Health Reform

Primary Care and the Patient Protection and Affordable Care Act.
The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act which are referred to together as the Affordable Care Act was signed into law in March 2010. The Act aims to improve quality of care, reduce health care related cost, increase access to care, and make health coverage obtainable for all Americans. In order to reach these goals, Congress included many provisions directed at improving primary care.

Primary care is a term that encompasses health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings such as a doctor’s office, community health center, long-term care facility or home care.

An effective primary care system provides a team approach to patient care and helps patients navigate the complex health care system. Ideally this will result in cost-savings by eliminating redundancy of high cost tests and other services; reducing over-utilization of services and doctor visit, especially emergency room visits; and by increasing patient engagement and compliance to provider instructions such as taking medications as directed and making healthy life-style changes.

There is debate, however, as to whether all these changes will strengthen primary care or create an unmanageable burden on the system. Below is a list of provision that will affect how primary care is financed and delivered in this country.

Coverage Expansions: It is estimated that 32 million more Americans will have health coverage by 2019. These newly insured individuals will seek medical care—often starting in a primary care setting. Below is a list of the key coverage provisions:

Individual Mandate. The individual mandate requires most individuals to have minimum acceptable coverage or pay a tax penalty beginning 2014. The penalty will increase incrementally until 2016 at 2.5% of taxable income; exemptions allowed for those who cannot afford coverage, religious objectors or for those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).

Exchanges. The creation of exchanges coupled with subsidies based on income aim to help low to middle income families pay for health insurance. It is estimated that 24 million people will get their health insurance through an exchange by 2019, many of these individuals will be newly insured. Since all insurance products sold through the exchange are required to contract with essential community providers, including community health centers, many of these newly covered people will be seeking care at health centers and other primary care facilities.

Medicaid. By January 2014, individuals with incomes up to 133 percent of the federal poverty level ($14,400 for an individual in 2010) will be eligible for Medicaid. For “newly eligible” people, states will receive 100 percent federal match for 3 years and then phased down to 95 and 90 percent match thereafter. It is estimated that 16 million more people will be eligible for Medicaid, including adults without children who historically have been excluded from many state Medicaid programs. This is significant to community health centers and other safety-net providers because they serve a significant percentage of Medicaid patients.
Payment Reform: Research shows that the number one reason health science students do not pursue a career in primary health is payment. This legislation attempts to lessen the pay gap between primary care and other specialty areas. Below are some key provisions that address payment reform for primary care:

**Increased payments for primary care services under Medicaid.** The Affordable Aare Act calls for Medicaid to increase payments for primary care services so that they match the required payments for similar services under Medicare. For the first two years, the federal government will cover 100 percent of this increase; in subsequent years, it will be up to the state Medicaid program whether to maintain the parity. There is concern in the states about the cost associated with maintaining this parity after the enhanced federal match is eliminated.

**Increased payments for primary care under Medicare.** Beginning in 2011, select primary care physicians will get a 10 percent bonus for Medicaid services for five years—until 2016. To qualify for the bonus, 60 percent of their Medicare charges must be for primary care services. There are concerns among some rural providers that this 60 percent threshold is too high based on the diversity of services they deliver as the area provider.

**Independent Payment Advisory Board.** The Act creates an independent payment advisory board starting in 2014 that will recommend Medicare spending reductions to Congress. However, hospital and hospice programs are exempt from the actions of this board until 2020.

**Medicaid Global Payment System.** The law authorizes a demonstration project in five states that changes payments to safety-net hospitals from fee-for-services to a global capitated payment model.

**Provisions for Community Health Centers:** The expansion of insurance coverage and Medicaid will mean more people can afford to seek the primary and preventive care that health centers provide. Below is a list of key provisions related to Community Health Centers:

**Increased Funding.** Beginning in 2011 the Affordable Care Act appropriates $11 billion to Health Centers over five years, $9.5 billion of this funding will allow health centers to expand their operational capacity to enhance their medical, oral, and behavioral health services. $1.5 billion of this funding is for capital expenditures. This will nearly double the amount of patients at health centers, it is estimated that nearly 20 million new patients will visit health centers by 2019. However, a subsequent cut of $604 million in the federal budget in 2011 means that fewer service expansions and new health centers than anticipated will be funded with the Affordable Care Act money.

**Payment Changes.** The law requires that health centers receive no less than their Medicaid reimbursement rate from private insurers offering plans through the new health insurance exchanges. It also adds preventative services to the Federally-Qualified Health Center (FQHC) Medicare payment rate.

**Teaching Health Centers.** Authorizes a new Title VII grant program for the development of residency programs at health centers and establishes a new Title III program that would provide payments to community-based entities that operate teaching programs. Directly appropriates $230 million over 5 years for the Title III payments.

**Workforce Provisions:** Strengthening the primary care workforce continues to be among the Obama’s administration’s priorities. The 2009 economic stimulus package included over $200 million of funding for the health care workforce. The Affordable Care Act continues that trend, below are key primary care workforce provisions:

Academic Assistance and Training Programs. There are two programs designed to create training
opportunities to home health aides and multiple programs aimed at increasing participation in science-based training programs or undergraduate work.

Professional and Post Graduate Training Programs. Over $200 million is dedicated to training primary care doctors, nurses and physicians assistance. Additionally, the National Health Service Corp program was expanded with the goal of addressing the maldistribution of primary care professionals.

Improving the Practice Setting. The Act includes several provisions aimed at improving the practice conditions for primary care providers, including tax benefits for those practicing in underserved areas. The Collaborative Care Model: Many health experts agree that increasing efficiencies within primary care is one way to control health care cost inflation. The Affordable Care Act hopes to identify ways to maximize these possible savings. Below are details on key collaborative care models:

Medical Homes. The Affordable Care Act creates a new Medicaid demonstration project that focuses on high need patients (patients with one or more chronic disease). It also allows the Centers for Medicare and Medicaid Services a great deal of flexibility to experiment with medical homes for Medicare.

Administrative Simplifications. There are several requirements for administrative simplifications in the Act, such as establishing a standardized claim form, streamlining process requirement and improving interoperability to allow more electronic information sharing.

Improved Coordination for Dual Eligible Beneficiaries. Patients that are eligible for both Medicare and Medicaid - improvised seniors - are some of the highest cost individuals to treat. To address this population’s special needs, the Federal Coordinated Health Care Office was established with the goal of improving coordination between the federal government and states. For more information on health reform, please click here.