Benefits Tips and Helpful Information

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Linda Bulla who is a Member of the CRA Benefits Committee prepared the following article to give us a better understanding of changes that are starting to take place in the delivery of medical care. Linda who has been a Member of the Committee for several years has more than 32 years' working experience. During her career she held management positions in hospitals and a medical school where she focused on inpatient and outpatient services, managed care, and physician management services. She holds two master's degrees in social work and business management. We are very fortunate to have Linda as a Member of our Committee.

IMPACT OF ACA ON PHYSICIANS AND HOSPITALS

With the January, 2014 implementation of sections of the Patient Protection and Affordable Care Act (ACA) which apply to medical providers, the focus of this article will be to look at their impact on physicians and hospitals. In reading this article, bear in mind that the overall objective of the ACA is to provide a framework for more consistent and improved medical outcomes for patients while also culminating in reducing the cost of medical care. Medical providers face the following hurdles in achieving this goal:

- Physicians will need to decide how to introduce research driven data into their patient care practices and services. Financially they may experience a reduction in Medicare reimbursements which result from a new Medicare payment schedule.

- Hospitals will need to ensure that they have appropriate procedures in place that foster an integrated approach to the care of patients by the hospitals and the physicians. Hospitals will also receive lower Medicare reimbursements; and they will be subject to penalties for avoidable Medicare readmissions occurring within thirty days.

Now, to the body of the article - the ACA is really divided into two broad sections which are the following:

1) Improving the quality of health care services.

2) Reducing the cost of health care.

The most challenging aspect for physicians should be the implementation of improving the quality of health services provided by their profession. To review this aspect, Sarah Freymann Fontenot's journal article in the July-August, 2013, issue of *Physician Executive* explained the importance of research driven data being used to provide the best quality outcomes for patients. The ACA created the Patient Centered Outcome Research Institute (PCORI), which is a non-profit research entity, funded by Congress through the PCORI fund and by fees which will be collected on health insurance plans created by the ACA. The role

of PCORI will be to work with the existing Institute of Medicine, other professional quality of care groups, and any other appropriate federal agencies to research physicians' treatment of chronic diseases and of patients' participation in their own medical decision making. To quote the author of the article on the PCORI, Fontenot stated the following: "The organizing theme is not all treatments are effective, and not all patients are appropriate for all treatments."

The article further explained that the PCORI is a board governed by twenty one individuals who are current stakeholders in the health care professions. This board will not decide what treatments should be implemented for patients' medical care or what the federal government will reimburse for patients' treatment. Thus, the ACA prohibits the Secretary of Health & Human Services from using PCORI research to make coverage determinations that will place value judgments on the value of life.

The two tenets of the ACA outlined for the PCORI are the following:

1) Improvement of health care outcomes should be driven by standardization of medical care decisions.

2) Health care outcomes should improve by patients having adequate information such that they are fully able to participate in their decision making about their care.

The author further related that the government did not implement the concept of quality patient care improvement or research based on medical practice patterns. This has been ongoing in the last sixty years. The Institute of Medicine in their research has found that on the average there is a seventeen year lag between the publication of best practice treatments and the incorporation by medical professionals of these treatments with their patients' care. Thus, the Institute proposed the systematic research approach to be used by the term, comparative effectiveness. Comparative Effectiveness Research (CER) is defined as a type of health care research that the results of one approach for managing a disease is more effective to the results of other approaches. To explain simply, these research studies will conclude what medicines, treatments, and medical devices work best for the majority of the population. Therefore, the PCORI will take this type of research as one of their factors in making decisions regarding the improvement of health care outcomes. Thus, to quote the journal article author, Fontenot, stated the following:

"PCORI success is integral to the success of the ACA in its entirety."

Physicians and the medical community will be challenged to become leaders in making this transformation with their patients in the provision of adequate disease education for their patients to make quality of care outcome decisions. In addition, physicians will have to balance the CER data without ruling out each individual patient's unique health history in its implementation.

In addition, financially there should be an impact upon physicians, as the ACA mandates that the new Medicare physician payment formula must be implemented after March 1, 2014. This could be amended by Congress or the Executive Branch of the government as has occurred since the ACA passage in 2010. Thus, this issue could immediately impact solo

physician practices and medical groups in cash flow operations. As a result, physicians will most likely make adjustments within their practices. The use of advanced practice providers such as physician assistants, nurse practitioners, and certified nurse midwives may be utilized in some offices. There also may be an upsurge of hiring medical billing and coding specialists. Cost efficiency and quality of care medical office staffs should be the emphasis and could result in some positions being displaced or eliminated.

Some physicians may by their own or by the insurance companies' decisions not be included in the approved state and federal Healthcare Insurance Marketplace exchanges. With regard to Medicare, physicians could opt out of the Medicare Advantage plans or the entire Medicare system, which means that some physicians may choose to treat only non-Medicare insurance patients or those who pay cash and have chosen to not participate in the state or federal Healthcare Insurance Marketplace exchanges.

In reviewing how hospitals will be impacted by the ACA, the most fundamental issue will be more integrated relationships between hospitals and physicians. According to the journal, *Modern Healthcare*, in the January-February, 2014 issue, the *New England Journal of Medicine* quoted that more than half of all practicing physicians are now employed by hospitals or integrated health care systems. This has also been fueled by the creation of Accountable Care Organizations (ACOs) as outlined by the ACA. According to the 2014 *Medicare & You* booklet, an ACO is a group of physicians and health care providers who coordinate with Medicare in the provision of patient care and services. Some hospitals have established these ACOs to improve the quality of care services and to reduce the cost of health care.

To accomplish the goals of the ACO, patients, who have original Medicare and have physicians who participate within ACOs, will receive notifications from their physicians. These notifications will request patients' permissions to share all Medicare information among all providers within the ACOs. Thus, the ACO physician and health care providers will know about their patients' care from other health care providers, which will enable them to have a comprehensive picture of their patients' health. If patients do not want their ACOs to coordinate their care, they can decline to participate by notifying the ACOs or Medicare. Even though patients decline, this will in no way impact patients' Medicare benefits, services, or protections. Medicare patients have rights to visit and receive care from any physicians or hospitals that accept Medicare.

To further explain the impact of the ACA on hospitals, the financial issue should also be evident through the slowing of Medicare spending over a ten year period to extend the life of Medicare's trust fund from 2016 to 2024. Therefore, hospitals are expected to experience a reduction of $260 billion in Medicare payments over this period. In addition, hospitals, which have treated a higher number of patients who were poor and dependent on public assistance, should gradually see their extra payments for treating this patient population disappear according to ACA. It was assumed that the ACA enactment would cover this population through the expansion of the Medicaid program or the new ACA insurance tax credits. To complicate this issue, the Supreme Court's decision in 2012 clarified that Congress could not require states to expand their Medicaid programs. Therefore, there was a triple impact through Medicare cuts, no extra payments for larger indigent patient

populations, and no new Medicaid patients resulting in nearly half of the states. Thus, Congress has enacted an additional two years for payments to those hospitals with large numbers of indigent patients, which will assist them from experiencing significant impacts.

The question is then asked as to how hospitals are strategically preparing and implementing action plans to cope with these potential financial issues. One way has been by acquisition and mergers or joint ventures between smaller hospitals and larger ones within geographical areas. As a result, these hospitals can focus on scale, cost savings, and efficiency. Obviously, the more supplies or the more services one purchases as an organization the better the pricing will result. The Chicago-based firm, Ponder & Company has seen hospital acquisitions or mergers double within the past four years and with these the larger the amounts of money that have been involved. The journal, *Modern Healthcare,* in its January 12, 2014, article by Jessica Zigmond, Paul Demko, and Virgil Dickson also noted the financial challenges with the ACA Hospital Readmission Reduction Program. This program is monitored by the Centers for Medicare and Medicaid Services (CMS) and will begin to withhold up to 3% of regular hospital reimbursements for hospitalizations that had avoidable patient readmissions within 30 days of patients' discharges for heart attacks, heart failure, pneumonia, chronic lung diseases or elective hip and knee replacements. Last year the CMS reported that they withheld up to 2% of hospital reimbursements for more than 2000 hospitals. CMS plans to continually lower hospital costs through decreasing readmissions.

Hospitals are responding to the above challenges by implementing education and training for their hospital and physician staffs in clinical integration programs. These will focus to increase quality of care and to control costs by addressing clinical treatments. They will also center on the use of evidence-based medicine and continuous process improvement.

By briefly highlighting the ACA impact on physicians and hospitals, one can conclude that we as patients should be actively involved with our health care providers in decision making. Essential will be educating us more about our illnesses and alternative treatments and about preventive measures to incorporate within our daily lives. The challenges of the ACA to physicians and hospitals will most likely impact us as patients to assume more responsibility.

As you can appreciate any changes that may result in how we receive medical care will most likely unfold over a period of time. I'm sure that we will see some "bumps along" the way, but as Linda points out the overall aim of the ACA is to improve medical outcomes while also reducing the cost of medical care. Her article reflects the current thinking of reliable sources as well as the applicable provisions of the ACA itself. She has attempted to bring to our attention some of the issues that will probably be faced by the medical community. We also should understand that as the changes are implemented it may be necessary for the Federal Government to revisit provisions of the ACA because they may not be practical in application. As we all know the "devil is in the details." This is strictly an educational piece and it is not our intent to form an opinion about the potential changes that may occur.

If you have any questions please let us know.