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Healthcare Strategists

Health Reform and the Local Health Department

Kansas Association of
Local Health Departments
Mid-Year Meeting – June 15, 2010

Patient Protection and Affordable Care Act of 2010 (“PPACA”)

- Nine titles
  1 Access to private health insurance
  2 Expanded Medicaid coverage
  3 Medicare reform
  4 Wellness and prevention
  5 Health care workforce
  6 Fraud and abuse
  7 Access to drugs and biologics
  8 CLASS Act
  10 Taxes
- Title 10 amends Titles 1 – 9 (Manager’s Amendment)
- Health Care and Education Reconciliation Act of 2010 Amends Titles 1-10 of PPACA

Amends Existing Statutes

- Public Health Services Act
- Social Security Act
- Employee Retirement Income Security Act
- Internal Revenue Code
- False Claims Act
- Criminal Code
- Indian Health Act

Two Intertwined Goals

- Better health insurance coverage more available and affordable for legal residents
  - Challenge for HPC
- Reform the health care delivery and payment system to provide better care in a more cost-efficient manner
  - Opportunity for HPC

The Uninsured

- 2008 U.S. Census Data – National
  - Private insurance: 201 million (66.7 %)
    - Employer-based: 176.3 million
  - Government programs: 87.4 million
  - Uninsured: 46.3 million (15.4%)
    - 9.5 million non-citizens
    - Income distribution
      - Less than $25,000 – 13.7 million
      - $25,000 to $49,999 – 14.9 million
      - $50,000 to $74,999 – 8.0 million
      - $75,000 or more – 9.7 million
- 2005 U.S. Census Data – Johnson County
  - 55,260 uninsured (11%)
    - 38,511 above 200% FPL
    - 16,749 below 200 FPL

Health Insurance Coverage Under PPACA

- By July 1, 2010
  - Interim high-risk pools
    - Access to affordable insurance for U.S. citizens who have been uninsured for at least 6 months due to pre-existing condition
    - $5 billion appropriation for 2010-2013
  - Interim early retiree reinsurance program
    - For each early retiree (age 55 and older; not active employee; not Medicare eligible) or his/her dependent, employer or union-sponsored health plan eligible for up to 80% of costs between $15,000 and $90,000
    - $5 billion appropriation for 2010-13

Health Insurance Coverage Under PPACA

- Tax incentives for small employers
  - To qualify:
    - less than 25 FTE
    - average annual wages below $50,000
    - cover at least 50 percent of premium cost
  - Capped at 35% of premium costs for 2010-13; 50% for 2014 and thereafter
    - Full amount if less than 10 employees and wages below $25,000
    - 25% and 35% for non-profits

Health Insurance Coverage Under PPACA

- Increased access to private health plans by 2014
  - Health insurance exchanges established in each state
  - Individual tax credits to purchase insurance through an exchange
  - Employer “free ride” penalties

Health Insurance Coverage Under PPACA

- Improved coverage under private health plans
  - *Effective 2010:*
    - Children up to age 26 covered on parents' policies and up to age 19 obtain coverage with no pre-existing condition exclusions
    - Lifetime caps ended; tight restrictions on annual limits
    - Restrictions on rescissions
    - New rate review authority process established
  - *Effective 2014:*
    - Guarantee issue coverage for all
    - No exclusions for pre-existing conditions
    - Minimum, essential benefits and standard benefit offerings

Expansion of Medicaid Eligibility

- Effective January 1, 2014, all persons with family incomes up to 133 percent FPL eligible for Medicaid.
  - Between 2014 and 2016, 100% FMAP for cost of covering newly-eligible individuals, gradually reducing to 90% FMAP
- Improved enrollment procedures through the Exchanges

Impact on Uninsured

- By 2016, reduce number of nonelderly uninsured residents to 22 million (includes undocumented immigrants)
  - 2010 –2012 – 50 million
  - 2013– 49 million
  - 2014 – 34 million
  - 2015 – 28 million
  - 2016 – 22 million
- Increase percentage of insured from 81 to 92 percent (83 to 94 percent if exclude undocumented immigrants)
- Approximately 1/3 of remaining uninsured (7.5 million) will be undocumented immigrants

Immigrants

- Naturalized citizens or lawfully residing non-citizens
  - 27.1 million, or 9% of the population
  - 12.5 million are uninsured (27.5% of total uninsured)
  - Barred from Medicaid and CHIP during first five years in the U.S. (state option to provide coverage for pregnant women and children)
  - Beginning in 2014, eligible for federal subsidies for exchange coverage on the same basis as citizens upon verification of citizenship status and income (including during the five-year Medicaid bar)
- Undocumented immigrants
  - 11.9 million, 4% of the population, 5.4% of workforce
  - 6.8 million are uninsured (15 percent of total uninsured)
  - Not eligible for participation in exchanges in any capacity

Bending the Cost Curve

- Fee for service
  - More services = more payment
  - No quality incentives
  - Complex regulations
- Managed care
  - Less care = more profit
  - Bureaucrats making medical decisions
- Outcome-based reimbursement
  - Generic term for strategies that link payment to quality and efficiency

Bending the Cost Curve

- November 1999
  - U.S. Institute of Medicine,"To Err Is Human: Building a Safer Health System"
- 2000-2009
  - Incubator approach: P4P; LeapFrog; Bridges to Excellence; Institute for Healthcare Improvement; Prometheus; HACs; PQRI; Medicare demonstration projects
- 2010-13
  - Lay the groundwork for transition to outcomes-based reimbursement for Medicare and Medicaid
- 2014 and beyond
  - Health care system that delivers better outcomes, keeps people healthier, and costs less???
  - Section 3601 – no reduction in guaranteed Medicare benefits

National Prevention, Health Promotion & Public Health Council

- Interagency council to promote healthy policies at federal level
- Chaired by Surgeon General
- Annual reports to Congress beginning July 1, 2010
- Establish a national prevention and health promotion strategy by March 2011
- 25-member advisory Group appointed by the President

Prevention and Public Health Fund

- Dedicated and stable funding stream for prevention, wellness, and public health activities
- Appropriations
  - 2010: $500 million
  - 2011: $750 million
  - 2012: $1 billion
  - 2013: $1.25 billion
  - 2014: $1.5 billion
  - 2015 and each year thereafter: $2 billion

Maternal, Infant, and Early Childhood Home Visiting Program

- $1.5 billion in grants for home visitation programs for 2010 to 2014
- Grant requirements for states
  - By September 2010, conduct needs assessment to identify communities at risk for poor maternal and child health and lacking home visitation programs
  - Utilize proven service delivery models and appropriate staffing
  - Establish and report 3- and 5-year benchmarks for identified goals (*e.g.,* improved maternal and newborn health)
- Non-profit organizations may apply if state is not approved for grant by 2012

Creating Healthier Communities

- Community Transformation Grant Program (Section 4201)
  - Grant funding for state or local governments or non-profit organizations to develop detailed plan addressing policy, environmental, programmatic, and infrastructure changes
  - Funding authorized (but not appropriated) for 2010-14
- Healthy Aging, Living Well Grant Program (Section 4202)
  - Grant funding for state and large local health departments to conduct pilot programs for 55- to 64-year-old population
  - Funding authorized (but not appropriated) for 2010-14
- Community-Based Collaborative Care Network Program (Section 10333)
  - Consortium of providers under joint governance that provides coordinated and integrated health care services for low-income populations
  - Grant funding for access to care, enrollment in health programs, locating medical homes, case management
  - Funding authorized (but not appropriated) for 2011-15
- Community Health Teams (Section 3502)
  - Grants available to state-designated entities to support primary care physicians in transition to medical home model
  - No funding authorization or timeline

Creating Healthier Communities

- Grants to Promote Positive Health Behaviors and Outcomes (Section 5313)
  - Use of community health workers in medically underserved communities
  - Outreach for other programs
  - "Eligible entity" defined broadly
  - No funding authorization or timeline
- Comprehensive Workplace Wellness Programs (Section 10408)
  - Grants to small businesses to provide wellness programs meeting specified criteria
  - $200 million appropriated for 2011–2015
- Incentives for Prevention of Chronic Diseases (Section 4108)
  - Grants to states to develop incentive programs to prevent chronic diseases in Medicaid population
  - $100 million appropriated for 2011– 2015

Community-Based Care Transitions Program

- Section 3026 creates five-year program beginning January 1, 2011, to provide improved care transition services for high-risk Medicare beneficiaries
- Funding available to hospitals with high readmission rates that partner with community-based organization
  - Submit application with specific intervention proposal
- $500 million appropriation

Medicare Shared Savings Program

- Section 3022 requires Secretary to establish shared savings program by January 1, 2012
- Providers must create accountable care organizations (ACOs) to participate

ACOs

- Combinations of physicians, physician organizations, and/or hospitals
  - “have established a mechanism for shared governance”
  - “have in place a leadership and management structure that includes clinical and administrative systems”
  - “define processes to promote evidence-based medicine and patient engagement,” quality reporting, and care coordination
  - “have a formal legal structure…to receive and distribute payments for shared savings….”
- “The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this Act.”

Shared Savings Payments

- Each ACO assigned at least 5,000 Medicare beneficiaries
- Providers paid same fee-for-service amounts
- Compare estimated average per capita Medicare expenditures
- If meet specified performance standards AND reduce costs, ACO receives a portion of the savings

Medicare and Preventive Care

- Coverage for annual wellness visit and personalized prevention services without co-payment or deductible
- No co-payment or deductible for preventive services recommended with grade A or B by U.S. Preventive Services Task Force
- Conduct comprehensive review of community prevention and wellness programs available to Medicare beneficiaries and identify opportunities for improvement
  - To be completed by end of FY2013
  - $50 million appropriation

Medicaid Health Home

- Section 2703 provides new "health home" option for Medicaid patients with chronic conditions
- A state can elect to include this benefit in state plan beginning January 1, 2011, or apply for a planning grant
- Health home = care management, care coordination, health promotion, transitional care, patient/family supports, referral for other services
- Eligible providers = physicians, RHCs, community health centers, CMHCs, and HHAs (individual/team)
- For first 2 years, state receives 90 percent FMAP
- State plan must require hospitals to refer ER patients with chronic conditions to designated providers

Medicaid and Preventive Care

- States may expand coverage for preventive services to include any grade A or B services
  - Receive 1 percent increase in FMAP for such services if no cost-sharing imposed
- States required to provide smoking cessation services for pregnant women without cost-sharing by October 1, 2010

Community Health Center Fund

- Section 10503 creates the Community Health Center Fund
- *Additional* monies appropriated for community health center program
  - 2011: $1 billion (entire amount for new services)
  - 2012: $1.2 billion ($200 million for new services)
  - 2013: $1.5 billion ($300 million for new services)
  - 2014: $2.2 billion ($700 million for new services)
  - 2015: $2.6 billion ($1.4 billion for new services)

  TOTAL: $9.5 billion
- Additional $1.5 billion for construction/renovation of community health centers between 2011 and 2015

New Access Points

- Assumptions
  - One-half of new money used for NAPs
  - Each new facility receives $650,000
- Projected numbers
  - 2011 – 770 NAPs
  - 2012 – 153 NAPs
  - 2013 – 230 NAPs
  - 2014 – 558 NAPs
  - 2015 – 1,077 NAPs
- Negotiated rulemaking on MUP/HPSA (notice expected in early May)

Other Uses for New Funds

- Base grant adjustments for current FQHCs
- Fund pending Facility Improvement Program applications
- Make available electronic health record loan funds
- Funding to state primary care associations for training and technical assistance

Community Health Center Fund

- Appropriates following amounts to National Health Services Corps in addition to current $142 million/year
  - 2011 – $290 million ($432 million)
  - 2012 – $295 million ($437 million)
  - 2013 – $300 million ($442 million)
  - 2014 – $305 million ($447 million)
  - 2015 – $310 million ($452 million)
  - 2016+ – continued increases based on formula
- Increased funding = 15,000 primary care providers in current shortage areas

Payment Protections and Improvements for FQHCs

- Expand scope of services to include all preventive services covered under Medicare (by Jan.1, 2011)
- Eliminate both the Medicare payment cap and provider productivity screens
- Implement FQHC Medicare prospective payment system by FY2015
- Require private insurance plans offered through the exchanges to contract with all safety net providers (defined as those eligible for 340B drug discount program)
- Requires exchange plans to pay FQHCs no less than Medicaid PPS rates

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