



Health Care Reform: Implications for Lung Health

*Wm Brendle Glomb, M.D., FCCP, FAAP
Office of the Medical Director
Medicaid and CHIP
Texas Health and Human Services
Commission*



Health Care Reform: Opportunities for Lung Health

*Wm Brendle Glomb, M.D., FCCP, FAAP
Office of the Medical Director
Medicaid and CHIP
Texas Health and Human Services
Commission*

Disclosures



NONE

...but...



I am from the government...
and I'm here to help...

REALLY!

3

Acknowledgements

Textual content of these slides borrows heavily from ***Focus on Health Reform*** by the Henry J. Kaiser Family Foundation, especially publication #8061 found on the website at: www.kff.org

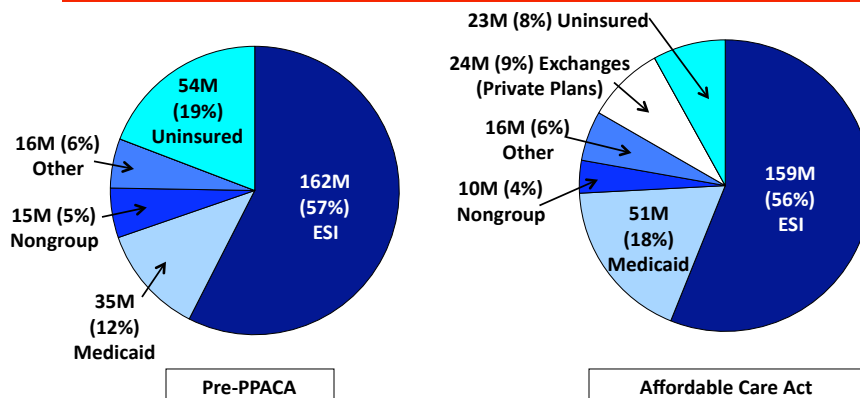
4

PPACA: Overall approach to expanding access to coverage

Patient Protection and Affordable Care Act (PPACA) to:

- Require most U.S. citizens and legal residents to have health insurance.
- Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits available to individuals/families with income between 133-400% of the federal poverty level (the poverty level was \$18,310 for a family of three in 2009) and create separate Exchanges through which small businesses can purchase coverage.
- Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers.
- Impose new regulations on health plans in the Exchanges and in the individual and small group markets.
- Expand Medicaid to 133% of the federal poverty level.

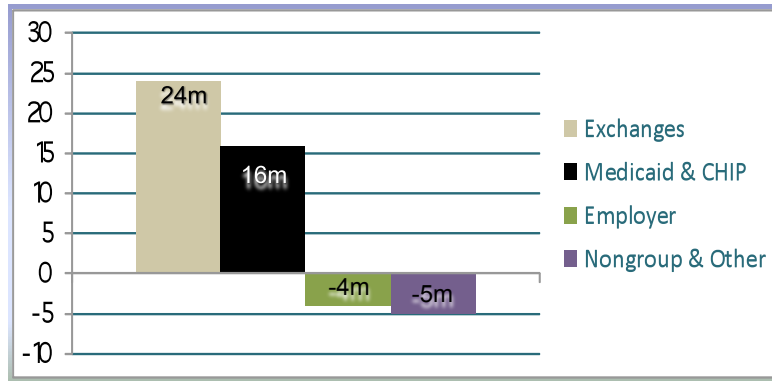
More Covered by Insurance with Affordable Care Act, by 2019



Among 282 million people under age 65

* Employees whose employers provide coverage through the exchange are shown as covered by their employers (5 million), thus about 29 million people would be enrolled through plans in the exchanges. Note: ESI is Employer-Sponsored Insurance. Source: S. R. Collins, K. Davis, J. L. Nicholson, S. D. Rustgi, and R. Nuzum, The Health Insurance Provisions of the Affordable Care Act: Implications for Coverage, Affordability, and Costs, The Commonwealth Fund.

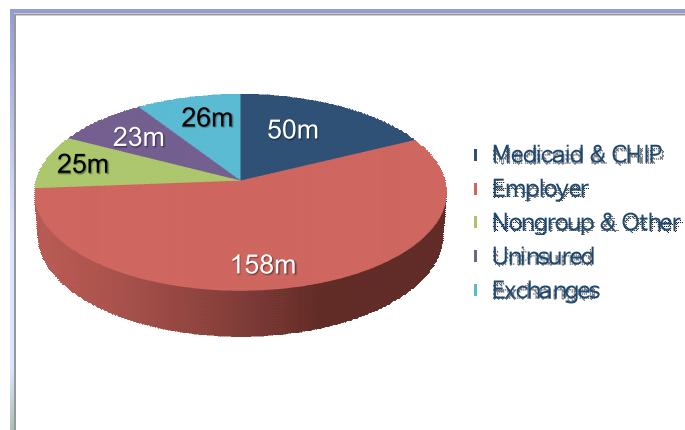
Projected Changes in Insurance Coverage (2019)



Total new coverage = 31 million

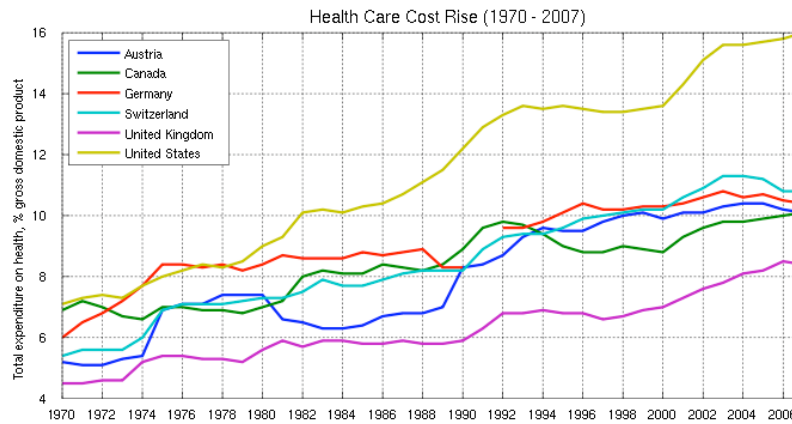
Source: Congressional Budget Office, [3/11/2010](#)

Sources of Coverage for Non-Elderly (2019)



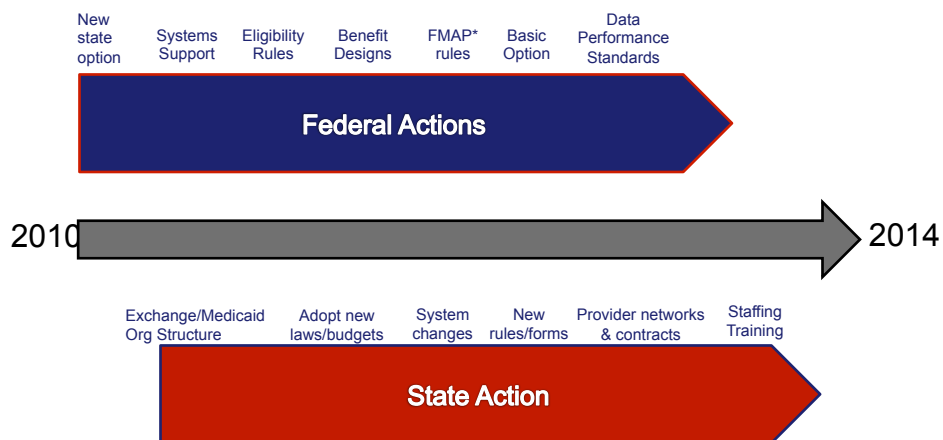
Source: Congressional Budget Office

The Cost Driver



9

State-Federal Partnership: More Critical Than Ever



*Federal Medical Assistance Percentages

2010

- Exchange planning and Federal grants
- Ombudsman Program for people with private coverage in individual and small group markets
- Establishment of an annual insurance premium review process
- High-Risk Pool
- Family Planning services option through Medicaid State Plan
- Face-to-Face encounter with patient required for certification of eligibility for home health services or durable medical equipment
- Money Follows the Person rebalancing demonstration extended through 2016
- Increase in federal prescription drug rebates

11

2010 (continued)

- Prevention and Public Health Fund
- Optional Medicaid Expansion up to 133% of FPL
 - Expand Medicaid to non-pregnant individuals under 65.
- Pharmacy reimbursement limits
- Funding for Aging and Disability Resource Centers
- Postpartum condition grants
- Medicare Part D
 - One-time \$250 rebate for all Part D enrollees who enter coverage gap ("donut hole").
 - Phase down from 100% to 25% by 2020.
- Elimination of pre-existing conditions for children
- Elimination of lifetime limits on benefits

12

2010 (continued)

- **Medicaid coverage for freestanding birth center services**
- **Extended coverage of young adults up to 26 years of age on parent's health insurance plan**
- **Rating areas for small and individual markets**
- **School-Based Health Center Grants**
 - Preference given to centers that serve a large population of children and families eligible for Medicaid and CHIP.
 - Could require changes to Medicaid and CHIP provider enrollment and claims payment.
- **Collection period for overpayments due to fraud**
 - Extends period to repay overpayments to one year.
- **Trauma care services grants**
 - States may not use more than 20% of the federal funds for administration of the program.

13

2010 (continued)

- **Emergency care response grants**
- **Personal responsibility grants**
- **Maternal, Infant, and Early Childhood Home Visitation Program**
 - Must conduct new statewide needs assessment no later than 6 months after date of enactment.
 - After completing new needs assessment, could apply for new home visiting program grant as early as FY10.
- **New option to provide Home and Community-Based Services through the Medicaid State Plan**
- **Mandatory use of National Correct Coding Initiative**
- **Tobacco Cessation for Pregnant Women**
- **Expansion of the recovery audit contractor program**
- **Website**
 - Secretary of HHS to establish an Internet website providing information on affordable health insurance coverage options.

14

2011

- **Community Health Centers**
 - Increase funding by \$11 billion.
- **Medicaid Emergency Psychiatric Demonstration Project**
- **Primary Care Extension Program (workforce)**
 - Increases training programs for primary care and nursing workforce.
- **Health IT Grant to facilitate enrollment in health subsidy programs**
 - HHS Secretary will establish standards, with grants available in 2011.
- **Elimination of Medicaid for certain adults above 133% FPL**
 - January 1, 2011 –December 31, 2013
- **Health homes for enrollees with chronic conditions**
 - Allows the HHS Secretary to award planning grants.

15

2011 (continued)

- **Community Living Assistance Services and Supports (CLASS)**
 - Long-term care insurance program that provides a cash benefit to adults who develop functional impairments for the purchase of community-based supports and services.
- **NPI on enrollment applications and claims**
- **Beginning January 1, 2011, or later if legislation is required:**
 - Termination of provider participation under Medicaid if terminated under Medicare or another state plan
 - Provider exclusion from participation
 - Alternate payees required to register under Medicaid
 - Reporting of data elements under MMIS to detect fraud and abuse
 - Prohibition on payments to entities located outside of the USA

16

2011 (continued)

- Healthy Lifestyles Grants (Incentives for prevention of chronic diseases)
- Medicaid preventive and obesity-related services public awareness campaign
- Enhanced screening for new health care providers
- Provider disclosure requirements
- Health Care Acquired Conditions
 - Tracking of hospital readmission rates.
 - E.g., effective September 1, 2010, Texas is applying Medicare regulations on payment for health care-acquired conditions to Medicaid.
- Community First Choice Option
- Incentives for Home and Community-based Services

17

2012

- Pediatric Accountable Care Organization demonstration project
- Demonstration project to evaluate integrated care around a hospitalization
- Medicaid payment bundling demonstration project
- Screening of existing providers
 - Requires enhanced screening procedures for health care providers to eliminate fraud and waste in the health care system.

2013

- Enhanced reimbursements for certain primary care services
- Federal evaluation of State Exchange implementation status
 - States evaluated for significant progress toward having exchange operational by 2014.
- Coverage of prevention services for adults in Medicaid

18

2014

- Reduction of DSH allocations
- State Exchanges begin January 1, 2014
- Reinsurance program for plan in the individual market
- Medicaid Expansion to 133% of FPL
 - Expand Medicaid to non-pregnant individuals under age 65
 - For 2014-2016, Federal government will pay 100% of costs for coverage for newly eligible individuals in Medicaid
 - States have option to expand Medicaid above 133% FPL
- Use of Modified Gross Income for Medicaid and CHIP income eligibility
- Medicaid for Former Foster Care Children

19

2014 (continued)

- Health Insurance Mandate
- Premium assistance tax credits
 - Prohibits state from requiring an individual to apply for employer-sponsored family coverage as a condition of Medicaid eligibility.
- Premium Assistance
 - Extends CHIPRA premium assistance option to adults.
- Elimination of exclusion of coverage of certain drugs
- Hospitals permitted to make presumptive eligibility determinations

20

2015

- Annual Medicaid Enrollment Report
- Hospital Contracting Requirements for Qualified Health Plans Offering Coverage in the Exchange
- Extension of CHIP Funding
 - –Current federal funding expires in 2015
- Increase the CHIP Match Rate
 - –States eligible for 23% point increase in regular CHIP match rate from October 1, 2015 through September 30, 2019

21

2016

- Health insurance plans may be offered in more than one state

2017

- Medicaid FMAP decreases to 95%

2018

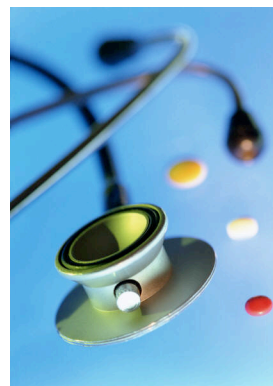
- Medicaid FMAP decreases to 94%
- Premium Taxes on “Cadillac Plans”

2019

- Medicaid FMAP decreases to 93%

2020

- Medicaid FMAP decreases to 90%



22

PPACA: Expansion of Public Programs

Medicaid

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income.
 - All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.
- Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014.

23

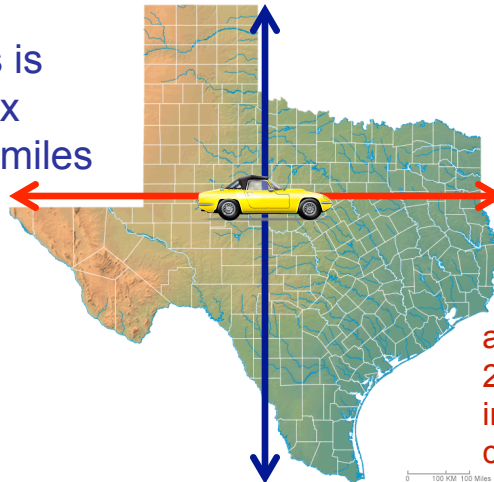
PPACA: Impact to Texas Provider Workforce Planning

- Demand for both primary care providers and specialists will increase as more Texans are insured.
- State will need to examine this increased demand as it relates to the supply of healthcare providers.
- Strategies for meeting increased demand will need to be explored, including:
 - Telemedicine
 - Additional use of mid-level and ancillary service providers

24

Texas: Big State...

Texas is
800+ x
800+ miles

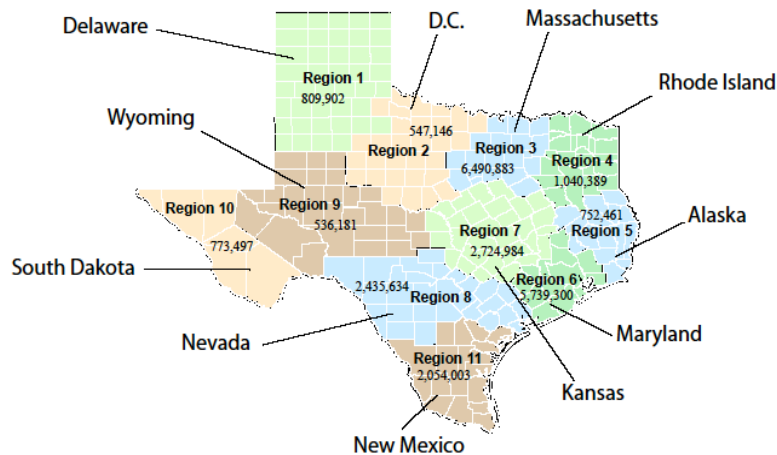


and covers
268,601 mi²
in 254
counties

25

...Big Population

Map: Health Service Regions with 2007 population estimates and states with comparable populations



PPACA: Changes to Private Insurance

Dependent coverage

- Provide dependent coverage for children up to age 26 for all individual and group policies. (already in effect)

Insurance market rules

- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prohibit insurers from rescinding coverage except in cases of fraud.
- Prohibit pre-existing condition exclusions for children.
- Prohibit individual and group health plans from placing annual limits on the dollar value of coverage.
- Eliminate waiting periods for coverage of greater than 90 days.

27

PPACA: Cost Containment

Medicare

- Allow providers organized as accountable care organizations (ACOs) who voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. To qualify as an ACO, organizations must agree to:
 - be accountable for the overall care of their Medicare beneficiaries
 - have adequate participation of primary care physicians
 - define processes to promote evidence-based medicine
 - report on quality and costs
 - coordinate care
- Create an Innovation Center within the Centers for Medicare and Medicaid Services (CMI).

28



Center for Medicare and Medicaid Innovations - Section 3021

Overview

- Section 3021 of the Affordable Care Act (P.L. 111-148) creates the Center of Medicare and Medicaid Innovations (CMI) for the purpose of testing innovative payment and service delivery models in Medicare, Medicaid or both, and CHIP in an effort to reduce program expenditures and enhance quality of care.
- In general, the CMI may select models to be tested where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor health outcomes or potentially avoidable expenditures (i.e., they may limit models to geographical areas).
- CMI must carry out their duties in consultation with respective states, federal agencies, and clinical and analytical experts.

29



Center for Medicare and Medicaid Innovations - Section 3021

Overview

- The center, expected to be in place by January 2011, “will be dedicated to testing innovative approaches to improving healthcare delivery, payment and quality.”
- The law funds a \$5 billion in start-up money for the CMI and \$10 billion over 10 years for new demonstration projects and pilot programs.

Funding

- CMS released published proposed rules on the process for approval of the CMI demonstration project September 17, 2010.

Demonstration Models and Considerations

- Models to be considered include, but are not limited to:
 - Health homes models
 - Interdisciplinary care teams
 - Supportive care models
 - Varying payment models
 - Medication therapy management
 - Community based health teams
 - Fully integrated care for dual-eligible (including management and oversight of all funds under the applicable titles)
 - All-payer payment reform for medical care
 - Disease specific incentive based payment models
 - Hospital care payment models



31

Demonstration Models and Considerations

- Considerations for selecting models include, but are not limited to:
 - Process for monitoring and updating patient care plans
 - Family and patient involvement in care team
 - Use of technology
 - Use of team-based approach
 - Access to shared real-time client-specific data
- CMI must evaluate each model and may terminate or modify the demonstration after testing has begun, unless the model is expected to improve quality and/or reduce spending. CMI may expand models if determined effective.

32

Comparative effectiveness research

- Support 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.

33

Medicare

- Establish 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, develop a plan for expanding the pilot program.
- Create 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.
- Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide a 10% bonus payment to primary care physicians in Medicare from 2011 through 2015. (Effective for 5 years beginning January 1, 2011)

34

Medicaid

- Create a new Medicaid state plan option to permit Medicaid enrollees with at least 2 chronic conditions, 1 condition and risk of developing another, or at least 1 serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home-related services, including care management, care coordination, and health promotion.
- Create new demonstration projects in Medicaid:
 - to pay bundled payments for episodes of care that include hospitalizations
 - to make global capitated payments to safety net hospital systems
 - to allow pediatric medical providers organized as ACOs to share in cost-savings
 - to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition.
- Increase Medicaid payments in fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) to 100% of the Medicare payment rates for 2013 and 2014. States will receive 100% federal financing for the increased payment rates.

35

National “quality strategy”

- Develop 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.
- Establish 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.

36

Prevention/Wellness

- Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities.
- Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs.
- Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services.

37

Prevention/Wellness (continued)

- Establish a Prevention and Public Health Fund for prevention, wellness, and public health activities including:
 - prevention research and health screenings
 - the Education and Outreach Campaign for preventive benefits
 - immunization programs.
- Establish a grant program to support the delivery of evidence-based and community-based prevention and wellness services, especially in rural and frontier areas, aimed at:
 - strengthening prevention activities
 - reducing chronic disease rates
 - addressing health disparities



38

Coverage of preventive services

- **Eliminate cost-sharing for Medicare covered preventive services** that are recommended (rated A or B) by the U.S. Preventive Services Task Force and waive the Medicare deductible for colorectal cancer screening tests.
- Authorize the Secretary to **modify or eliminate Medicare coverage of preventive services**, based on recommendations of the U.S. Preventive Services Task Force.
- Provide states that **offer Medicaid coverage of and remove cost-sharing for preventive services** recommended (rated A or B) by the U.S. Preventive Services Task Force and **recommended immunizations** with a one percentage point increase in the FMAP for these services.
- Authorize **Medicare coverage of personalized prevention plan services**, including a **comprehensive health risk assessment**, annually. Require the Secretary to publish guidelines for the health risk assessment and a health risk assessment model.
- **Reimburse providers 100% of the physician fee schedule amount with no adjustment for deductible or coinsurance for personalized prevention plan services** when these services are provided in an outpatient setting.
- Provide **incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs**.
- Require **Medicaid coverage for tobacco cessation services for pregnant women**.
- Require qualified health plans to provide at a minimum **coverage without cost-sharing for preventive services** rated A or B by the U.S. Preventive Services Task Force, **recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women**.

39

Wellness programs

- Provide **grants** for up to five years to **small employers** that establish **wellness programs**.
- Provide technical assistance and other resources to evaluate employer-based wellness programs.
- Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.
- **Permit employers to offer employees rewards** (premium discounts, waivers of cost sharing requirements, or benefits that would otherwise not be provided) of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.
- Establish **10 state pilot programs** to permit participating states to apply similar rewards for participating in wellness programs in the individual market and expand demonstrations in 2017, if effective.
- Require a report on the effectiveness and impact of wellness programs.

40

PPACA: Long-term Care

Medicaid

- Provide states with new options for offering **home and community-based services** through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan.
- Establish the Community First Choice Option in Medicaid to provide **community-based attendant supports and services** to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program.
- Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to **increase the proportion of non-institutionally-based long-term care services**. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term services and supports.

41

PPACA: Other Investments

Workforce - Improve workforce training and development:

- Establish a multi-stakeholder Workforce Advisory Committee to develop a national strategy.
- **Increase the number of Graduate Medical Education (GME) training positions** by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios; increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings; and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for payments for the expenses associated with operating primary care residency programs.
- **Increase workforce supply** and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. Support the **development of interdisciplinary mental and behavioral health training programs and establish a training program for oral health professionals**.
- Address the projected shortage of nurses and retention of nurses by **increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing**. Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics.
- Support 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.

42

Community health centers and school-based health centers

Improve access to care by increasing funding by \$11 billion for community health centers and by \$1.5 billion for National Health Service Corps over five years; establishing new programs to support school-based health centers and nurse-managed health clinics.

43

Texas HHS agencies are tracking over 40 potential grant and demonstration opportunities available through the PPACA.

- ✓ The Department of State Health Services (DSHS) has applied for nine grants. Eight grants have been awarded and one was denied funding.
- ✓ The Department of Aging and Disability Services (DADS) has applied for five grants. Four have been awarded to DADS and one is pending award announcement.
- ✓ HHSC partnered with the Texas Department of Insurance (TDI) on the Health Benefit Exchange Planning Grant which TDI submitted on September 1, 2010. Texas was awarded \$1 million on September 30, 2010.

44

Analysis in Progress

- TX HHSC is assessing optional provisions in the PPACA that states may consider, including:
 - ✓ Having the Medicaid HMOs administer the prescription drug benefit for their clients.
 - ✓ Covering children of state employees in federally-matched CHIP if states meet certain maintenance of effort or hardship criteria.
 - ✓ Opportunities to reform payment/reimbursement systems to promote quality care and cost savings.
 - Quality-based reimbursement
 - Value-based reimbursement

45

Quality-Based Reimbursement

Background

- Medicare and other payers have begun to test alternative reimbursement strategies for healthcare services designed to improve the quality of service and reduce costs. The Texas Health and Human Services Commission is currently reaching out to Medicaid and CHIP stakeholders, including hospitals, provider groups, and managed care organizations, to solicit pilot initiative ideas to move toward quality-based payment in Medicaid and CHIP.

Projects

- Pilots may include clinical integration pilots, bundled payment pilots and other ideas which are cost-effective for the state and improve the quality of care in Medicaid and CHIP. HHSC is collecting stakeholder ideas to determine the feasibility of various proposals and their affects on providers. Based on the input received, HHSC has issued requests for proposals related to quality-based payment initiatives.

46

Proposals

TX HHSC is now soliciting proposals for quality-based payments initiatives. Areas of interest include but are not limited to the following:

- Asthma
- Autism
- Diabetes
- ADHD
- Depression and mental health more broadly (bipolar or other conditions)
- Heart failure
- Central line infection
- NICU utilization
- Birth trauma

47

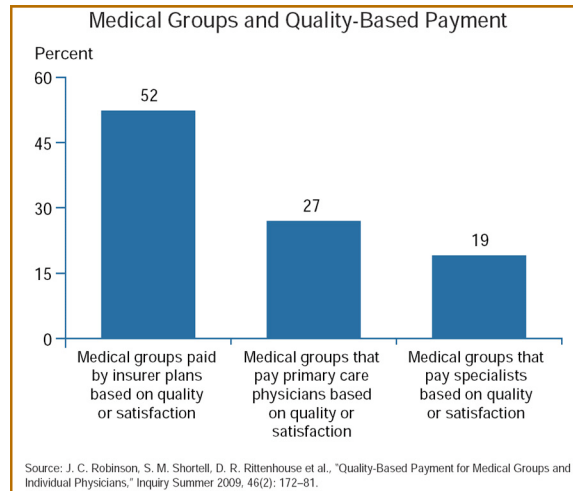
The Issue

- Public and private insurers are increasingly using incentive programs that offer health care providers financial bonuses for improving performance, as measured by clinical quality and patient satisfaction. There is considerable debate as to whether these bonuses should be paid to individual physicians or to the physician organizations to which they belong. This study measures the extent to which large medical groups (20 or more physicians) receive pay-for performance bonuses from insurers, as well as the extent to which those groups provide similar incentives to their primary care and specialist physicians.

Robinson CJ, Shortell SM, Rittenhouse DR, et al. Quality-based payment for medical groups and individual physicians. *Inquiry* Summer 2009, 46(2);172-81.

48

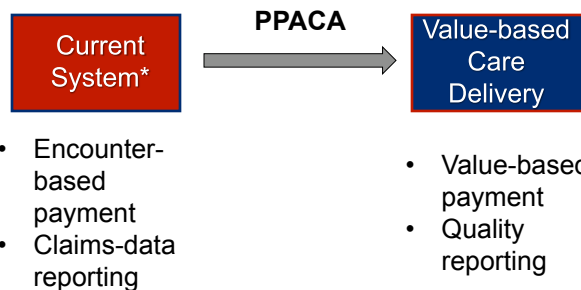
Quality-Based Reimbursement



"The extent to which a medical group decides to pay performance bonuses to its individual physicians is significantly associated with whether the group is itself paid by health plans based on analogous measures."

49

Value-Based Reimbursement



**Traditional fee-for-service (FFS) does not reward care coordination*

50

Value-Based Reimbursement

- Traditional, encounter-based reimbursement models have been associated with high costs and inefficient utilization of services.
- PPACA focuses on rewarding providers for efficient physician service and positive treatment outcomes.
- Current reimbursement models do not adequately address specialty reimbursement, where bulk (80%) of healthcare costs are initiated.
- Physician payments are currently tied to rudimentary process measures that do not adequately measure total medical costs or outcomes.
- Outcomes measures and predictors may be misunderstood and misrepresented.
- Encounter-based programs that attempt to enforce process measures designed to encourage favorable medical practices are inefficient because they lack actionable and timely data.
- Encounter-based payment systems do not account for physician practice variation.
- A disconnect between disease management programs and encounter-based programs may create duplication in efforts and administrative costs.