Surviving in Health Reform Implementation
INSTITUTE FOR HEALTHCARE IMPROVEMENT
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YOUR FACULTY

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AGENDA

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<td>8:30-9</td>
<td>Review of Day</td>
<td>Kavita Patel</td>
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<td>9-9:30</td>
<td>Brainstorming in Health Reform</td>
<td>Kavita</td>
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<td>9:30-10:30</td>
<td>Broad Overview of Health Reform</td>
<td>Kavita</td>
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<td>10:30-10:45</td>
<td>Break</td>
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<td>10:45-Noon</td>
<td>ACO/PCMH/Workforce</td>
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<td>Noon to 1</td>
<td>LUNCH</td>
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<td>HIT/HIE/MU</td>
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<td>Exchange Implementation</td>
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<td>3-3:15</td>
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<td>Brainstorming/Wrap-Up</td>
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BRAINSTORMING ACTIVITY

1. IDENTIFY ASPECTS OF HEALTH REFORM THAT ARE
   1. CONFUSING AND REQUIRE MORE EXPLANATION
   2. TROUBLESOME FROM AN IMPLEMENTATION PERSPECTIVE

2. IDENTIFY YOUR ORGANIZATION’S TOP PRIORITIES THIS YEAR WITH RESPECT TO HEALTH REFORM

3. IDENTIFY WAYS YOU OR YOUR ORGANIZATION HAVE BEEN ABLE TO FILL ANY KNOWLEDGE GAPS WITH RESPECT TO #1 AND #2
   1. Workshops, consultants
Health Reform: The Patient Protection and Affordable Care Act (PPACA)

- The federal government’s response to America’s health care system crisis. It attempts to:
  - Curb cost growth
  - Improve quality of care
  - Improve population health
  - Strengthen health professional workforce & system capacity
  - Increase access to affordable and comprehensive coverage
  - Move away from “cottage industry”

Health System Crisis

- U.S. only developed country that does not guarantee health coverage to its citizens
- 46 million uninsured; 25 million underinsured
- Cost of uninsured is borne by those with insurance
- Providers charge higher prices to patients with private coverage to make up for uncompensated care and low public program reimbursement
- Cost-Shifting: costs are passed on to consumers in the form of increased premiums
Pressure to control health care cost is intense

CBO Long-Term Federal Spending Projections as a Percentage of GDP

Source: 2011 CBO Long-Term Budget Outlook

Deficit consequences of health care reform legislation

Source: Congressional Budget Office Presentation to the Institute of Medicine, May 26, 2010
In 1990 health care represented 12% of Federal spending

Breakdown of Federal Outlays: 1990

Total federal outlays in 1990 (in millions) = $1,252,994

By 2016 health care will consume 25% of Federal spending, making it harder to fund other programs

Breakdown of Federal Outlays: 2007

Projected Breakdown of Federal Outlays: 2016

Total federal outlays in 2007 (in millions) = $2,728,686
Total projected federal outlays in 2016 (in millions) = $4,467,806
Results?

- Unaffordable coverage
- Lack of effective risk pooling makes individual and small business market unsustainable
- Expensive patients are excluded from individual market
- Expensive treatments are excluded from coverage
- Plans compete on their ability to segment risk; not on price, not on quality of the benefit package

Pressure to improve the quality and control the cost of health care is intense and rising

**Significant Changes Required in Health Care Delivery**

- Public opposition to approaches that could restrict access to needed care
- Continuing gap between care currently delivered and high-value care
- Policy changes needed to support reforms in care

**Clinician Leadership Required**

- Must act now to address rising health care costs while addressing immediate issues like SGR
- Need pathway to better financing policies – must be practically feasible
- Leadership and management skills are required for real health care reform – currently are not a big part or routine training in the health professions
Impact of Affordable Care Act, if implemented

- New world of challenges, opportunities & responsibilities
- No one size fits all approach
- Successful implementation of law rests on the decisions, preferences, political will and needs of individual states
  - Medicaid expansion
  - Health insurance exchanges
  - Health system capacity & planning
  - Population health improvements
  - Health care markets & industry transformation
  - Access to care/affordability

Timeline

- 2010
  - Consumer protections
  - Adult dependent coverage
  - Small business tax credits
  - Premium rate review
  - Medicare drug rebate
  - Insurance plan appeals process
  - Coverage of preventive benefits
- 2011
  - MLR
  - Medicare prevention benefits/increases payment for primary care
  - GME redistribution
  - State exchange planning
- 2012
  - Medicare ACOs
  - Independence at home demo
  - Medicare provider payment changes/reduced payment for readmission
Timeline

– 2013
  • State notification regarding exchanges
  • Medicare bundled payment pilot program
  • Increases Medicaid payments for primary care

– 2014
  • Medicaid expansion
  • Individual mandate
  • Health insurance exchanges
  • Health insurance premium and cost sharing subsidies
  • Consumer protections
  • EHBs
  • No annual limits
  • Employer requirements
  • Reduces Medicare/Medicaid DSH payments

– 2015
  • Increases federal match for CHIP

– 2018
  • Tax on high-cost insurance

Pillars of PPACA

– Access to Care
– Personal Responsibility
– Cost Containment
– Delivery System Reform
Access to Care: Stability

- Insurance Market Reform
  - Major Regulatory Changes to the Marketplace to increase:
    - Stability
    - Quality
    - Affordability
  - State Regulation of Insurance
    - Every state regulates the terms and conditions of insurance sold within its borders
    - Many different strategies to ensure solvency, improve access
    - PPACA empowers states with considerable influence over new regulatory scheme

Insurance Market Reform: Stability

- Individual Mandate
  - All individuals must purchase insurance meeting minimum standards or pay a tax penalty
  - Individuals must report coverage information to IRS
  - Religious/hardship exemptions

- Insurance Exchanges
  - New marketplaces to shop and compare prices and benefits
  - State or federally run (partnership options)
  - Establish by January 1, 2014
  - Many decisions about design structure need to be decided state by state
  - Federal government can take over if states do not comply with guidelines or make timely progress

- Grandfathered Plans
  - Exempts plans that existed on March 23, 2010 from certain provisions in the health reform law, including some new insurance protections
  - Must still comply with many requirements
  - Preserves existing small group or individual plans
Insurance Market Reform: Quality

- Medical Loss Ratio
  - Uniform federal standards for MLRs starting in 2011
  - % Premiums spent on medical care
  - Large group market (85%)
  - Small group and individual (80%)
  - Insurers failing to meet standards must offer rebates to enrollees
  - Regs from NAIC adopted by HHS
  - States can apply for MLR waivers
    - Approved states: Iowa, KY, Maine, NV, NH
- Essential Health Benefits
  - HHS Secretary will determine benefits
  - Goal is standardized benefits
  - Comparable to employed-based coverage (DOL survey)
  - IOM meetings, report October 7, 2011
  - Expect regs in May or June 2012

Insurance Market Reform: Quality

- Consumer Protections: insurers must comply with new federal regulations mandating a federal floor of consumer protections
  - Starting in 2010:
    - no children can be denied coverage for pre-existing conditions
    - restricts lifetime or annual limits
    - dependents up to 26 can stay on parents’ plan
    - no rescissions
    - no co-pays for preventive care

  - Starting in 2014:
    - HIPAA limits but does not forbid coverage denials for pre-existing conditions
    - No health insurer can deny coverage because of health status or past illness
    - EHBs, standardized federal appeals process, limited waiting periods, guaranteed issues and renewal, adjusted community rating
Access to Care: Medicaid Expansion

- Medicaid expansion
  - Significantly increase coverage and reduce the number of uninsured; approx. 16 million
  - Most substantial cost of PPACA for states
  - Costs will vary according to uninsured/enrollment gaps and outreach efforts
  - 100% federal financing 2014-2016 for newly eligible; 90% by 2020
  - Childless adults below 133% FPL eligible

Federal Medicaid Spending Increase
(2014-2019)

Budget Battle & Medicaid Expansion

- Medicaid largest line item in many state budgets; state spending for Medicaid to increase to 29% of state budgets in 2012
  - Largest increase in history
  - 2012 state budgets account for expiration of extended FMAP (ended June 2011)
- Medicaid officials in nearly every state enacting variety of cost cutting measures
  - 18 states reported eliminating, reducing or restricting benefits
  - 39 states lowered provider payments in 2011; 46 in 2012

Options

- States cannot realistically opt-out of Medicaid; maintenance-of-effort provisions prohibit reducing eligibility
- Critical to address delivery system challenges, rising costs and high uninsurance/under-insurance rates
  - Increase community-based care options, move long term care out of institutional setting
  - Increase care management & medical home models (chronic disease and dual eligible population)
  - Emphasis on community, prevention & wellness interventions
  - Managed care
  - Reimbursement reductions/benefit reductions
  - Super Committee considered dual eligible change to managed care plans
**Personal Responsibility**
- Individual mandate
- No co-pays for preventive benefits
- Medicare personalized prevention plan
- Workplace wellness
- Fight obesity and chronic disease

**Cost Containment**
- Payment reform
- Value over volume:
  - Care coordination
  - Prevention of acute management of chronic conditions
  - Evidence-based quality measures
  - Provider accountability for quality and cost targets
  - Transparency in charges
  - Penalizing avoidable infections and readmissions
  - Medicare reimbursement cuts
  - Strategic payment reductions for avoidable conditions
Delivery System Reform & Cost Containment
- Pilots and Demos
  - Center for Medicare and Medicaid Innovation Center
  - ACOs
  - Bundled Payments
  - PCMH model
  - Value based purchasing programs
- Workforce Development
  - New models of care delivery
  - Strengthening health professional workforce
  - Grants, loans, scholarship programs
  - Redistribution of GME
- Health Information Technology
  - Meaningful Use Incentives (HITECH)

Strengthening the Health Care Workforce: Opportunities in Health Care Reform
- National health care workforce commission
  - Rec. to Congress and President on how to align federal health workforce resources with national needs
  - Unlikely to receive funding
- State health care workforce development grants
  - Competitive, comprehensive health workforce development strategies at the state and local levels
- Loan repayment for:
  - Pediatric subspecialists, children’s mental/behavioral health in MUs and HPSAs
  - Allied health professionals in MUs and HPSAs
  - Public health students and workers (in return for 3 years service)
- Funding for National Health Service Corps
Strengthening the Health Care Workforce: Opportunities in Health Care Reform, continued

- Promote diversity, enhance minority recruitment
  - Health professions training for diversity: scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, expands loan repayments for individuals who will serve as faculty in eligible institutions
- Primary care workforce
  - Provides a 10 percent Medicare payment bonus for five years to primary care practitioners and general surgeons practicing in health professional shortage areas starting in 2011
  - Directs HHS to implement a Medicare payment to reimburse Federally Qualified Health Centers
  - Increases supply of primary care physicians via residency programs

ACOs: an introduction

- Affiliated group of providers held accountable for quality and cost of care delivered through incentive payments or penalties
- Moving away from FFS, goal to improve care quality while lowering costs
- Regulations:
  - Movement on Medicare Shared Savings Program ACO, not Pediatric Medicaid ACO
  - Proposed rule April 7, 2011 criticized by stakeholders as too risky, very low reward
  - Final rule October 20, 2011 better received: less restrictive, less risk, greater payments
  - FTC and the DOJ released complementary guidance: no mandatory antitrust reviews
ACOs: movement toward increased provider integration
- Accountable care requires coordination between providers
- Collaboration that improves care vs. collusion that violates antitrust, self-referral, or fraud, waste and abuse laws
- Market increasingly integrated – payers buying providers, hospitals buying smaller physician practices

Implementation: Reality vs. Rhetoric
- All states have taken action to implement reform (blue states moving faster)
- Efforts include:
  - Creating health reform tasks forces, commissions, special committees and boards (at least 31 states, DC and the Virgin Islands have developed one or more health reform entities)
  - Appointing officials
  - Passing legislation (17 states have passed exchange legislation)
  - Applying for federal grants (all states except AK)
Legal Challenges to Health Care Reform

- Legislators in at least 40 states proposed to limit, alter or oppose selected state or federal action
- Conflicting appellate court decisions
  - 11th Circuit – struck down individual mandate
  - 6th Circuit – upheld mandate
  - 4th Circuit – can’t decide until 2014
  - DC Circuit – upheld mandate
- 2012 Presidential election; Republican president empowered to repeal law

Budget Challenges to Health Care Reform

- Ongoing battles over the deficit
  - Previous budget deal to avert government shutdown in April contained $8B in health spending cuts
  - Super Committee’s failure to find $1.2 trillion in savings by November; sequestration
- Mandatory spending is untouchable; discretionary spending is vulnerable
  - Starving PPACA through appropriations
Key Insights: SCOTUS Ruling
- Anti Injunction Act could delay ruling past 2014 – if insurance penalty deemed a tax
- Law could be struck down in part (mandate) or in whole – "severability" clause
- Constitutionality of mandated Medicaid expansion