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Analysis of Patient Protection and Affordable Care Act

American Academy of Emergency Medicine

On March 23, 2010, President Obama signed comprehensive health reform, the ***Patient Protection and Affordable Care Act*** (P.L. 111-148), into law. The following summary focuses on those provisions of interest to AAEM members.

EMERGENCY MEDICINE/TRAUMA PROVISIONS

Emergency/Trauma Regionalization

- Directs the Secretary of Health and Human Services (HHS), acting through the Assistant Secretary for Preparedness and Response, to award at least four multi-year contracts or competitive grants to support pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive and accountable emergency care and trauma systems.

Trauma Centers

- Establishes three programs to award grants to qualified trauma centers to (1) assist in defraying substantial uncompensated care costs; (2) further the core missions of trauma centers including addressing costs associated with patient stabilization/transfer, trauma education/outreach, coordination with local/ regional trauma systems, essential personnel and other fixed costs, and expenses associated with employee/non-employee physician services; and (3) provide emergency financial relief to ensure the continued/future availability of trauma services.

Emergency Medicine Research

- Requires the HHS Secretary to support federal programs administered by the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC) and other agencies involved in improving the emergency care system to expand and accelerate research in emergency medical care systems and emergency medicine, including:
 - ❖ the basic science of emergency medicine;
 - ❖ the model of service delivery and the components of such models that contribute to enhanced patient health outcomes;
 - ❖ the translation of basic scientific research into improved practice; and

- ❖ the development of timely and efficient delivery of health services. In addition, the HHS Secretary is required to support research to determine the estimated economic impact of, and savings that result from, the implementation of coordinated emergency care services.

Pediatric Emergency Medicine Research

- Requires HHS Secretary to support federal programs administered by NIH, AHRQ, HRSA, CDC and other agencies involved in improving the emergency care system to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including:
 - ❖ an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;
 - ❖ the role of pediatric emergency services as an integrated component of the overall health system;
 - ❖ system-wide pediatric emergency care planning, preparedness, coordination and funding;
 - ❖ pediatric training in professional education; and
 - ❖ research in pediatric emergency care, specifically on the efficacy, safety and health outcomes of medications used for infants, children and adolescents in emergency care settings in order to improve patient safety.

Emergency Medical Services for Children (EMSC)

- Reauthorizes the EMSC program for five years. The federal EMSC program provides grant funding to conduct multi-institutional research into the prevention and management of acute illnesses and injuries in children and youth across the continuum of emergency medical care.

Medicaid Reimbursements for EMTALA Services Provided at Private Psychiatric Hospitals

- Requires the Secretary of HHS to establish a three-year demonstration program that would reimburse private, psychiatric hospitals for EMTALA services provided to Medicaid enrollees ages 21 thru 64.

IMPROVING QUALITY/HEALTH SYSTEM PERFORMANCE

Medical Malpractice

- Awards five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that (1) have developed alternatives in consultation with relevant stakeholders; (2) have proposals that are likely to enhance patient safety by reducing medical errors and adverse events; and (3) have developed programs that are likely to improve access to liability insurance. (Funding appropriated for five years beginning in fiscal year [FY] 2011.)

Financial Disclosure

- Requires 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. (Report due to Congress April 1, 2013.)

National Quality Strategy

- Develops a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures involving input from multiple stakeholders and for selecting quality measures to be used in reporting to and payment under federal health programs. (National strategy due to Congress by January 1, 2011.)
- Establishes 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. (Funds appropriated for five years beginning in FY 2011.)

Medicare

- Establishes a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extends the Medicare physician quality reporting initiative beyond 2010. (Effective October 1, 2012.)
- Establishes a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, the pilot program will be expanded. (Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016.)
- Creates 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 if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. (Effective January 1, 2012.)
- Provides payments totaling \$400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending.

Medicaid

- Creates new demonstration projects in Medicaid to
 - ❖ Pay bundled payments for episodes of care that include hospitalizations (Effective January 1, 2012 through December 31, 2016.);

- ❖ Make global capitated payments to safety net hospital systems (Effective FY 2010 through 2012.);
- ❖ Allow pediatric medical providers organized as accountable care organizations to share in cost-savings (Effective January 1, 2012 through December 31, 2016.); and
- ❖ Provide Medicaid payments to institutions that offer mental health and substance abuse care for adult enrollees who require stabilization of an emergency condition. (Effective October 1, 2011 through December 31, 2015)

Comparative Effectiveness Research

- Supports comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute to identify research priorities and conduct research that compares the clinical effectiveness of medical treatments. The Institute will be governed by an appointed multi-stakeholder Board of Governors and assisted by expert advisory panels. Findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment or used to deny coverage. (Funding available beginning FY 2010.)

WORKFORCE

Workforce Commission

- Establishes National Health Care Workforce Commission that will review current and projected health care workforce supply and demand; make recommendations to Congress and the Administration concerning national health care workforce priorities, goals and policies; and submit annual reports to Congress on these topics.

Graduate Medical Education

- Increases the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priority given to primary care and general surgery and to states with the lowest physician-to-population ratios. (Effective July 1, 2011.)
- Increases flexibility in laws and regulations that govern GME funding to promote training in outpatient settings. (Effective July 1, 2010.)
- Ensures the availability of residency programs in rural and underserved areas.

Training Programs (Funds appropriated for six years beginning FY 2010.)

- Increases workforce supply and supports training of health professionals through scholarships and loans.
- Provides state grants to providers in medically underserved areas.
- Provides medical residents with training in preventive medicine and public health.

- Promotes cultural competence training of health care professionals.
- Supports the development of interdisciplinary mental and behavioral health training programs. (Effective FY 2010.)
- Supports 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. (Funds appropriated for five years beginning FY 2010.)

HEALTH PLANS

Essential Health Benefits Package

- Requires health plans to provide a minimum, or essential, set of health care benefits, which would include emergency services, ambulatory patient services, hospitalization, maternity and newborn care, mental health and substance use disorders, prescription drugs, rehabilitation, laboratory services, preventive/wellness services and chronic disease management, as well as pediatric services, including oral and vision care.
- Essential health benefits must also provide coverage for emergency department services without prior authorization; whether the emergency physician is a participating provider; and limit the patient co-payment amount for out-of-network services to the same level as in-network services.

Prudent Layperson

- Extends prudent layperson standard to group health plans and insurance issuers offering group or individual health plans.

COST CONTAINMENT

Medicare

- Reduces Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. (Effective FY 2014.)
- Reduces Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions. (Effective October 1, 2012.)
- Reduces Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective FY 2015.)
- Creates an Innovation Center within the Centers for Medicare and Medicaid Services to test, evaluate, and expand in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) different payment structures and methodologies to reduce program expenditures while maintaining or improving quality of care. Payment reform models that improve quality and reduce the rate of cost growth

could be expanded throughout the Medicare, Medicaid, and CHIP programs. (Effective January 1, 2011.)

- Establishes a new Independent Payment Advisory Board to recommend ways to reduce Medicare spending if the increase in Medicare per capita growth rates exceeds certain targets.
 - ❖ The Board is prohibited from submitting proposals that would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums), or would result in a change in the beneficiary premium percentage or low-income subsidies under Part D prior to 2019.
 - ❖ Beginning in 2014, if the projected per capita Medicare spending growth rate exceeds a target growth rate, the Board is required to submit recommendations to achieve specific spending reductions to the President, who subsequently submits the recommendations to Congress. The HHS Secretary is required to issue recommendations if the Board fails to do so and to implement the Board's recommendations (or the Secretary's) unless Congress enacts alternative proposals that achieve the same level of savings.
 - ❖ The Board is required to submit a proposal to Congress to reduce Medicare spending by a specified amount if the projected five-year average growth rate in Medicare per beneficiary spending is projected to exceed the target growth rate. Prior to 2018, the target growth rate is the projected five-year average rate of change in the CPI for All Urban Consumers (CPI-U) and the CPI for Medical Care (CPI-M). In 2018 and beyond, the target growth rate is the projected five-year average percentage increase in the nominal per capita gross domestic product (GDP) plus 1.0 percentage point.
 - ❖ Beginning in July 2014, the Board is required to produce an annual report with standardized information on system wide health care costs, patient access to care, utilization and quality of care, including comparisons by region, type of services, types of providers, for both Medicare and private payers, and including information on provider practice patterns and costs.
 - ❖ The Board is required to submit recommendations every other year to slow the growth in national health expenditures while preserving quality of care, beginning January 1, 2015.

Medicaid

- Reduces aggregate Medicaid DSH allotments by \$.5 billion in 2014, \$.6 billion in 2015, \$.6 billion in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. Requires the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments in states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH. (Effective October 1, 2011.)

- Prohibits federal payments to states for Medicaid services related to health care acquired conditions. (Effective July 1, 2011.)

Waste, Fraud, and Abuse

- Mandates provider screening not later than September 23, 2011. Enhances oversight periods for new providers and suppliers, including initial claims of durable medical equipment (DME) suppliers. Requires Medicare and Medicaid program providers and suppliers to establish compliance programs.
- Develops a database to capture and share data across federal and state programs, and increases funding for antifraud activities.
- Requires providers, physicians, and suppliers to provide, upon request, documentation for DME and home health referrals. (Effective January 1, 2010.)
- Requires physicians to have a face-to-face encounter with the patient before certifying the need for DME or home health services for Medicare or Medicaid. (Effective January 1, 2010.)
- Enhances penalties for marketing violations by Medicare Advantage and Part D plans. (Effective January 1, 2010.)
- Increases penalties for submitting false claims and for failing to comply with investigations. (Effective January 1, 2010.)