013, the Centers for Medicare and Medicaid Services (CMS) rewards Medicare physicians in eligible acute care hospitals for high quality care for five of the most prevalent conditions, with more conditions to be added over time(3). A percentage of Medicare reimbursement is tied directly to achieving certain quality benchmarks related to heart failure, pneumonia, surgeries and hospital-related infection, as well as efficiency and patient satisfaction (4). Hospitals that meet or exceed the benchmarks set by CMS will receive higher payments (5). The ACA outlines a plan to expand value-based payment strategies for other Medicare providers, including skilled nursing facilities, home health care providers, hospice care, rehabilitation hospitals, and ambulatory surgery facilities (6).

Medicare Physician Quality Measure Reporting (PQMR), Effective January 1, 2015 providers (not just hospitals) will be reimbursed for their Medicare patients based on value, not volume, meaning that physicians will see their payments modified so that those who provide higher quality care will receive higher payments than those who provide lower quality care(7). Penalties in 2015 will be based on 2013 performance (8).

Furthermore, the ACA established the Physician Quality Reporting System (PQRS), which offers incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.

### 3. Bundled Payments for Care Initiative (9)

The Bundled Payments for Care Improvement Initiative (Bundled Payments Initiative) is a program of the Center for Medicare and Medicaid Innovation (CMMI), established under the ACA, to develop more efficient and cost-effective ways to pay for health care to a growing population of Medicare and Medicaid beneficiaries. Launched in January 2013, the first group of funded programs includes 16 sites in Arizona. (See the CMMI website Where Innovation is Happening - <http://innovation.cms.gov/initiatives/map/> - for these and other Arizona CMMI Innovation projects.)

The program provides hospitals and doctors with new incentives to coordinate care because it aligns payments for services delivered across an episode of care—beginning three days before hospital admission and ending thirty days after the patient is discharged (10)(5). The new payment system will help to ensure continuity of care across settings by paying for an episode rather than paying for services separately and thereby reduce duplication of services and preventable medical errors, help patients heal without harm, and lower costs (11). There are four different bundled payment models of care supported in this pilot program that link payments for multiple services received during episodes of care for 48 diagnoses.

- Model 1 is the Acute Care Hospital Stay where the episode of care is defined as the inpatient stay at the acute care hospital.
- Model 2 is the Retrospective Acute Care Hospital Stay plus Post-Acute Care where the episode of care is the inpatient stay plus all related services with the episode ending either 30, 60 or 90 days after hospital discharge.
- Model 3 is the Retrospective Post-Acute Care only where the episode of care will begin at the initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.
- Model 4 is the Acute Care Hospital Stay only where the bundled payment would include all services furnished during the inpatient stay by the hospital, physicians, and other practitioners.

There is also a special bundled payment program for serving Medicare patients with End Stage Renal Disease (ESRD). CMMI has also launched the

Comprehensive ESRD Care program, a new payment service and delivery model for non-Medicare patients.

Private insurers, including United Health, Aetna and many Blue Cross and Blue Shield have started making bundled payments to groups of providers and hospitals (12).

### 4. Medicare Hospital Readmissions Reduction Program

This program reduces payments to hospitals that exceed preventable readmissions standards, applying to hospital discharges as of October 1, 2013. The Hospital Readmissions Reduction Program begins with penalizing hospitals for excess preventable readmissions for pneumonia, acute myocardial infarction (AMI), and heart failure, and will add additional diagnoses in future years.

This program incentivizes hospitals to create smoother transitions with better discharge planning and coordination of care for patients, rewarding hospitals that are successful in reducing avoidable readmissions (13)(14). CMS works with hospitals at the local level to reduce avoidable readmissions through its Quality Improvement Organizations (QIO) (6). Quality Improvement Organizations are private, often non-profit, organizations whose staff review medical care and assist people with complaints about the quality of care received. They are funded to protect the integrity of Medicare payments ensuring they pay for services that are necessary and reasonable and to improve the quality of care patients receive. There is one funded in each state as well as in the District of Columbia, Puerto Rico and the U.S. Virgin Islands (15).

The Community-based Care Transition Program is a five-year program created by the ACA in which hospitals and community-based organizations will work together to improve care transitions, including post-discharge follow-up, and thus aim to reduce readmissions for high-risk Medicare beneficiaries (16). Hospitals will be looking for additional strategies to prevent readmissions, such as home visiting, nurse follow-up calls, and case management. The program funds community-based organizations to coordinate post-hospital care with funding preference for Area Agencies on Aging to assist with care transitions in partnership with hospitals and providers that serve medically underserved populations as well as small and rural communities (16). Medicare QIOs can help applicants analyze relevant local hospital re

data, propose root causes and convene local stakeholders to develop a program and interventions (16).

## 5. Penalties for hospital-acquired infections (HAIs)

Beginning in 2015, the top 25% of hospitals with the highest rates of hospital-acquired conditions such as bedsores, complications from extended use of catheters, and injuries caused by falls, will face payment penalties of one percent of their Medicare payments. Medicaid will also stop reimbursing for treatment required for HAIs. Moreover, hospitals will be required to post their HAI rates online.

## 6. New Models - Center for Medicare and Medicaid Innovation (CMMI)

CMMI is funding a range of new models of care that focus more on coordination and integration of care and addressing comprehensive patient needs, such as Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMH). These structures are intended to accomplish the triple aim of improving

quality, population health outcomes and reducing the cost of care. They have in common new levels of accountability for outcomes, and in many cases, CMMI is specifically looking for projects that integrate community resources with clinical care. Categories of CMMI funding include:

- Accountable Care Systems
- Bundled Payments for Care Improvement
- Primary Care Transformation
- Initiatives Focused on the Medicaid and Community Health Improvement Plan (CHIP) Population
- Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
- Use of Community Health Workers
- Initiatives to Speed the Adoption of Best Practices.

It is advised for health departments to become familiar with CMMI's work and the models being promoted, and to stay abreast of funding opportunities to partner with health care providers for innovative models that link clinical care to community care.

**Selected Key Medicare Cost Containment Strategies in the Affordable Care Act\* (6)**

Cost Containment Strategies	Key Provisions	Ten-Year Cost Savings
Improve the quality of care	Reduces the number of hospital readmissions.	\$8.2 billion
	Reduces hospital-acquired conditions.	\$3.2 billion
	Bundling payments for End Stage Renal Disease (ESRD)**	\$1.7 billion
	Improves physician quality reporting	\$1.9 billion
Reform our delivery system	Promotes Accountable Care Organizations	\$4.9 billion
	Establishes the Independent Payment Advisory Board (IPAB)	\$23.7 billion
TOTAL		43.6 billion

\* Modified from Figure 3 in Centers for Medicare and Medicaid Affordable Care Act Update: Implementing Medicare Cost Savings

\*\*Estimates for cost savings here are for ESRD. The Bundled Payments Initiative is broader than ESRD and includes services delivered like hip replacements or heart bypass.

The Independent Payment Advisory Board (IPAB) was established with the ACA and began its work in 2012. The Board monitors the fiscal health of the Medicare program and will make annual recommendations to Congress regarding how to improve quality of care for Medicare beneficiaries while containing cost growth (3).

The new incentives for prevention, and the aforementioned mandated changes in provider reimbursements, might have ripple effects that need monitoring. For example, there may be some cost-shifting such that providers may increase rates for non-CMS patients to avoid losing money from the changes in the Medicare/Medicaid reimbursement models. This could potentially result in increased premiums for non-CMS patients. Furthermore, although this hasn't happened yet, private insurers might also limit payment for hospital-acquired infections or preventable hospital readmissions. It is important to closely monitor these considerations as the ACA is implemented in the coming months and years.

1. Primary Care Physician Workforce – Health Reform GPS: Navigating the Implementation Process [Internet]. Available from: <http://www.healthreformgps.org/resources/primary-care-physician-workforce/>
2. Zuckerman S, Goin D. How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees [Internet]. Kaiser Commission on Medicaid and the Uninsured. 2012 [cited 2013 May 4]. Available from: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8398.pdf>
3. Affordable Care Act Update: Implementing Medicare Cost Savings [Internet]. [cited 2013 Jun 1]. Available from: <http://www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf>
4. Healthcare Reform: Impact on Hospitals. Health Care Capital Topics. [Internet]. 2011 [cited 2013 Jun 1]. Available from: [http://www.healthcapital.com/hcc/newsletter/1\\_11/aca.pdf](http://www.healthcapital.com/hcc/newsletter/1_11/aca.pdf)
5. Healthcare Reform: Impact on Hospitals. Health Care Capital Topics. 2011.
6. Affordable Care Act Update: Implementing Medicare Cost Savings.
7. Key Features of the Affordable Care Act. [Internet]. [cited 2013 Jun 1]. Available from: <http://www.healthcare.gov/law/timeline/full.html>
8. American Medical Association. Physician Quality Measure Reporting.
9. CMS Factsheet: Bundled Payments for Care Improvement Initiative. [Internet]. [cited 2013 Jun 1]. Available from: <http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4515&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chNewsType=6&intPage=&showAll=&pYear=&year=&desc=&boOrder=date>
10. Affordable Care Act initiative to lower costs, help doctors and hospitals coordinate care [Internet]. [cited 2013 Jun 1]. Available from: <http://www.hhs.gov/news/press/2011pres/08/20110823a.html>
11. Affordable Care Act initiative to lower costs, help doctors and hospitals coordinate care.
12. Jepsen B. Though Obamacare Pays Less, Providers Flock To “Bundled” Medicare Payments - Forbes. Forbes [Internet]. 2013 [cited 2013 Jun 25]; Available from: <http://www.forbes.com/sites/brucejepsen/2013/02/01/though-obamacare-pays-less-medical-providers-flock-to-bundled-medicare-payments/>
13. Hospital Readmissions Reduction Program [Internet]. [cited 2013 Jun 1]. Available from: <http://healthreformgps.org/wp-content/uploads/Jane-Readmissions-PDF.pdf>
14. Centers for Medicare and Medicaid Services. Readmissions Reduction Program [Internet]. 2013 [cited 2013 Apr 15]. Available from: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>
15. 1Overview. 2013 May 20 [cited 2013 Jun 25]; Available from: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs>
16. 1Community-based Care Transitions Program | Center for Medicare & Medicaid Innovation. [cited 2013 Jun 5]; Available from: <http://innovation.cms.gov/initiatives/CCTP/>