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Re-Examining the Affordable Care Act

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Re-Examining the Affordable Care Act

Healthcare is an ever-changing environment, presenting an uncertain future due to the challenges associated with the Affordable Care Act (ACA). In light of the ACA, fire/rescue and EMS professionals must be adaptive and well prepared to embrace healthcare reform.

In this paper, we will briefly discuss a few noticeable changes in healthcare, examining the relationship between the Centers of Medicare and Medicaid Services (CMS) and the ACA. We will analyze how this relationship has affected Part A providers—physicians and hospitals—and will impact the future of Part B ambulance suppliers—both fire-based and nonfire-based EMS services—in years to come.

What is the ACA?

The ACA was signed into law on March 23, 2010, marking the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The ACA was enacted with the goals of “increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government” (CenCal Website, 2014).

From a strategic perspective, the ACA intends to implement the Institute of Healthcare Improvement (IHI) Triple Aim to:

- Improve the patient-care experience
- Improve the health of patient populations
- Reduce the per-capita cost of healthcare

The U.S. healthcare system accounts for 17% of the gross domestic product, with estimates that it will grow to 20% by 2020 (*National Health Care Expenditure Projections, 2010-2020*, Centers for Medicare and Medicaid Services, Office of the Actuary). Through its IHI Triple Aim philosophy, the ACA intends to improve the quality of medical care while controlling healthcare costs. With these goals in mind, the ACA has drastically changed the complexities of healthcare, and it will continue to change throughout 2015 and beyond.

Although these looming changes in healthcare await, there is a misperception among many Part B providers (fire/rescue and EMS) that the ACA will not affect their industry. This misconstrued belief may derive from a lack of knowledge or simply the limited references to Part B providers within the ACA legislative language. Regardless of the reason, this common misunderstanding can be detrimental to a provider’s ability to prepare for the upcoming changes that will inevitably occur under healthcare reform.

CMS’s Relationship with the ACA

To proactively adapt to the future of healthcare, you must understand the relationship between CMS and the ACA. CMS is a federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children’s

Health Insurance Program and health-insurance portability standards (CMS.gov, under regulations and guidance). Simply put, CMS has been tasked with the implementation of the ACA.

With CMS acting as the implementing agency of the ACA, fire/rescue and EMS professionals' must redirect their attention away from monotonous legislative language within the law and focus on CMS and the changes that have already occurred. These include the shift to pay-for-performance programs that are being used by Part A providers and will soon be enforced on Part B providers.

By examining the current trends of CMS, EMS professionals will have the opportunity to understand the clear intent of CMS to change EMS delivery, allowing them to strategically prepare for the future. Those who choose to not adapt and prepare themselves for changes anticipated to be implemented by CMS will be threatened or replaced by innovative service providers who do evolve to meet to the new healthcare standards and regulations.

Part A Providers – The Shift to Pay-for-Performance

The ACA was designed to encourage improvements in the quality of healthcare. Because of this overarching goal, CMS has introduced various pay-for-performance programs that are being utilized by Part A providers (National Conference of State Legislatures (NCSL) article, 2014).

The best-known pay-for-performance program is the Accountable Care Organizations (ACOs), a group of providers that agree to coordinate care and be held accountable for the quality and costs of the services they provide (NCSL article, 2014). Here are several other programs:

- **Value-based purchasing** – The ACA expanded pay-for-performance efforts in hospitals by establishing a hospital value-based purchasing program, which rewards hospitals based on how well they perform on a set of quality (Process of Care) measures and how much they improve in performance relative to a baseline. The better a hospital does on its quality measure scores from patients and customers, the greater the financial reward it will receive. The law also requires CMS to develop value-based purchasing programs for Part B providers, such as home health agencies, skilled nursing facilities, ambulatory surgical centers, specialty hospitals such as long-term care facilities, hospice programs and medical transportation services/providers.
- **Physician quality reporting** – The healthcare law extended through 2014 the Medicare Physician Quality Reporting System that provides financial incentives to physicians for meeting specific quality benchmarks. Beginning in 2015, the incentive payments are eliminated and physicians who do not satisfactorily meet the quality benchmarks will see their payments from Medicare reduced.
- **Hospital-acquired infections/readmittance** – Medicare has also eliminated payments to hospitals that have a patient readmitted due to a hospital-acquired infection or to resolve a problem they were previously discharged for within the past 30 days.

A study by Health Affairs concluded that “despite limited evidence of effectiveness, pay-for-performance remains popular among policy makers and public and private insurers as a tool for improving quality of care and containing health care costs” (*Health Affairs*, 2012).

It continued by stating supporters of pay-for-performance point out that their primary goal has been measuring the quality of care and motivating providers to improve it while ensuring that quality doesn't decline even as costs are lowered (*Health Affairs*, 2012).

Although there is limited proof that pay-for-performance improves quality and affordability, one thing remains constant—change is happening in healthcare. Professional societies, including the American Medical Association (AMA), have been actively involved in designing pay-for-performance programs as well as monitoring their implementation (*Health Affairs*, 2012). Based on this finding, the fire/rescue and EMS communities have an incredible opportunity to become engaged in influencing the design of pay-for-performance programs and leading the implementation process.

Although fire/rescue and EMS providers are well known as safety-net providers, individuals have raised serious concerns about the impact of pay-for-performance approaches on poorer and disadvantaged populations (*Health Affairs*, 2012). For this reason alone, it is paramount for fire/rescue and EMS personnel to become involved in the development of these quality-focused programs.

Part B Providers – Envisioning the Future

In an article in *EMS World*, Matt Zavadsky, MS-HSA, EMT, stated, “For the first time, the CMS is releasing charge and payment data for all Medicare Part B providers.” This news can be viewed as good and bad for the industry. Zavadsky states that the good news is that by releasing EMS payment data, CMS clearly identifies fire/rescue and EMS as healthcare services, which he states is a major step that positions the industry to help achieve healthcare reform goals. However, the bad news is that this charge-and-payment data portrays fire/rescue and EMS in a negative light. (*EMS World*, 2014)

In September 2013, the CMS Office of Inspector General found the following:

- Since 2002, Medicare Part B payments for ambulance transports have grown at a faster rate than all Medicare Part B payments.
- From 2002 to 2011, the number of beneficiaries who received ambulance transports increased 34%, although the total number of Medicare fee-for-service beneficiaries increased just 7%.
- The number of dialysis-related transports increased 269%.

Due to these findings, it is clear that CMS will expand pay-for-performance efforts to all Part B providers: fire/rescue and EMS. These providers will be financially rewarded based on how well they perform on a set of quality measures as well as on how much they improve in performance relative to a specific baseline. The better the performance is as it relates to quality measures, the greater the financial reward.

The law also requires CMS to develop value-based purchasing programs for Part B providers. Additionally, CMS is actively looking at modifying the ambulance-transport benefit to provide for a more-focused emergency service reimbursement as opposed to general ambulance reimbursement. Dialysis transports are the first portion of the ambulance-transport benefit to come under increased scrutiny by CMS due to perceived overutilization. Nationally, it is estimated that only 11% of end-stage renal disease patients truly require ambulance transport. Ambulance services need to expect more of this type of utilization analysis on transports in the future.

Hospitals have been utilizing a value-based purchasing model since 2012, with physicians implementing a similar model starting in 2015. With these changes soon to occur, fire/rescue and EMS needs to proactively prepare for the new economic model, along with determining outcome metrics to be measured and reported.

Typically, when fire/rescue or EMS professionals think of metrics that could be utilized in measuring value, the first metric that comes to mind is response time. Having said this, there has been a fair amount of debate about the impact on patient outcomes.

However, the true value that fire/rescue and EMS professionals bring to the healthcare system includes mobile integrated healthcare strategies that embrace the IHI Triple Aim philosophy. Dr. Patrick Conway, MD, CMS' chief medical officer, previously expressed strong support for additional demonstration projects for EMS-based MIH programs. With this knowledge, fire/rescue and EMS providers can work to develop an EMS payment model for the future (*EMS World*, 2014).

Action Plan

Now that we have examined the current state of healthcare, with a glimpse of forthcoming changes, we will establish a plan of action to strategically prepare for the future. To effectively adapt to CMS, fire/rescue/EMS professionals should consider these action items:

- CMS will most likely develop a comprehensive list of key performance indicators (KPIs) for Part B providers. *Align your services to perform well within these indicators.*
- CMS will most likely require Part B providers to assess KPIs including, but not limited to, a customer/patient surveys of your service. *Implement a patient survey tool that effectively assesses established KPIs associated with medical and nonmedical transportation.*
- CMS will most likely implement a tool to assess the financial efficiency of a fire/rescue and EMS delivery system. For example, the CMS may examine a delivery system for the following: Could the services you provide be accomplished by a cheaper component of the healthcare delivery system? Did your patients require a 9-1-1 response unit as well as transportation to the emergency room or could they have been cared for in more cost-effective manner? *Think about how these changes could be made in your agency to provide more effective and appropriate patient care.*
- Part B providers will most likely be rewarded for how well they perform on a set of quality measures as well as on how much they improve in performance relative to a baseline. The better a provider performs on its quality measures, the greater the financial reward it will receive. In the beginning, this incentive may be in the form of a bonus payment. However, once an implementation period to allow all providers to implement the quality measures has elapsed, expect the reward program to change. If the physician and hospital quality process is any sort of indicator, the ultimate goal will be to reduce payments to those services that do not reach the benchmarks.
- As CMS did with physicians, they will most likely incentivize Part B providers to provide data to CMS. This process will most likely use an electronic data set based upon a predetermined industry standard and language. *Ensure you have the electronic data that meets national standards and regulations.*
- Understanding who has received innovation grants, presently and in the future, will provide a clear path to what the CMS desires from fire/rescue and EMS providers. *It is vital to closely monitor the history and future of CMS's innovation grant awardees.*

Summary

With the constant evolution of healthcare, it is vital for providers to be well prepared for the future. The goal of this paper was to bring light to the drastic changes in healthcare by examining the ACA and the role of CMS. By analyzing this relationship, we acknowledged the ACA's current effects on hospitals and physicians while exploring the foreseeable changes that are expected for Part B providers.

With a clear understanding of the effects of the ACA on fire/rescue and EMS providers, we are able to strategically recommend a plan that proactively suggests actions to consider. We need to ensure that fire/rescue and EMS professionals have a seat at the table in the development of standards and metrics that will be utilized to evaluate Part B providers' performance and the associated reimbursement.

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