Healthcare Reform After the Supreme Court Ruling

Implications for Nurse Executives

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ABSTRACT

On June 28, 2012, the US Supreme Court upheld the provisions of the Patient Protection and Affordable Care Act of 2010, as amended by the Healthcare and Education Reconciliation Act of 2010, with the exception that the Department of Health and Human Services may not withhold existing Medicaid funding from states that refuse to adopt the Medicaid expansion, but rather only new Medicaid funding associated with the expansion. This article will review the impact of this ruling on healthcare providers with a focus on the practice of the nurse executive.

On March 23, 2010, the Patient Protection and Affordable Care Act (Pub. L. 111-148) (PPACA) was enacted. The Healthcare and Education Reconciliation Act of 2010 (Pub. L. 111-152) was passed on March 30, 2010, and amended certain provisions of Pub. L. 111-148. These 2 Acts are collectively known as the Affordable Care Act (ACA). The ACA has a number of goals: to improve the quality of Medicare services, to support innovation and the establishment of new payment models in Medicare, to better align Medicare payments with provider costs, to strengthen Medicare program integrity, and to improve Medicare's financial status. The Act's attempts to improve quality include provisions that expand value-based purchasing, broaden quality reporting, improve the level of performance feedback available to suppliers, create incentives to enhance quality, improve beneficiary outcomes, and increase the value of care.

Almost immediately after the ACA was passed, lawsuits were filed by a number of different stakeholders seeking to overturn

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the law. The lawsuits focused on 2 provisions of the Act, those providing for an individual insurance mandate and for the expansion of the Medicare program. The suits proffered the argument that the ''individual mandate'' provision, which declared that individuals must purchase health insurance coverage to avoid being charged a penalty by the government, was unconstitutional as a violation of the Commerce Clause of the Constitution. The Medicare expansion provision was attacked as overstepping the Congress' power to require the states to regulate and as violating the Spending Clause of the Constitution. Those lawsuits worked their way through our judicial system up to the US Supreme Court for a final determination. The US Supreme Court's ruling was released on June 28, 2012. Importantly, the ruling left intact the large majority of the law's provisions, with a notable exception. The court decided that that the Department of Health and Human Services may not withhold existing Medicaid funding from states that refuse to adopt the Medicaid expansion, but rather may withhold only new Medicaid funding associated with the expansion. Therefore, it is this aspect of the Court's ruling that will have the greatest impact on hospitals and healthcare providers.

Medicaid Coverage

The ACA expands the scope of the Medicaid program and increases the number of individuals that the states must cover. The Act requires state programs to provide Medicaid coverage to adults with incomes up to 133% of the federal poverty level. Currently, many states cover adults with children only if their income is considerably lower, and do not cover childless adults at all (see §1396a(a)(10)(A)(i)(VIII)). The Act increases federal funding to cover the states' costs in expanding Medicaid coverage, although States will bear a portion of the costs on their own (§1396d(y)(1)). As the Act was originally written, if a state does not comply with the Act's new coverage requirements, it may lose not only the federal funding for those requirements but also all of its federal Medicaid funds (see §1396c). The Court's ruling held that this part of the Act was unconstitutional because it left the states with an all-or-nothing choice as far as Federal Medicaid dollars. As such, the ruling dictates that Medicaid cannot apply §1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.

The Medicaid expansion, originally scheduled to become mandatory in all states starting in 2014, is now optional given the Supreme Court's ruling. States may choose to accept the funds voluntarily but are not required to do so. Under PPACA, the federal government will pay the full cost of covering those newly eligible for Medicaid for 3 years, from 2014 to 2016. The federal share will then gradually decline; it will be 90%, starting in 2020. For traditional Medicaid populations, the federal government pays an average of 57% of the total Medicaid costs in a state.

Although the increased Federal funding for the Medicaid population could make the expansion attractive to states, many states may be concerned about the additional costs that they must incur to administer an expanded program. In addition, some states may anticipate that, if individuals who are already eligible for Medicaid under current state rules learn about the expansion and apply for Medicaid, the state will bear the increased financial burden because the new federal funds apply only to the newly eligible, or ''expansion,'' population. There is not currently a deadline for states to declare their intentions as to whether they plan to participate in the expansion.

Other Medicaid provisions in PPACA will probably still apply even if a state chooses to opt out of the expansion. These provisions range from the mandated increase in primary care reimbursement rates to the mandated decreases in Disproportionate Share Hospital funding. States also will have to determine how their decision will interact with the establishment of the Health Insurance Exchanges. The development of these exchanges will go forward as planned under the law because the Supreme Court upheld the individual mandate. The impact of the Court's ruling on Medicaid enrollment will vary greatly depending on the state. States with current low enrollment are anticipated to see an increase, whereas states with current high enrollment will likely not see great changes in their numbers. Healthcare providers in states with currently low enrollment, therefore, may see an increase in the numbers of their patients covered by Medicaid. Many of these patients may currently be uninsured, with the result that providers may see payments for patients who were previously charity care recipients. However, this potential increase in revenue may be offset by the fact that (*a*) Medicaid expansion is now optional for states, (*b*) Disproportionate Share Hospital reductions remain in effect for hospitals, and (*c*) PPACA contains billions of dollars in reimbursement reductions in coming years for hospitals. Community and safety-net hospitals in states that do not adopt the Medicaid expansion may end up with less favorable revenue impact than those in states that do adopt Medicaid expansion.

The nurse executive would be well served to have a thorough understanding of the political climate in the state in which he/she practices to be able to anticipate whether that state will opt in or out of the Medicaid expansion and to engage in a discussion with colleagues in the finance department to be able to gauge the financial impact on their facility's income. Companies that operate on a June 30 end of fiscal year date will have already established budgets for the current fiscal year, and executives at those facilities may need to prepare for the need to make budget adjustments depending on the projected impact in their state. The nurse executive who works in a community or safety-net hospital may wish to engage with their colleagues in government relations to formulate a strategy to communicate with state officials regarding the likely impact to their facility of the official's decisions regarding adoption of Medicaid expansion.

Individual Mandate

Possibly, the biggest surprise of the Court's ruling was the upholding of the ''individual mandate.'' This is the

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part of the law that requires most Americans to maintain ''minimum essential'' health insurance coverage (26 USC §5000A). For individuals who are not exempt and who do not receive health insurance through an employer or government program, to satisfy the requirement, they would need to purchase insurance from a private company. Beginning in 2014, those who do not comply with the mandate must make a ''[s]hared responsibility payment'' to the Federal Government (§5000A(b)(1)). The Act provides that this ''penalty'' will be paid to the Internal Revenue Service with an individual's taxes and ''shall be assessed and collected in the same manner'' as tax penalties (§§5000A(c), (g)(1)). As a result, individuals will be required to obtain healthcare insurance or they will be subject to a penalty. The shared responsibility payment will be calculated as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance (§5000A(c)). As the Court noted, in 2016, for example, the penalty will be 2.5% of an individual's household income but no less than $695 and no more than the average yearly premium for insurance that covers 60% of the cost of 10 specified services (eg, prescription drugs and hospitalization) (42 USC §18022). However, the Internal Revenue Service cannot use several of its normal enforcement tools, such as criminal prosecutions and levies, to enforce these payments (§5000A(g)(2)). In addition, some individuals who are subject to the mandate will not be forced to pay the penalty, such as those with income below a certain threshold and members of Indian tribes (§5000A(e)). Arguably, as a result of this part of the Court's ruling, more individuals will obtain insurance than will opt to pay the penalty. As a result, providers can expect to see higher numbers of insured patients in general.

The individual mandate may therefore have an impact on a facility's revenue, depending on the current patient population, but the effects will not be seen until after it becomes fully operational in 2014. Nurse executives should therefore keep abreast of developments in their state and coordinate with colleagues in the finance department when developing projections for budgets from 2014 forward.

Accountable Care Organizations

We can now be confident that the portion of this law establishing accountable care organizations (ACOs) will continue to be implemented as planned. Healthcare organizations who have been working toward ACO status will likely find the work to have been worth the effort and can anticipate an uptick in the funding of new types of care delivery entities. Nurse executives working in an organization that has not yet begun to explore the idea of becoming an ACO will need to become familiar with what this is and how ACO participation can benefit their facility.

As a review, the regulations to implement section 3022 of the ACA (the portion of the act dealing with ACOs) note that value-based purchasing is a concept that links payment directly to the quality of care provided. Thus, it is a strategy that aims to transform the current payment system by rewarding providers for delivering high-quality, efficient clinical care. In addition to improving quality, value-based purchasing is expected to reduce growth in healthcare expenditures, by better coordinating care and reducing unnecessary services. The regulations also list several specific ideals and goals towards achieving improved quality of care:

1. Value-based payment systems and public reporting should rely on a mix of standards, processes, outcomes, and patient experience measures, including measures of care transitions and changes in patient functional status. These outcome and patient experience measures should be adjusted for risk or other appropriate patient, population, or provider characteristics.
2. Measures should be aligned across Medicare and Medicaid's public reporting and payment systems. A focused core set of measures appropriate to each specific provider category that reflects the level of care and the most important areas of service and measures for that provider will be developed.
3. The collection of information should minimize the burden on providers, and measures should be aligned with the adoption of meaningful use standards for health information technology, so the collection of performance information is part of care delivery.

Specific ideals/goals of the Act and the Regulations implementing it related to lowering expenditures include the following:

1. Providers should be accountable for the cost of care, be rewarded for reducing unnecessary expenditures, and be responsible for excess expenditures.
2. Providers should continually improve the quality of care they deliver and must honor their commitment to do no harm to beneficiaries.
3. Providers should apply cost-reducing and quality-improving redesigned care processes to their entire patient population.

ACOs and the Shared Savings Program

Section 3022 of the ACA requires the Secretary of the Department of Health and Human Services (the Secretary) to establish the Medicare Shared Savings Program (SSP), which is intended to encourage the development of ACOs in Medicare. The Medicare Shared Saving Program is intended to be a program ''that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.'' The SSP is a new approach to the delivery of healthcare aimed at the following:

1. Better care for individuals, as described by all 6 dimensions of quality in the Institute of Medicine report: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity;

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2. Better health for populations with respect to educating beneficiaries about the causes of ill health, such as poor nutrition, physical inactivity, substance abuse, economic disparities, as well as the importance of preventive services such as annual physicals and flu shots; and
3. Lower growth in expenditures by eliminating waste and inefficiencies while not denying any needed care that helps beneficiaries.

The Centers for Medicare and Medicaid Services refers to this approach as the 3-part aim. Those ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for "shared savings" from the SSP.

Sections 1899(b)(1)(A) through (E) of the Act indicate that the following groups of providers of services and suppliers are eligible to participate:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Such other groups of providers of services and suppliers as the Secretary determines appropriate

Section 1899(h)(1) of the Act defines the term *ACO professional* as a physician or a practitioner described in section 1842(b)(18)(C)(i) of the Act (a physician assistant, nurse practitioner, or clinical nurse specialist).

Sections 1899(b)(2)(A) through (H) of the Act list the requirements that eligible groups of providers of services and suppliers must meet to participate in the program as ACOs:

- The ACO must be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service (FFS) beneficiaries assigned to it.
- The ACO must enter into an agreement with the Secretary to participate in the program for at least 3 years.
- The ACO must have a formal legal structure that would allow it to receive and distribute payments for shared savings to participating providers of services and suppliers.
- The ACO must include primary care ACO professionals that are sufficient for the number of Medicare FFS beneficiaries assigned to the ACO. At a minimum, the ACO must have at least 5000 such beneficiaries assigned to it to be eligible to participate in the SSP.
- The ACO must provide information regarding ACO professionals participating in the ACO as the Secretary requires to support the assignment of Medicare FFS beneficiaries to an ACO, the implementation of quality and other reporting requirements, and the determination of payments for shared savings.
- The ACO must have in place a leadership and management structure including clinical and administrative systems.
- The ACO must define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
- The ACO must demonstrate that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

The regulations define an ACO as a legal entity that is recognized and authorized under applicable state law, as identified by a Taxpayer Identification Number, and composed of an eligible group of ACO participants who work together to manage and coordinate care for Medicare FFS beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO's decision-making process.

To be eligible to participate in the SSP, an ACO must provide documentation in its application describing its plans to (*a*) promote evidence-based medicine, (*b*) promote beneficiary engagement, (*c*) report internally on quality and cost metrics, and (*d*) coordinate care. This option is intended to allow ACOs the flexibility to choose the tools for meeting these requirements that are most appropriate for their practitioners and patient populations. Nurse executives have significant experience in promoting evidence-based care, patient and family engagement, promotion of quality, and coordination of care. The nurse executive will be well positioned to lead these aspects of an organization's planning and operations development in preparing to become or participate in an ACO.

Conclusion

The primary impact of the Supreme Court's ruling on the healthcare reform law will be a financial one, with a likely impact of providing a net improvement in a healthcare facility's revenue over the next several years, depending on how the Medicare expansion regulations are developed in light of the Court's ruling. The nurse executive needs to be prepared to work with colleagues in finance to develop budgets that reflect a reasonable projection of the impact on their facility, taking into account the state-specific considerations that will drive the ultimate dollar impact of this law. Nurse executives also need to be prepared to work with colleagues in government relations to be an advocate for their facility and patients if it appears that state leaders will decide to forego participation in Medicare expansion. Lastly, the nurse executive is well positioned to have an important role in leading the organization through the process to become an ACO based on domains of expertise in quality improvement, patient engagement, and evidence-based care.

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