NATIONAL HEALTH REFORM: IMPACT ON PROVIDERS

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Health reform is an unavoidably complex undertaking. Yet, as we get closer to implementation, it will be important to grasp how the reforms will impact practical access to care and coverage. Polling shows that the public looks to doctors, nurses and other providers for guidance on this issue. Providers have their own legitimate concerns about the reforms and their impact on their ability to practice medicine. Although the 2 bills aren't perfect—no major bill ever us—both bring us much closer to the goal of improving access, containing costs, and increasing quality. We offer this matrix as a tool for the provider community: to make sense of the proposed changes and to help motivate Utah's congressional delegation to support the final bill later this month.

THE IMPACT OF HEALTH REFORMS ON PROVIDERS: SENATE & HOUSE BILL COMPARISON

Adapted from the Kaiser Family Foundation Comparison Tool

	Senate Bill, the starting point for negotiations with the House on the final bill **(H.R. 3590) Patient Protection and Affordable Care Act** (passed by the Senate on December 24, 2009)	House Bill **(H.R. 3962) Affordable Health Care for America Act** (passed by the House on November 7, 2009)
Overall Approach to Expanding Coverage	• Individual Mandate • Create state-based Health Benefit Exchanges through which individuals and seperately small businesses can purchase coverage • Through the individual exchange, offer premium subsidies and cost sharing credits for families earning up to 400% of the federal poverty level (FPL) • Require employers to pay penalties for employees who receive tax credits of health insurance through an Exchange, with exceptions for small employers, and provide certain small employers a credit to offset the costs of providing coverage. • Enacts new regulations on the individual and small group insurance markets. • Expand Medicaid to all individuals with incomes up to 133% FPL	• Individual Mandate • Create Health Insurance Exchange through which individuals and smaller employers can purchase health coverage, with premium and cost-sharing credits available to individuals/families with incomes up to 400% of the federal poverty level. • Requires large employers to provide coverage to employees or pay into a Health Insurance Exchange Trust Fund, with exceptions for certain small employers, and provide certain small employers a credit to offset the costs of providing coverage. • Enacts new regulations on plans participating in the Exchange and in the small group insurance market. • Expand Medicaid to 150% of the poverty level.
Improving health system performance	• **Support comparative effectiveness research (CER)** by establishing a non-profit Patient-Centered Outcomes Research Institute. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. • **TORT REFORM**: Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. • **Establish Medicare pilot program to develop and evaluate paying a bundled paymen**t for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care	• **Support comparative effectiveness research** by establishing a Center for Comparative Effectiveness Research to conduct, support, and synthesize research on outcomes, effectiveness, and appropriateness of health care services and procedures. An independent CER Commission will oversee the Center. Provides that CER findings may not be construed as mandates for payment, coverage, or treatment or used to deny or ration care. Establish the Comparative Effectiveness Research Trust Fund. • **TORT REFORM** : Incentive payments to states that enact alternative medical liability laws that make the medical liability system more reliable through the prevention of or prompt and fair resolution of disputes, encourage the disclosure of health care errors,

	that begins 3 days prior to a hospitalization and spans 30 days following discharge. • Create the Independence at Home demonstration program to provide high-need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings • Establish a **hospital value-based purchasing program** in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. • Improve care coordination and more effectively integrate Medicare and Medicaid benefits for dual eligibles • Create a new Medicaid option to permit enrollees with at least 2 chronic conditions, 1 condition and risk of developing another, or at least one serious and persistent mental health condition to **designate a provider as a health home**. • **Create Medicaid demonstration projects to pay bundled payments for episodes of care** that include hospitalizations; to make global capitated payments to safety net hospitals; to allow pediatric medical providers organized as accountable care orgs to share in savings; and to provide Medicaid payments to mental disease institutions for adult enrollees requiring stabilization of an emergency condition • Develop a national quality improvement strategy with priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures and for selecting quality measures for reporting to and payment under federal health programs. • Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations. • **Require disclosure of financial relationships between health entities**, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. • Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. Analyze the data to monitor trends in disparities.	and maintain access to affordable liability insurance. • Strengthen primary care and care coordination by **increasing Medicaid payments for primary care providers to 100% of Medicare rates** (phased-in beginning in 2010 through 2012) and providing **Medicare bonus payments to primary care practitioners** (with larger bonuses paid to primary care practitioners serving in health professional shortage areas) beginning January 1, 2011. • Require the Secretary to develop a plan to reform Medicare payments for post-acute services. • Conduct Medicare and Medicaid pilot program to **test payment incentive models** for accountable care organizations and to assess the feasibility of reimbursing qualified patient-centered medical homes. • Establish the Center for Medicare and Medicaid Innovation to test payment and service delivery models to improve quality and efficiency. Evaluate all models and expand those models that improve quality without increasing spending or reduce spending without reducing quality, or both. (Effective January 1, 2011) • Require Institute of Medicine to conduct study on geographic adjustment factors in Medicare and require the Secretary to issue regulations to revise the geographic adjustment factors based on the recommendations… • Require the Secretary to improve coordination of care for dual eligibles through new office or program w/in CMS. (Report due within one year of enactment) • Establish Center for Quality Improvement to identify, develop/evaluate/disseminate/implement best practices in the delivery of health care services…(dates vary) • Establish Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, manage chronic conditions • **Require disclosure of financial relationships between health entities**, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. (Effective March 2011) • Reduce racial and ethnic disparities by conducting a study on the feasibility of developing Medicare payment systems for language services…
Prevention & Wellness	• Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Create task forces to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. • Strengthen prevention activities, reduce chronic disease rates and address health disparities, especially in rural and frontier areas, through a grant program delivering evidence-based & community-based prevention & wellness services	• Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out.

	• Eliminate cost-sharing for preventive services in Medicare and Medicaid. **Increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates**. • Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan. Provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs. Require Medicaid coverage for tobacco cessation services for pregnant women. • Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. • Provide grants for up to 5 years to small employers with wellness programs. Provide technical assistance to evaluate employer-based wellness programs. • Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or other benefits—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. Establish 10-state pilot programs by July 2014 to permit participating states to apply similar rewards for participating in wellness programs in the individual market. Report on the effectiveness and impact of wellness programs. • Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.	• Establish a three-year demonstration program in four states to evaluate the effectiveness of recommended core competencies for personal and home care aides and training curriculum and methods to provide long-term services and supports. • Improve transparency of information about skilled nursing facilities and nursing facilities.
Other Investments Pertaining to Providers	• Make improvements to the Medicare program: ○ Provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap for enrollees, other than those who receive low-income subsidies and those with incomes above $85,000/individual and $170,000/couple. Increase the Part D initial coverage limit by $500 ○ **Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015;** and ○ Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program. ○ **Creates an independent Advisory Board** to make recommendations to Congress on reducing costs and improving the quality of care in Medicare and in the private sector. ○ **Creates a "Physician Compare" website** for Medicare beneficiaries to compare physician quality and patient experience. • **Improve workforce training and development:** ○ Establish a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. ○ Increase the number of Graduate Medical Education (GME) positions	• Make improvements to the Medicare program: ○ Modify the initial coverage limit and catastrophic thresholds to reduce the coverage gap by $500 and eventually eliminate the Medicare Part D coverage gap by 2019; require drug manufacturers to provide a 50% discount on brand-name prescriptions filled in the coverage gap. ○ Cover through Medicaid the Part B deductible and cost-sharing for Medicare beneficiaries under age 65 with incomes below 150% FPL (and resources at or below two times the SSI level); finance these costs with 100% federal funding in 2013 and 2014 and 91% federal funding in subsequent years.) • **Improve workforce training and development:** ○ Establish a multi-stakeholder Advisory Committee on Health Workforce Evaluation and Assessment to develop and implement a national health workforce strategy. ○ Reform Graduate Medical Education to increase training of primary care providers by redistributing residency positions and promote training in outpatient settings, including through a Teaching Health Center demonstration project. ○ Support training of health professionals through scholarships and loans; establish a primary care training and capacity building program; establish

	by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios; increase flexibility in laws and regulations to promote training in outpatient settings; and ensure the availability of residency programs in rural and underserved areas. ○ Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including FQHCs and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. ○ Increase workforce and support training of health professionals through scholarships and loans; support primary care training and capacity building; **provide state grants to providers in medically underserved areas**; **train and recruit providers to work in rural areas**; **establish a public health workforce loan repayment program**; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce and promote cultural competence training. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. ○ **Address the projected shortage of nurses and retention of nurses** by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. Provide grants for up to 3 years to employ and provide training to family nurse practitioners who provide primary care in FQHCs and nurse-managed health clinics. • Support the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. • Improve access to care by increasing funding for community health centers and the National Health Service Corps; establishing new programs to support school-based health centers and nurse-managed health clinics • Require non-profit hospitals to conduct a community needs assessment every 3 years, adopt an implementation strategy to meet the identified needs; adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements.	a loan repayment program for professionals who work in health professions needs areas; establish a public health workforce corps; promote training of a diverse workforce; and provide cultural competence training for health care professionals. Support the development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals. ○ **Address the projected shortage of nurses and retention of nurses** by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. ○ Support the development of interdisciplinary health training programs that focus on team-based models, including medical home models and models that integrate physical, mental, and oral health services. • Establish the Public Health Investment Fund for financing designated public health provisions. • Establish a new trauma center program to strengthen emergency department and trauma center capacity and to establish new trauma centers in urban areas with substantial trauma related to violent crimes. Create an Emergency Care Coordination Center within HHS; develop demonstration programs to design, implement, and evaluate innovative models for emergency care systems. • Improve access to care by increasing funding by $12 billion over five years for community health centers; establish new programs to support school-based health centers and nurse-managed health centers, and set criteria for the certification of federally qualified behavioral health centers. • Provide grants to each state health department to address core public health infrastructure needs.