The Affordable Care Act (ACA) was the most consequential piece of health care legislation in decades and remains deeply controversial among the American public more than two years after becoming law. Even though some individuals have strongly held opinions about the law, much of the public still has a relatively poor understanding what reforms are in the ACA. Yet, educating the public about the ACA is critical to its success because its reforms affect many people in a variety of significant ways.

Health care providers are one of the communities that the ACA will substantially affect. The law establishes both new requirements for certain providers and a number of new opportunities for the health care workforce. To take advantage of these opportunities and to be key partners in the effort to improve health care in the U.S., it will be critical for providers to be knowledgeable about these changes. This brief outlines the major elements of the ACA that focus on providers and explains the effects that the reforms are designed to achieve.

Physicians

Payment Reforms

Medicaid Payment Increase for Primary Care Services: States will be required to pay physicians 100% of Medicare rates for primary care services in 2013 and 2014, and the federal government will pay for the full cost of this increase. These payment increases will be limited to physicians in family medicine, general internal medicine, and pediatric medicine. Services eligible for the increased payments include those in the Evaluation and Management category in Medicare’s Healthcare Common Procedure Coding System (HCPCS), as well as immunizations. This increase would be sizeable for California primary care providers, who were paid 56% of Medicare rates in 2008.

Medicare Bonus Payments to Primary Care Providers and General Surgeons: From 2011 through 2015, Medicare will provide a 10% bonus payment for primary care services provided by professionals for whom at least 60% of their Medicare allowed charges in a prior period were for primary care services. Similarly, this provision extends a 10% bonus payment for major surgical procedures to general surgeons providing care in a health professional shortage area (HPSA).

These Medicaid and Medicare payment increases to primary care providers and general surgeons offer larger financial incentives, considerably larger in the case of Medi-Cal, to provide these services to program beneficiaries or to accept more beneficiaries in their panels. Depending on providers’ response to these payment increases, they may have the effect of improving beneficiaries’ access to these services.

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1 Kaiser Family Foundation, August Tracking Poll. Available at: http://www.kff.org/kaiserpolls/8342.cfm
Incentives to Improve Quality of Care

Improvements to the Physician Quality Reporting Incentive (PQRI): Eligible professionals who report quality data will receive bonus Medicare payments of 0.5% from 2012 to 2014. For those who do not participate, their Medicare payments will decrease by 1.5% in 2015 and 2% in 2016 and beyond. Again, depending on providers’ response to these payment adjustments, they may improve data reporting from providers.

Improvements to the Medicare Physician Feedback Program: The program will require reports based on an episode grouper that combines clinically related services into an episode of care for which a physician or group of physicians are accountable. The episode grouper will be used to compare resource use among different physicians or physician groups for similar patients and conditions; physicians’ assessments and the assessment methodology will be publicly available. Increased data collecting and public data reporting will have the effect of informing both the Medicare program and providers about comparative resource use and variations among providers.

Value-Based Payment Modifier for the Medicare Physician Fee Schedule: Payments will be adjusted based on quality and cost metrics and risk-adjusted to reflect patient characteristics. The measures of cost and quality that will be measured will be released in 2012, and the HHS Secretary will provide information about the quality and cost of care that physicians provide in 2014 before putting the payment modifier in place for some physicians and groups in 2015, and for all physicians in 2017. The HHS Secretary will take into account the special conditions of providers in rural and underserved areas. This payment adjustment, and the cost and quality measures upon which it will be based, will provide a financial incentive for providers to deliver more efficient and higher-quality care. For groups of physicians that are not currently satisfactory reporters under the PQRI, CMS has proposed an adjustment of 1.0% in addition to the 1.5% adjustments in the Medicare PQRI described above. However, physician groups that are already satisfactory reporters under the PQRI would be exempt from further evaluation and payment adjustment.

Public Reporting of Medicare Physician Performance Information: The HHS Secretary will develop a website that displays information about all of the physicians and other health professionals participating in the Medicare Physician Quality Reporting Initiative. Beginning January 2013, the website will make publicly available performance information regarding coordination of care, efficiency, safety, effectiveness, and timeliness of care. The Secretary may begin a demonstration program that offers beneficiaries financial savings for choosing to see physicians with higher quality ratings, based on the data in this system. While public reporting of performance data could motivate providers to improve care quality, HHS may provide an additional incentive, such as reduced cost-sharing, to steer consumers to providers with higher quality ratings.

Accountable Care Organizations in Medicare: The ACA authorizes the Secretary of Health and Human Services (HHS) to establish a shared savings program for Medicare providers recognized as accountable care organizations (ACOs). ACOs are organizations that take responsibility for all of patient population’s health care needs, including the cost and quality of the care delivered. These organizations can be
partnerships between physicians, physician assistants, nurse practitioners, clinical nurse specialists and hospitals.  

According to Department of Health and Human Services (HHS) regulations, ACOs must achieve a savings rate of 2% before sharing in savings. ACOs can choose one of two models, a “one-sided” or “two-sided” risk model. The one-sided model offers less risk and less reward, while the two sided offers the ACO greater risk and reward. In the one-sided risk model, an ACO will share in 50% of all savings, if it achieves at least a 2% savings rate; the shared-savings is capped at 10% of the ACO’s overall spending benchmark. However, the ACO does not bear any financial risk of financial loss in the event of cost overruns in the one-sided model. In the two-sided model, ACOs will receive 60% of all savings if they realize savings of 2% or more, and they can receive as much as 15% of the overall spending benchmark in total shared savings. However, in this model, they will also bear 60% of the cost of budget overruns in excess of 2% of the spending benchmark, with losses capped at 5% in year 1, 7.5% in year 2, and 10% in year 3. To receive shared savings, ACOs must meet performance benchmarks based on 33 quality of care measures.  

The Centers for Medicare and Medicaid Services (CMS) have also created an advance payment ACO model to support investments in infrastructure that certain providers will have to make to meet ACO requirements and to improve their delivery systems. ACOs in this model will repay advance payments as a portion of their future shared savings. 

This new model of care delivery for Medicare providers could present an important opportunity to improve patient outcomes and achieve savings in the program. If the model successfully yields savings and improves quality, other insurers could adopt it as an approach to reducing costs in the future.

Health Homes in Medicaid: Under a new option for states, the federal government will cover 90% of the incremental cost of health home services for Medicaid beneficiaries with chronic conditions for two years. The Incremental services included under this option are care management, care coordination, health promotion, transitional care from inpatient to other settings, patient and family support, referral to community and support services, and health IT when appropriate. Eligible providers are individual health professionals or teams of professionals in freestanding, virtual, hospital, community health center, and academic health center facilities, as well as in clinics, physicians’ offices, and group practices. 

States may pay eligible providers on a per member per month basis or in an alternate form. Increased federal funding for providers who serve as health homes encourages states to build provider capacity to offer these critical services for beneficiaries with chronic conditions. Improved case management and care coordination holds the possibility of both increasing the quality of care and reducing costs by avoiding duplicative and inappropriate services for beneficiaries with greater health care needs.

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3 Unless otherwise noted, descriptions of provisions in the Affordable Care Act are based on a summary of the law prepared by Health Policy Alternatives, Inc. Available at:
4 Zezza M, Guterman S. 2011. Accountable Care Organization Final Regulations Give health Care Providers More Flexibility. The Commonwealth Fund Blog. Available at:
**Nurses and Nurse Practitioners**

**Nurse-Managed Health Clinics:** The ACA establishes a new grant program to support the operation of nurse-managed health clinics (NMHC). NMHCs must be associated with a nursing school or department, a federally qualified health center (FQHC), or an independent, nonprofit social service agency. Nurses must be the major providers of services, and at least one nurse must hold an executive management position to qualify for grant funding. The NMHC must provide primary care to patients without regard to income or insurance status during the grant period, as well as establish a community advisory board within 90 days of receiving the grant. By supporting nurse-managed health clinics, this provision seeks to broaden access to care, particularly primary care for underserved populations, by increasing the supply of professionals who can provide these services.

**Hospitals**

*Payment Reforms*

**Disproportionate Share Hospital Payments:** Disproportionate Share Hospital (DSH) payments will decrease as the uninsured population declines as a result of the coverage expansions in the ACA. Reductions in DSH funding will be targeted toward states with the lowest rates of uninsurance, and these reductions will be smallest for hospitals with the higher volumes of Medicaid patients and uncompensated care.

These DSH reductions are intended to balance the expected increase in payments from private insurers and Medicaid to hospitals for services provided to patients who will be newly insured through the ACA’s coverage expansions. Safety net hospitals are concerned they will continue to see a high percentage of residually uninsured patients, and lose their newly insured patients to competitors and thus despite the targeted nature of these reductions, this reduction in DSH payments may pose a threat to their finances.

**Reductions in Medicare Payment Updates:** These reductions include a decrease in the annual payment update by 0.25% in 2010 and 2011 for inpatient and outpatient hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units. Reductions in payment updates will be 0.1% in 2012-13, 0.3% in 2014, 0.2% in 2015-16, and 0.75% in 2017-19. Similar reductions will also be applied to payments to Long-Term Care Hospitals. Home Health Agencies, and Hospice Providers will see similar reductions although the size and schedule of the modifications vary somewhat (1.0% in 2011-13 for home health agencies and 0.3% in 2013-2019 for hospice providers). These payment reductions seek to lower the overall level of growth in spending in Medicare, and counterbalance additional federal spending through the coverage expansions in the ACA.

*Incentives to Improve Quality of Care*

**Medicare Hospital Value-Based Purchasing Program:** In the Medicare hospital inpatient prospective payment system, payments will be adjusted based on quality measures related to the following areas: acute myocardial infarction (AMI), heart failure, pneumonia, surgical care, health care associated infections, and patient perceptions of care (measured by Consumer Assessment of Healthcare Providers and Systems, or CAHPS). Beginning in FY 2014, efficiency measures, including spending per beneficiary, will also be included.
Health Care Associated Infections: Federal Medicaid funds will no longer pay for treatment of health care associated infections. In the Medicare program, hospitals in the top quartiles for hospital-acquired conditions will have their payments for all discharges reduced by 1% starting in 2015. Prior to 2015, hospitals in the top quartile will receive confidential reports from the Secretary.

Medicare Hospital Readmissions Reduction Program: The ACA will reduce payments to Medicare Prospective Payment System (PPS) Hospitals based on a risk-adjusted expected readmission rate, but reductions will only apply to base diagnosis-related group (DRG) payments; it does not apply to adjustments for indirect medical education (IME), disproportionate share hospital (DSH) payments, or other additional supplemental payments for sole community hospitals and Medicare-dependent rural hospitals. Reduction caps will increase from 1% in FY 2013 to 3% in FY 2015 and beyond.

Quality Reporting in Medicare for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, Hospice Programs, and Psychiatric Hospitals: Quality measures will be developed and publicly reported for these facilities. Mandatory reporting will begin in 2014. Facilities that do not report quality data will be assessed a 2% payment reduction.

Pay-for-Performance Pilot Program for Certain Medicare Providers: Pilot is designed to test value-based purchasing for psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, PPS-exempt hospitals, and hospice programs.

Each of the preceding quality enhancement provisions is intended to hold hospitals responsible for, and to ultimately improve, the quality of care that they provide to beneficiaries by linking payment to quality performance or to reporting quality data. Together with value-based payments for physicians, these reforms increasingly transform the Medicare program into a quality-focused purchaser of care that rewards high-performing providers. The greater focus on quality has the potential to improve the way that providers deliver care, given the leverage that Medicare has in the health care market as the largest single purchaser of health services in the United States.

Health Centers and Clinics

Federally Qualified Health Centers (FQHCs): The number of Medicare-covered preventive services at FQHCs will increase, and the HHS Secretary is required to develop a new PPS for FQHCs by 10/1/2014. Funds for FQHCs will increase from $2.99 billion in FY 2010 to $8.33 billion in FY 2015.

Community Health Centers: The Community Health Center Fund will provide $8 billion (FY 2011 – FY 2015) for the operation of community health centers, and an additional $1.5 billion for the construction and renovation of community health centers.

These funding increases to FQHCs and community health centers will provide added support to these safety net providers, allowing them to expand the set of services that they provide in underserved areas. The additional financial resources will be critical to these providers because they will likely provide care to many people who will be newly insured through the coverage expansions in the ACA. As a consequence of these facilities’ locations and existing relationships with the uninsured population, they will be central to ensuring that many groups will have adequate access to care.
Assistance for Education and Training to Expand and Support the Health Care Workforce

Modifications to Rules for Federally Supported Student Loans: The ACA reduces the eligibility requirement that professionals must practice primary care for the full duration of the loan repayment period to a period of 10 years, and lowers the interest rate for non-compliance with this rule from 18% to 2% per year greater than the rate the student would have paid if compliant.

Nursing Student Loan Program: The cap on the annual loan amount in this program rises from $2,500 to $3,300 per year, and the annual cap for each of the final two academic years rises from $4,000 to $5,200. The cap for all years in the program rises from $13,000 to $17,000.

New Funding for Workforce Training Programs: New opportunities include grants or contracts to educational institutions to develop, expand, and operate training programs in primary care, dentistry, social work, graduate psychology, and child and adolescent mental health; funding for geriatric education centers to offer traineeships to advanced education nursing students and fellowship programs for medical and other health professions faculty to study geriatrics, chronic care management, and long-term care. Workforce training provisions also include financial assistance for advance practice nurses, clinical social workers, pharmacists, or psychology students who are pursuing a doctorate or other advanced degree in geriatrics and agree to teach or practice in the field of geriatrics, long-term care, or chronic care management for at least 5 years. Opportunities also include grants to provide tuition assistance to direct care workers in long-term care training programs.

To increase the numbers of faculty in nursing, the cap on annual loan amounts in the Nurse Faculty Loan Program rises from $30,000 to $35,000. The ACA also authorizes the Health Resources and Services Administration (HRSA) to enter into loan repayment agreements with nurses who have enrolled in or have completed masters or doctoral training and agree to serve for 4 years as full-time faculty members in accredited schools of nursing. HRSA can pay up to $10,000 per year and $40,000 in total to master’s recipients and $20,000 per year and $80,000 in total for doctoral recipients.

Summary

These reforms have the core goals of motivating and enabling providers to improve the quality and value of care, increasing consumers’ access to care, and attempting to reduce the rate of growth in health care costs. Some of the ACA’s elements that affect providers include reimbursement for care to the newly insured, higher pay for primary care, reductions in the annual payment updates for some providers (e.g. hospitals and skilled nursing facilities), and new reporting requirements and financial incentives and structures to improve quality of care. While some of these changes may provoke opposition from some providers, and while other reforms, such as DSH payments to safety net hospitals, may require state and federal adjustments in the future, the ACA contains many provisions that are both attractive to providers and beneficial to patients. These elements include: bonuses for improved quality performance, targeted payment increases within Medicare and Medicaid to expand access to primary care services, and coverage for those who will be newly insured through the law’s coverage expansions.

Many of the provider-focused elements of the ACA use Medicare and Medicaid to drive improvement in the quality and efficiency of care in the broader health care system. While individuals can disagree about the merit of certain details of the law, it is designed to push the health care system in a positive
direction by simultaneously rewarding providers that provide high-value care and enabling individuals to utilize those services—objectives that providers can wholeheartedly support.