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ABSTRACT

Decreasing healthcare expenditure has been one of the main objectives of the Affordable Care Act (ACA). To achieve this goal, the Centers for Medicare and Medicaid Services (CMS) has been tasked with experimenting with provider reimbursement methods in an attempt to increase quality, while decreasing costs. The purpose of this research was to study the effects of the ACA on physician reimbursement rates from CMS to determine the most cost effective method of delivering healthcare services. CMS has experimented with payment methods in an attempt to increase cost effectiveness. Medicare has offered shared cost savings incentives to reward quality care to both primary care providers and preventative services. CMS has determined fee-for- service payments obsolete, opting instead for a Value Based Purchasing (VBP) method of payment. Although a universal payment method has yet to be adopted, it has been evident that a VBP model and preventative care can be used to decrease healthcare expenditure.

Key Words: Affordable Care Act, Centers for Medicare and Medicaid Services, fee-for-service, physician reimbursement, value based payments

INTRODUCTION

In 2014, the United States (U.S.) spent $3 trillion totaling 17.5% of the nation's gross domestic product on health care expenditure (CMS, 2014). Additionally, according to the Center for Medicare and Medicaid Services (CMS), Medicare expenditure totaled $618.7 billion and Medicaid expenditures totaled $495.8 billion, or 20% and 16 % of the nation's healthcare expenditures, respectively (CMS, 2014).

The Affordable Care Act's (ACA) goals upon enactment were to slow the rising cost of health care and encourage a more efficient and higher-value health care delivery system (Sparer & Thompson, 2015). The best way to contain cost over the next five to ten years is through reformed provider payment to gradually decrease Fee-For-Service (FFS) payments (Ginsburg, 2013).

To lower costs, the ACA has embraced efforts to move away from volume based FFS reimbursement and linked government payments for health services to provider performance (Blumenthal, Abrams, & Nuzum, 2015). The ACA tasked CMS with establishing a value based payment modifier that could be applied to a select group of physicians by January 1, 2015 and to all physicians by January 1, 2017 (Painter & Painter, 2014). This Value Based Purchasing (VBP) system was designed to reward physicians who exceedingly provided quality care in a cost effective manner and penalized those physicians who did not provide cost effective care (Chien & Rosenthal 2013). Physicians were provided a 2% bonus for quality care delivered or a 1% fee for poor quality of care (Chien & Rosenthal 2013).

Accountable Care Organizations (ACO) have been key to the ACA achieving quality care at decreased costs (Perez, 2014). According to Perez (2014), the Congressional Budget Office estimated ACO's could save Medicare $5.3 billion between 2010 and 2019 (Perez, 2014). ACOs have encouraged collaboration and integration of care among a group of providers who managed the care and who are responsible for the cost of this care. ACO's received their funding in one of three ways; an upfront fixed payment, an upfront variable payment, or a varying monthly payment depending on the size of the ACO (CMMI, 2016). Regardless of the method of funding, providers who have created these ACO's have been able to share in the financial savings accrued under the Medicare Shared Savings Program of the ACA (Blumenthal et al., 2015).

According to the US Department of Health and Human Services, 20 million adults have gained health coverage under Medicaid expansion (HHS, 2016). Approximately 70% of these patients were enrolled in an ACO or other managed care programs where providers have been reimbursed through a capitation system, with rates established by each state (Medicaid, 2016). Additionally, FFS physician payments have represented the minority of Medicaid payments, however, these payments have been made at a percentage of what Medicare pays for equivalent services (Medicaid, 2016). According to the Kaiser Institute, Medicaid has paid 66% of what Medicare paid for equivalent services when comparing FFS payments (HKFF, 2014). Low reimbursement and varying rates from state to state have resulted in physicians in the most populous states, including Florida, California, and New York, refusing to accept Medicaid patients (Bindman, 2015).

The ACA created the Center for Medicare and Medicaid Innovation, which allowed CMS to conduct experiments with a wide range of payment methods (Ginsburg, 2013). For example, by 2018, 50% of Medicare payments must be alternatives to FFS payments, focused on a VBP model (Burwell, 2015). Whatever the model, the payer system must provide some incentive for physicians and providers to change their behavior. Many physician's behavior has been explained by rational economics; by shifting the paradigm of incentives, the mindset of physicians' also changes from a volume based approach, to a value based approach (Khullar et al., 2015).

The purpose of this research was to study the effects of the ACA on physician reimbursement rates from CMS to determine the most cost effective method of delivering healthcare services.

METHODOLOGY

This research project has been accomplished via literature review. The Marshal University library database was utilized for reference identification. The databases specifically utilized were CINAHL Complete, MEDLINE (Proquest), and PubMed. Additionally, Google and Google Scholar search engines were utilized for additional references not available through Marshall University Library databases. CMS, The Kaiser Family Institute, and HHS websites were utilized as well. Online searches were conducted using keywords ACA and physician reimbursement and CMS, OR 'CMS,' OR, 'fee for service,' OR 'value based payments.' Article abstracts were screened prior to review for relevance and content. The research was limited to the English language. The literature sought was between the dates of 2009 and 2016. In total, 32 sources have been utilized to complete this paper. The research was conduct by BB, DN, CW, AW and was approved by AC, who acted as a second reader and verified that references met inclusion criteria.

RESULTS

Medicaid Expansion under the Affordable Care Act

Medicaid has been the largest source of insurance among American families, providing coverage to more than 66 million people in 2014 (Rosenbaum 2014). The ACA originally mandated that Medicaid provided coverage to any person with an income less than 138% of the federal poverty level but this mandate was overruled by the supreme court in 2012 allowing the individual states to decide if they would expand Medicaid coverage (Crowley & Golden, 2015). Medicaid expansion and the ACA have been credited with decreasing the amount of unpaid hospital care services by $7.4 billion dollars from 2103 to 2014 (Jones, Scott, Arnoff, Pierce, & Glasheen, 2015). This was accomplished by the 28 states and Washington D.C. that expanded Medicaid coverage during this time period (Jones, Scott, Anoff, Pierce, & Glasheen, 2015).

A study that took place in 2014 among a hospitalist group in Colorado, a state that chose to expand Medicaid, has shown a decrease from 18.4% to 6.3% in uninsured encounters while showing a very significant increase in Medicaid insured encounters from 17.3% to 30%, which has resulted in an $3.38 per visit increase in compensation among this hospitalist group between 2013 and 2014 (Jones et al., 2015). These researchers have found a smaller but still significant decrease from 14.1% to 13.3% in the overall number of private payer encounters which has been considered a contributor to the increase in compensation.

Lower reimbursement of Medicaid programs, only 58% of what Medicare reimbursed, had inspired a two year reimbursement increase of an estimated 73% to providers that had accepted Medicaid patients, which has had a positive response, but this increase expired in 2014 and was not renewed (Rosenbaum 2014). This study also

suggested that the removal of reimbursement incentive removed provider motivation to accept Medicaid patients stating that of the 85% of physicians accepting new patients only 65% had accepted Medicaid patients. Aside from the low reimbursement rates providers have reported several other obstacles that have prevented them from providing care including complex program and billing requirements, delayed payment process and difficulty of working with patients with a high level of social and health risk (Rosenbaum 2014).

Medicare Quality of Care Incentives

Claffey, Agostini, Collet, Reisman, and Krakauer (2012) examined 750 Medicare members at a hospital in Portland, Maine regarding the effects of Medicare quality of care pertaining to provider reimbursement. The authors reported prior to the ACA and focus on accountable care, the hospital noted nearly 24% readmission rates among Medicare patients. Similarly, financial rewards for quality care has accounted for less than 5% of Medicare provider's yearly salary practicing in this hospital. Following the enactment of the ACA and motivation for accountable care, these authors had noted a nearly 20% decrease in readmission rates along with increased provider reimbursement for quality care measures. In 2011, Medicare readmission rates dropped to less than 18%. Correspondingly, quality of care payments for Medicare providers increased to nearly 10% of yearly salaries (Claffey et al., 2012).

Free Preventative Care-Reimbursement and Financial Implications for Providers

Kohn and Sebelius (2010) examined aspects of the ACA and promoting preventative care of Medicare patients. Before the ACA, Medicare patients utilized only half of the preventative care services available in the U.S. Nearly 80% of Medicare patients neglected preventative care services due to exceedingly high out-of-pocket costs associated. A direct correlation between the minimal utilization and truncated Medicare reimbursement for providers was noted. These authors polled providers and found nearly 60% of preventative care providers refused to accept new Medicare patients due to low reimbursement concerns. To combat this issue, the ACA has removed out-of-pocket costs for free preventative services and declared full Medicare reimbursement for these services to providers. A nearly 25% increase in preventative care utilization among Medicare patients was noted in 2010. Ultimately, a 25% increase in Medicare patient utilization and full Medicare reimbursement for preventative care has resulted in nearly 20% increase in provider income (Koh & Sebelius, 2010).

Bodenheimer (2009) illustrated prior to the ACA, primary care providers noted income increases of nearly 21% whereas specialist noted income increases of nearly 38%. This has resulted in a 50% decrease in primary care residency among medical schools. Despite the low number of primary care providers, nearly 90% of Medicare patients sought initial consultation and preventative services with primary care providers. Following implementation of the ACA, primary care providers described income increases of nearly 30%. This financial incentive has subsequently resulted in a 20% increase of primary care residents in medical school (Bodenheimer, 2009).

Financial Incentives to Medicare Providers

Basu, Phillips, Bitton, Song, and Landon (2015) depicted a financial incentive for primary care providers created by the ACA. Previously, Medicare providers could only bill for face-to-face services provided. The ACA granted primary care providers non-visit based payments for care of chronically ill Medicare patients. If this form of reimbursement were properly utilized, primary care practices could see nearly $75000 per year increases in revenue as opposed to face-to-face visit reimbursement (Basu, et al.,2015).

The ACA has set up a financial incentive program for primary care providers. This program offered financial incentives to Medicare providers and practitioners designated to family practice, internal medicine, pediatrics, and geriatrics (CMS.gov, 2012). Incentives were granted if 60% (or greater) of their practice focused on primary care over a 12-month period. Providers who met criteria for incentives received payments equaling ten percent of total Medicare paid amounts. In 2012, this amount was over $64,000,000 (CMS.gov, 2012). Table 1 illustrates the distribution of these funds by specialty in 2012.

Table 1- 2012 Primary Care Incentive Payment Program Payment Distribution by Medicare Specialty Designation

Specialty		Bonus Payment
Family Practice	37.9%	$251,733,340

Internal Medicine	49.4%	$327,923,480
Pediatrics	0.3%	$2,169,957
Geriatrics	1.9%	$12,309,017
Nurse Practitioners	7.5%	$49,693,372
Other	3.1%	$20,519,747

Source: (CMS.gov, 2012)

Fee for Service Transitions to Value-Based Purchasing

The FFS method of payment has been based strictly upon the volume of patients seen/treated by the physician. Payment received by the physician under this method of payment has been 80% (Cleverley, Cleverley, Song, 2011). Unfortunately, with this form of pay, readmission rates have not been taken into account. Readmission rates in 2010 were 18% for pneumonia patients, 20% for myocardial infarction patients and 25% of heart failure patients discharged from acute care facilities (MPAC, 2012). Due to high readmission rates in 2012, the United States Commission had recommended Congress raise the prices of inpatient and outpatient care by 1.0% (MPAC, 2012). For readmission rates to be part of a new method of payment, positive clinical outcomes and decreased readmission rates would need to be maximized to provide cost-efficient care (Schroeder & Frist, 2013).

A new method of payment, in 2010, had examined healthcare readmission rates and quality of care. Physicians no longer received rewards for providing poor care to patients, with high readmission rates (VanLare & Conway, 2012). The ACA has changed the payment of choice to VBP which conventionally improved healthcare outcomes across the continuum (VanLare & Conway, 2012). VBP has provided an incentive for physicians to provide excellent care to patients and penalized physicians for providing inadequate care. Patient care has been quantitatively monitored through data and concentrated on patient readmission rates (Aroh, Colella, Douglas, & Eddings, 2015). This model has accentuated clinical measures as well as patient satisfaction, although these two portions were not equal in a final score. A score created on a scale from 0-10 (with 10 being the best/highest quality care), 70% of the score focused on clinical outcomes while 30% included patient satisfaction scores (Matthes, 2010).

The VBP model was applied to all hospitals and facilities who accepted Medicare for payment. High-quality hospital reimbursement occurred at a much higher amount than poor quality services (Aroh et al., 2015). If a hospital achieved a perfect score on both the clinical side as well as the patient satisfaction portion, the hospital was eligible to receive an additional 1% reimbursement on the total cost of the patients bill (Matthes, 2010). VBP has decreased healthcare costs, hospital readmissions, and improved quality of care in 96% of hospital facilities (VanLare & Conway, 2012).

DISCUSSION

The purpose of this research was to study the effects of the ACA on physician reimbursement rates from CMS to determine the most cost effective method of delivering healthcare services. A singular method of payment has not been developed for reimbursement, despite implementation of multiple experimental payment methods initiated by CMMI. Incentive based, cost sharing methods have proven to be the most effective reimbursement methods, as they provide a mutually beneficial payer system.

The ACA substantially decreased the number of uninsured Americans but the majority of this decrease was accomplished through the expansion of Medicaid. This method may eventually prove effective in reducing healthcare costs overall but further research is needed to determine if the Medicaid expansion has improved patient outcomes and preventative healthcare. There has been concern about the increased financial burden that has been placed on both the state and federal governments and ultimately the American tax payer.

Research has shown an increase in provider reimbursement related to an increase in patient's that have been insured by Medicaid, but there is need for further research as the increase in reimbursement is not equivalent to the percentage increase in patients who were insured by Medicaid. The two-year increase in physician reimbursement from Medicaid that expired in 2014 proved to be strong motivating factor when providers consider accepting Medicaid patients and as such a permanent increase should be considered with a focus on preventative practices and better patient outcomes that are within the control of the provider.

Historically, Medicare providers have been reimbursed on a FFS basis. Reimbursements, traditionally, have been provided regardless of patient outcomes or readmission rates. The patient could have been discharged from the hospital and readmitted the following day and the physician would have received reimbursement for both hospitalizations. Following the ACA, Medicare providers have lost the traditional reimbursement strategy of FFS and have begun to receive reimbursement for accountable care. Ultimately, the ACA has sought to decrease Medicare payment for unnecessary services and improve patient outcomes resulting in reductions of Medicare expenditure and financial incentives to Medicare providers (Ginsburg, 2012).

The transition of payment systems from FFS to VBP has been a change that has greatly affected every hospital and physician across the country. This transition has been difficult for physicians, but has proven to be more effective than the FFS method of payment. VBP has made it imperative for physicians to provide high quality care and focus on decreasing readmission rates. In doing so, VBP has offered providers incentives in the form of increased reimbursement for quality care delivered. For every good outcome the physician receives a point. If the physician received a score of ten, additional points were rewarded, and increased reimbursement from insurance companies was rewarded.

Finally, the ACA has changed the way Medicare providers receive payment. Notwithstanding efforts designed by the ACA to reduce provider payment, many Medicare provider reimbursements are likely to increase until the U.S. achieves a nationwide, uniform healthcare payment system (Oberlander, 2012).

This literature review was limited by the search strategy. Publication bias along with a restricted number of databases accessed, may have constrained the contents of the review. Similarly, researcher bias may have also been present which could limit the analysis. The developing transformations in healthcare associated with the ACA may also have limited the discoveries of the review.

Further research should focus on examining financial implications for providers associated with Medicare and Medicaid following the ACA. Other studies may identify how the ACA affected Medicare and Medicaid provider reimbursement. In sum, the ACA has altered reimbursement for both Medicare and Medicaid providers. Emphasis on increasing quality and accountability while decreasing expenditure of government insurance programs will likely be the topic of many U.S. healthcare delivery system reforms in the future (Devers & Berenson, 2009).

CONCLUSION

The US healthcare system has continued to experiment with provider payment methods in an attempt to control healthcare expenditure, however, a universal payment method has not been established. FFS payment methods have been greatly reduced as they have been proven to be costly and ineffective, and VBP methods have replaced them. To create a lasting, meaningful change, it is imperative to adopt a payor system that is both mutually beneficial, financially, where both payor and provider accept equal shares of the risk.

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