

Health Reform Implementation: What Communities Need to Know



National
Association
of Public
Hospitals
and Health
Systems



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National Association of Public Hospitals and Health Systems (NAPH):

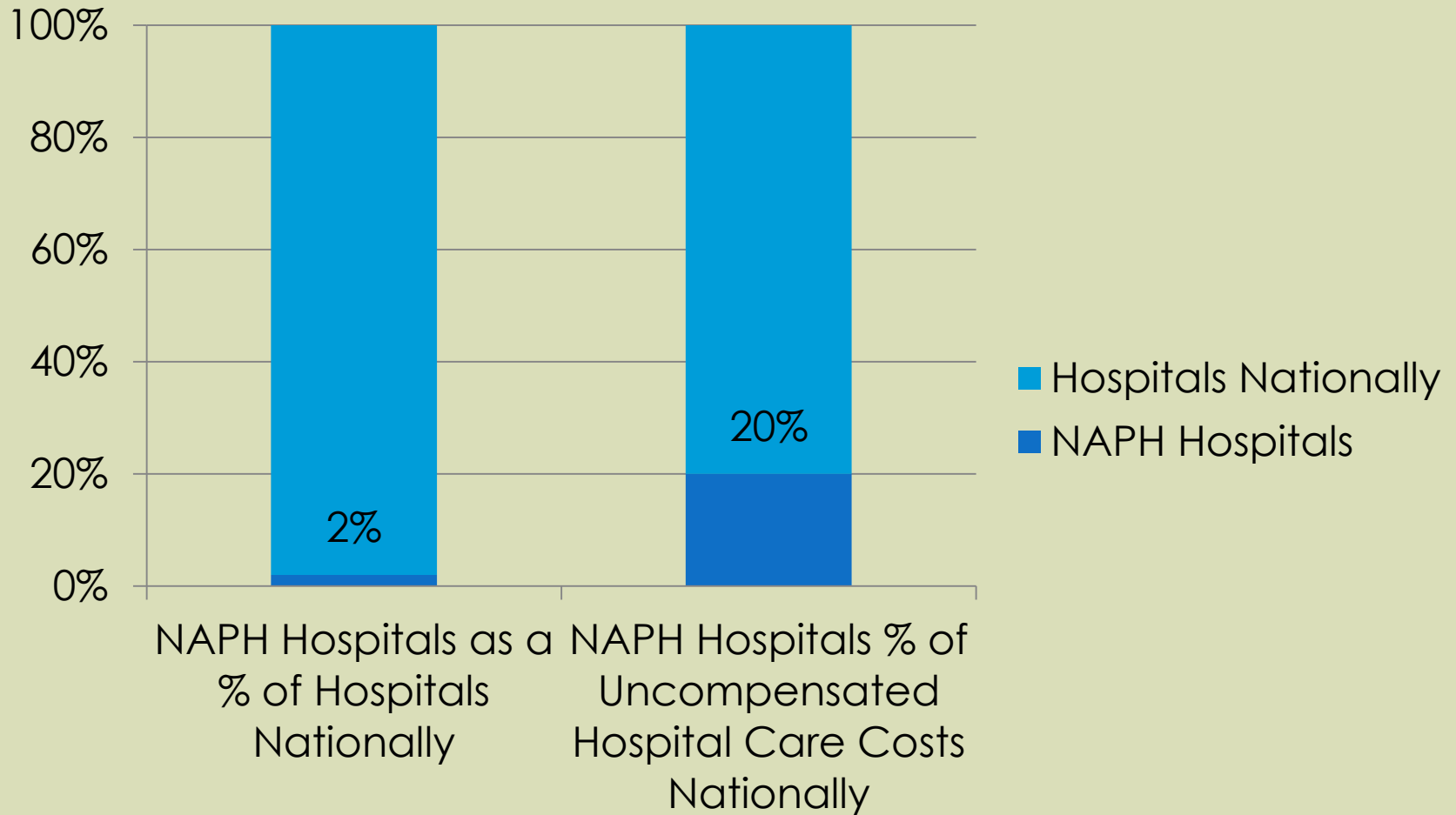
- For 30 years has advocated for safety net hospitals and health systems
- NAPH.....
 - Represents 140 hospitals with a shared mission—access for all
 - Effectively advocates at the federal level on issues of concern to safety net hospital systems
 - Conducts research and shares innovations on health system changes at member hospitals
 - Communicates value of the safety net to policymakers and the public

Some Major Accomplishments of NAPH

- Secured Disproportionate Share Hospital (DSH) funding for safety net hospitals
- Stopped billions of dollars in Medicaid cuts
- Secured a seat at the table for safety net providers for the development of quality measures
- A voice for safety net providers in the health reform debate

Disproportionate Share of Care to the Uninsured

NAPH hospitals represent only 2 percent of the acute care hospitals in the nation, but provide 20 percent of the uncompensated care.

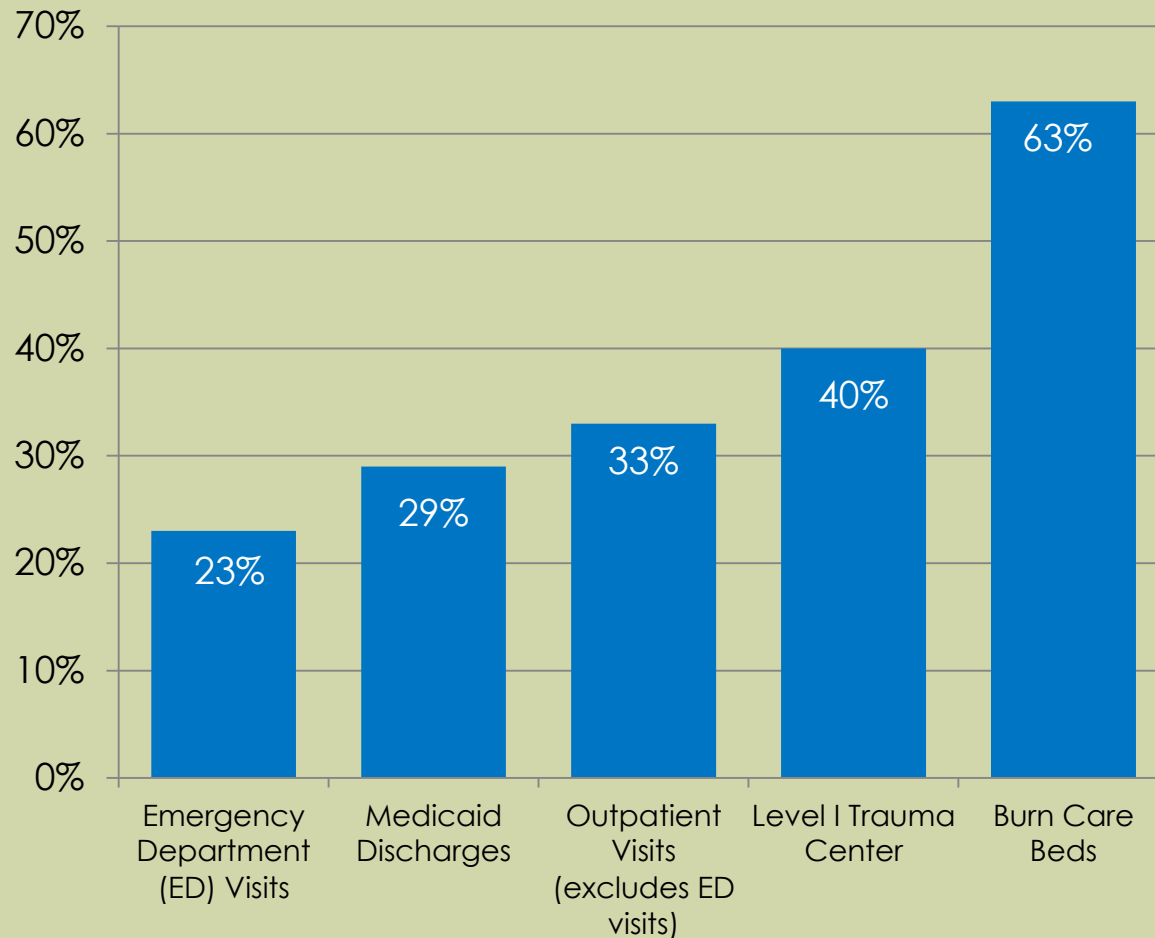


Source: Analysis of NAPH Hospital Characteristics Survey, FY 2009.

How do our hospitals serve their communities?

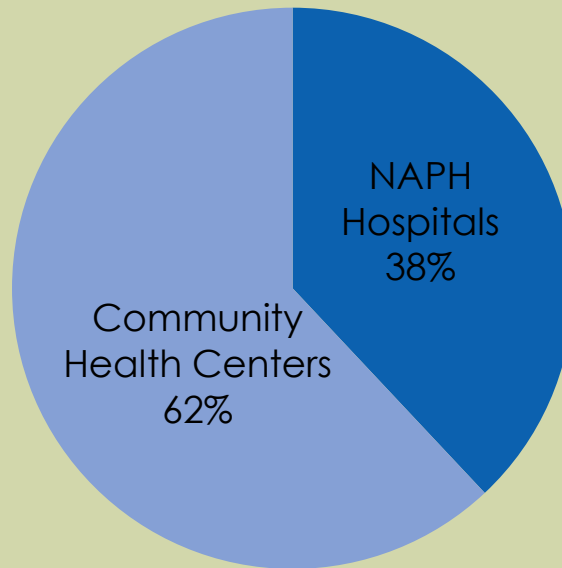
- One-third of all **outpatient** visits
- One out of four **emergency room** patients
- One out of five **babies** born
- 40 percent of all Level I **trauma** centers
- 60 percent of **burn** care beds
- One fifth of **uncompensated care**
- Train **one quarter of US physicians**

Percentage of Services Provided by NAPH Members in the 10 Largest U.S. Cities, 2009



Source: Analysis of AHA Annual Survey of Hospitals, 2009.

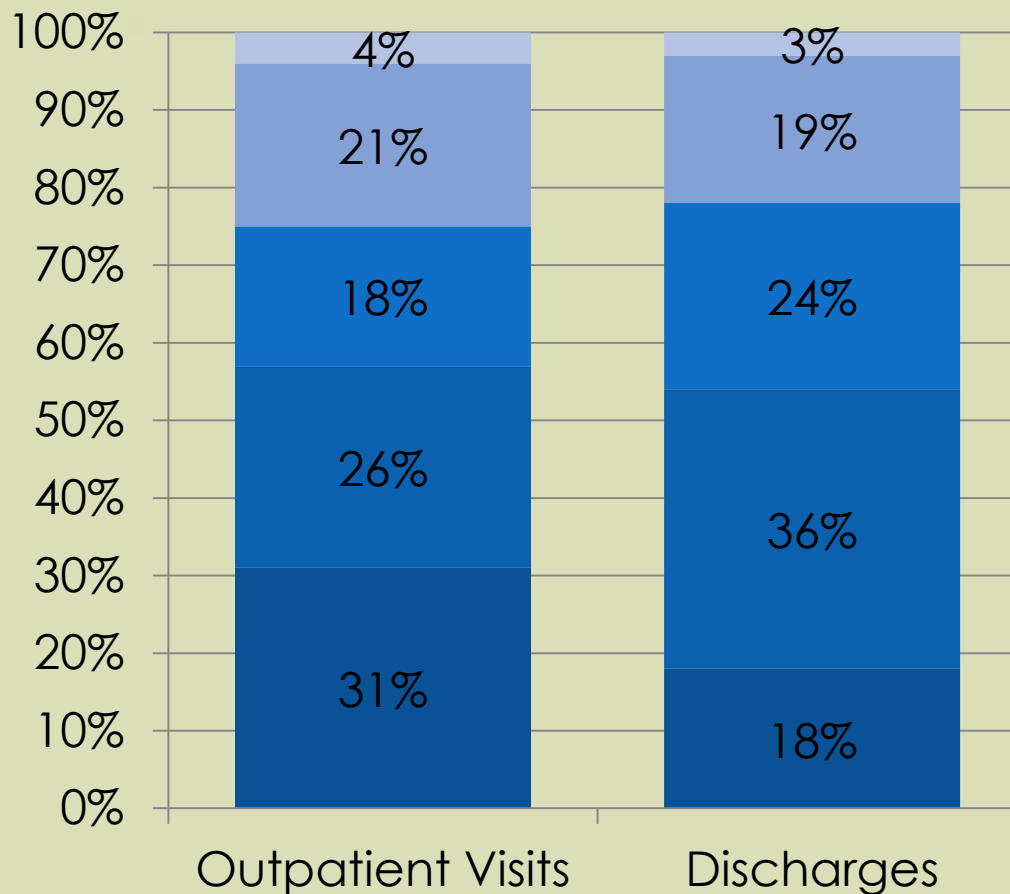
Outpatient Visits to Safety Net Providers, 2009



This data from FY 2009 represents 1,131 community health centers that received HRSA Bureau of Primary Health Care grants and the 92 public hospitals that participated in the NAPH Hospital Characteristics Survey.

Source: Analysis of NAPH Hospital Characteristics Survey, 2009 and U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Uniform Data Set (UDS), 2009.

Outpatient Visits and Discharges at NAPH Member Hospitals and Health Systems, by Payer Source, 2009

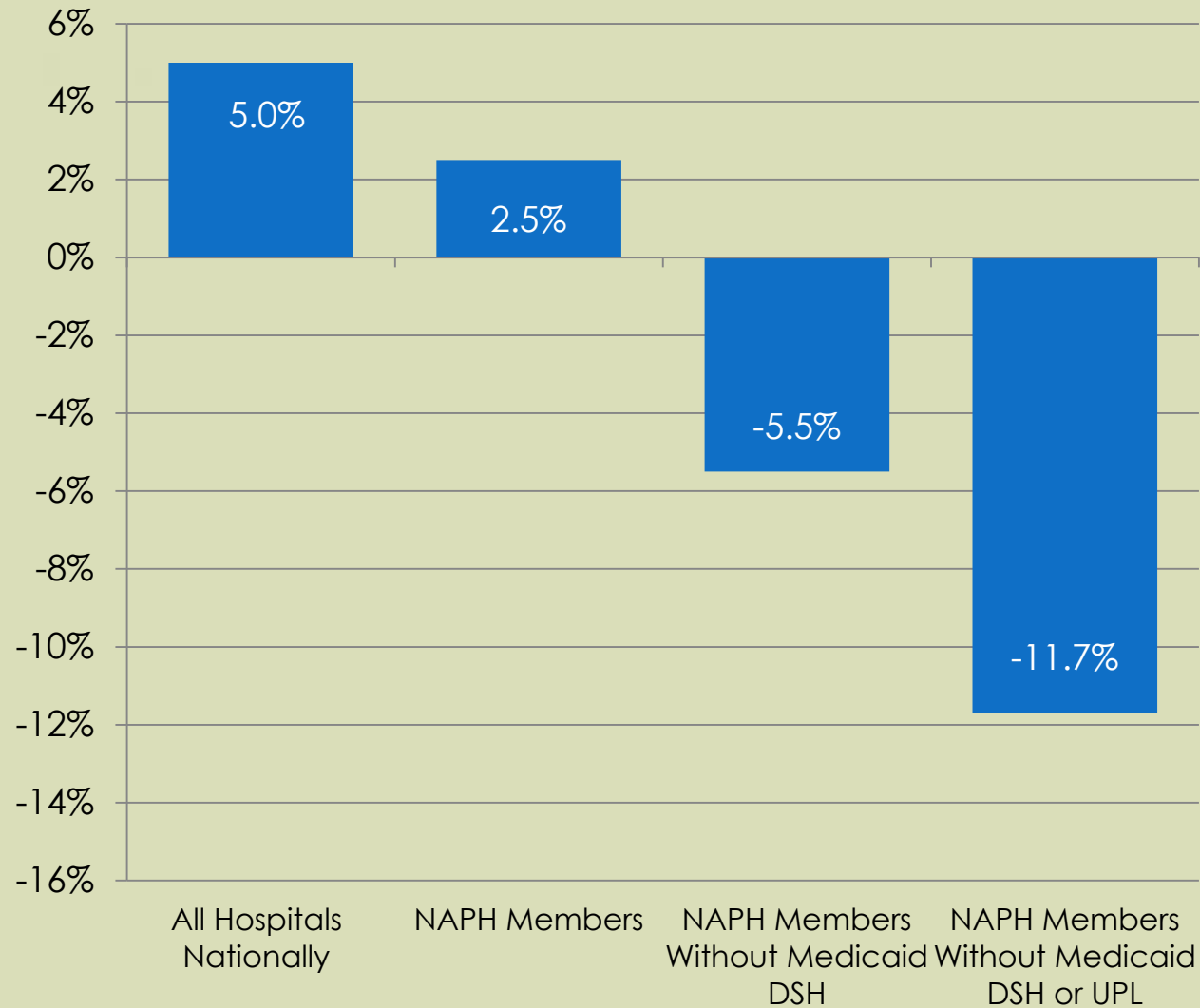


■ Uninsured ■ Medicaid ■ Medicare ■ Commercial ■ Other

Source: Analysis of NAPH Hospital Characteristics Survey, 2009

National Association of Public Hospitals and Health Systems

Hospital Margins, 2009



Source: Analysis of NAPH Hospital Characteristics Survey, 2009 and AHA Hospital Statistics, 2009.

Health Reform

What's in the Affordable Care Act?

Expands Coverage and Access

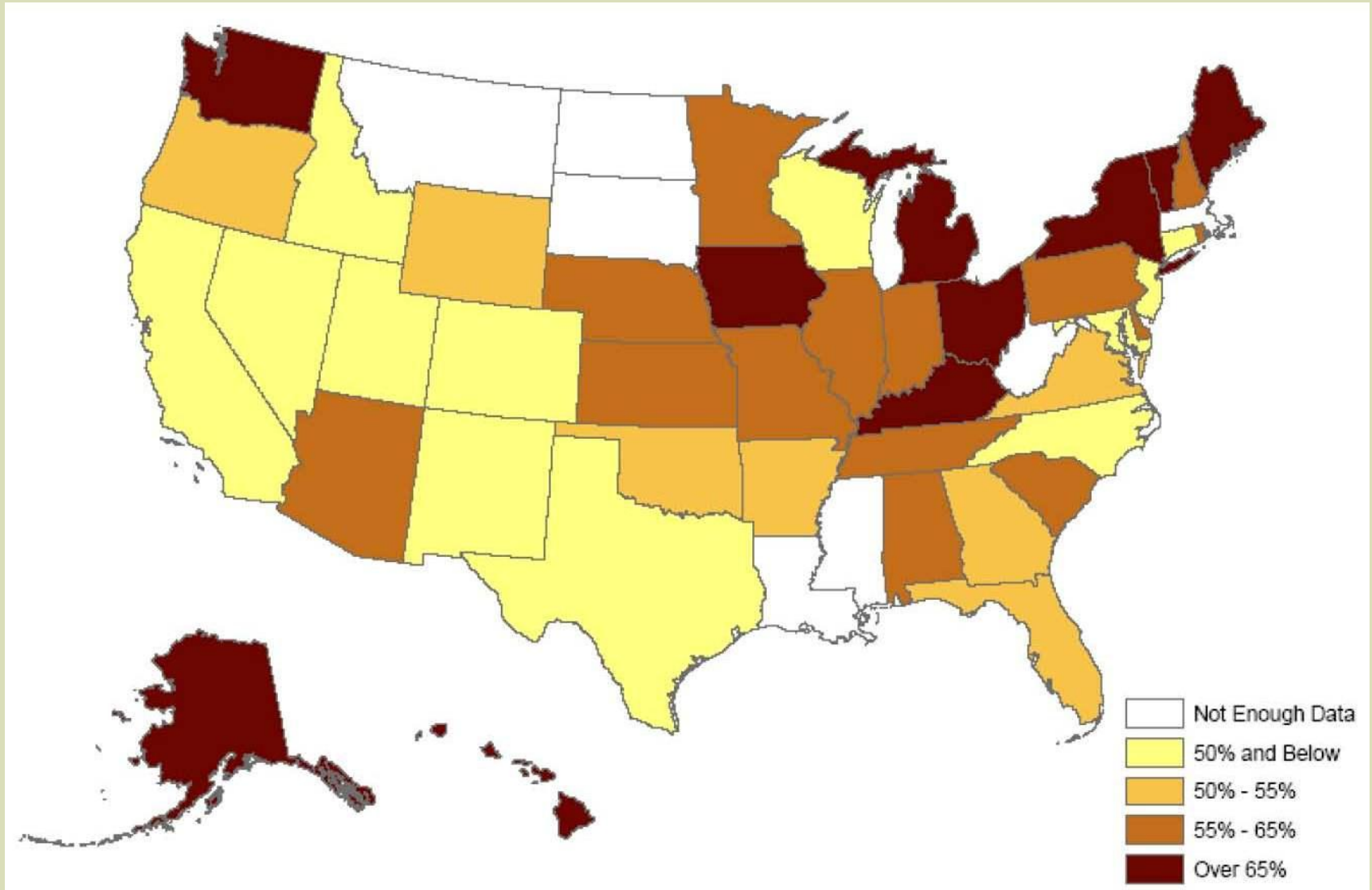
- **Medicaid** Expansion
- State Health Insurance **Exchanges**
- 32 million Americans covered by 2019
 - 94% of non-elderly US citizens
 - 92% covered if undocumented included
- 23 million left uninsured
 - Roughly 8 million undocumented immigrants

How will coverage look by 2019?

CBO estimates:

- **Medicaid/CHIP:** 16 million new enrollees
- **Exchange Plans:** 29 million
 - 24 million individuals receiving subsidies
 - 5 million via employers
- **Employer Coverage:** 3 million fewer
 - 6-7 million gain coverage who do not have it today
 - 8-9 million lose coverage who have it today
 - 1-2 million buy coverage via exchange rather than employer

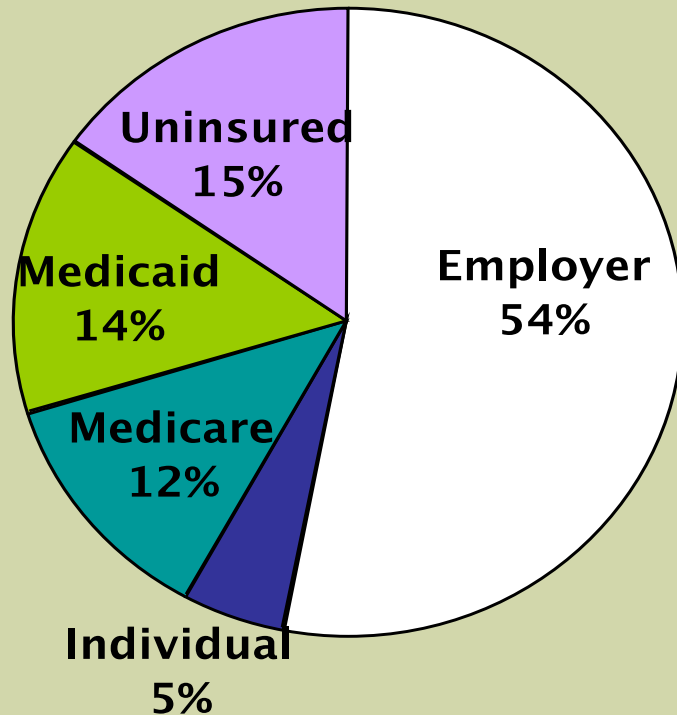
Percent of Uninsured Adults Eligible for Medicaid or Exchange Subsidies



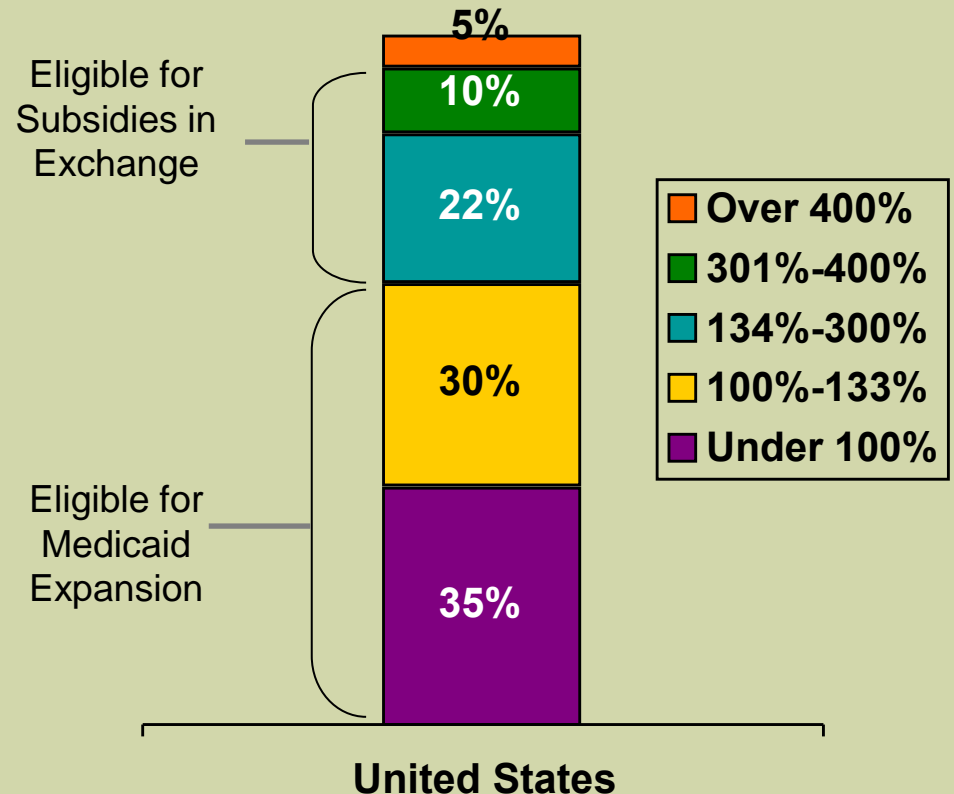
Source: Buettgens, Matthew and Mark A. Hall, "Who Will Be Uninsured After Health Insurance Reform?" Urban Institute, March 2011.

Current U.S. Coverage

Current U.S. Health Insurance Coverage



Current U.S. Nonelderly Uninsured by FPL



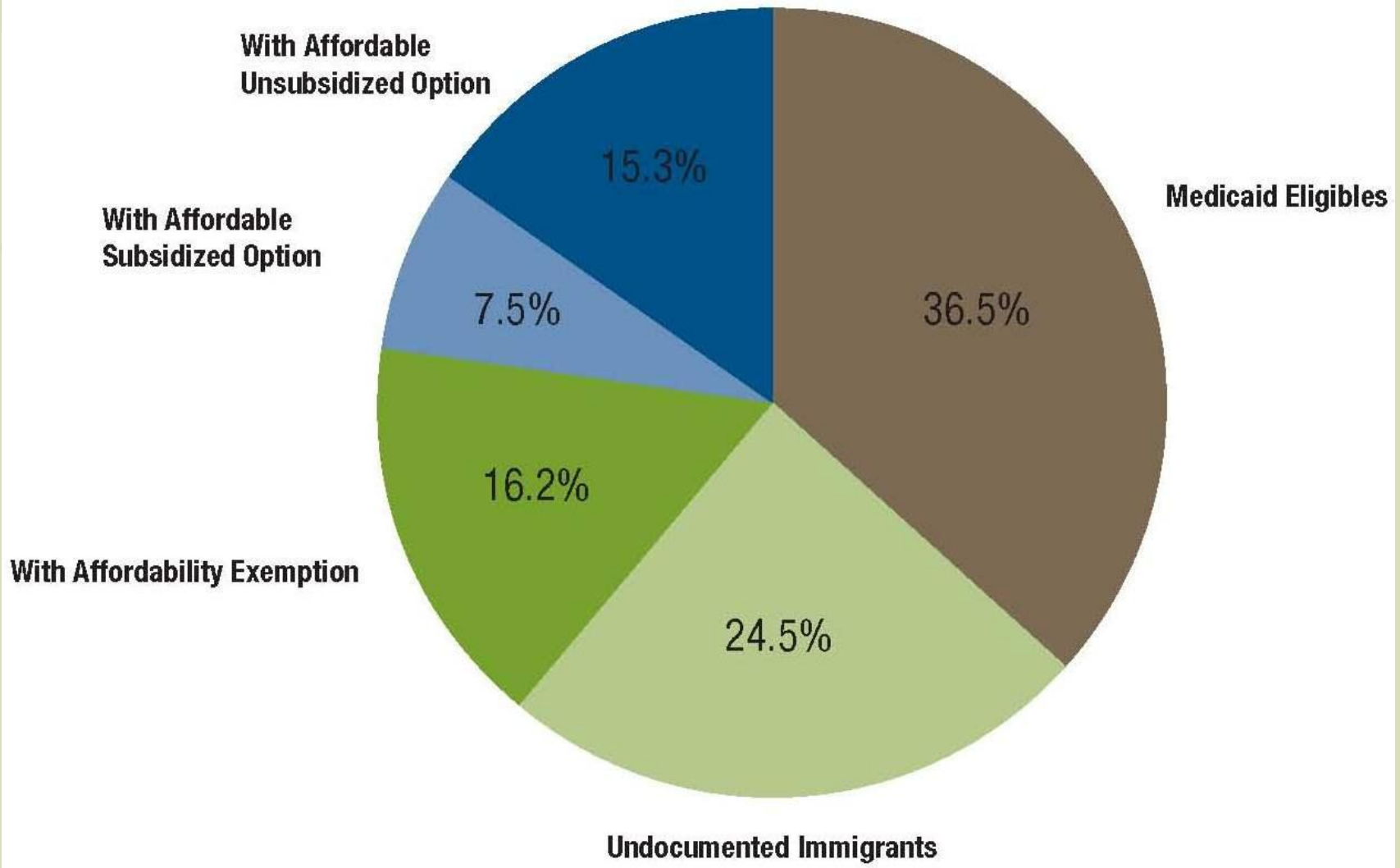
2008 U.S. Data, from The Kaiser Family Foundation, "State Health Facts: Health Coverage & Uninsured"

Remaining Uninsured

Who are they?

- Undocumented immigrants
- Those cycling on and off coverage
- Exempt from penalties
- Financial hardship, religious objections, American Indians, without coverage for < 3 months, incarcerated individuals, lowest cost plan option > 8% of income, income below the tax filing threshold
- Those who accept penalties

Distribution of Nonelderly Uninsured Adults Under the ACA



Source: Buettgens, Matthew and Mark A. Hall, "Who Will Be Uninsured After Health Insurance Reform?" Urban Institute, March 2011.

Medicaid Expansion

Medicaid Expansion (Pre-2014)

States may voluntarily “phase-in” coverage to 133% FPL

- Guidance released (April 9, 2010)
- Regular FMAP (not ARRA enhanced)
- Cannot cover higher income before lower income
- No asset test
- Benchmark or benchmark-equivalent coverage
- Only states with existing state-funded coverage likely to take advantage of this option
- Budget neutrality implications for waiver states

Medicaid Expansion

- Medicaid maintenance of effort (MOE) until 2014 (2019 for children)
- Expands Medicaid to non-elderly at or below 133% FPL (2014)
 - Reduce state-by-state variation in eligibility
 - Include childless adults under 65
 - Benchmark coverage or benchmark-equivalent coverage that at least meets Exchange plans' minimum essential health benefits
 - Benefits flexibility guidance issued April 30
- Hospitals participating in the Medicaid program will be permitted to make presumptive eligibility determinations (2014)

Medicaid Expansion

- Feds pay 100% to cover new eligible (2014-2019)
 - Phases down to 90% (2020-beyond)
- Expansion states (already covering parents and childless adults up to 100% FPL) receive phased-in federal assistance for non-elderly, non-pregnant, childless adults up to 133% (2014-2019)
 - 90% federal funding for these populations in 2020
- Restricts states from requiring political subdivisions to pay a greater percentage of non-federal share, but permits voluntary increases

Medicaid Expansion

Key Questions to Consider:

- How many uninsured patients below 133% FPL are in your community?
- How will Medicaid expansion impact your community?
- Will option to expand early impact your community?
- How can you help with enrollment, outreach, and education efforts?

State-based Exchanges

Who is in the exchange?

- Initially small business (50-100 employees) employees and individuals
- In 2017, open to businesses with more than 100 employees

Premium credits and cost sharing subsidies for individuals between 133-400% FPL (2014)

- 100% FPL for those ineligible for Medicaid (5 yr bar)
- Used to purchase insurance via exchange
- Caps premiums at 2%-9.5% of income
- Assistance with out-of-pocket costs

Exchange Subsidies

If single income at or below*	Max Monthly Premium
\$14,512/134%FPL	\$24
\$16,245/150%FPL	\$54
\$21,660/200%FPL	\$114
\$27,075/250%FPL	\$182
\$32,490/300%FPL	\$257
\$37,905/350%FPL	\$300
\$43,320/400%FPL	\$343

*Single adults, based on 2009 HHS poverty guidelines

State-based Exchanges

Key Questions to Consider:

- How many uninsured patients above 133% FPL are in your community?
- How will coverage through the exchanges impact your community?
- How can you help with enrollment, outreach, and education efforts?

Employer Coverage

Small Business:

- Tax credits (beginning 2010)
 - Business must contribute 50% of employee premium
 - Eligible if under 25 employees and wages under 50K
 - Full credit available for businesses with 10 or fewer employees and wages under 25K
 - Covers 35% of premium contribution (2010-2013)
 - Covers 50% of premium contribution (2014-2019)

Over 50 employees:

- Grandfather Policy: those that like current plan keep it
- No employer mandate. But, penalties for companies with employees eligible for premium exchange subsidies
- Free Choice Vouchers: For employees below 400% FPL where premium is 8-9.8% of income. Employer must offer voucher to be used in Exchange.

CHIP

- Extends current CHIP reauthorization thru Sept. 30, 2015
- Requires states to maintain income eligibility levels for currently eligible children until Sep. 30, 2019
- Federal matching rate for CHIP is increased by 23 percentage points (2015-2019)
- CHIP-eligible children not able to enroll due to federal allotment caps will be eligible for public subsidies in the state exchange (2014)
- Simplifies enrollment process and coordination with state health insurance exchanges

Opportunities for Communities: Stimulating Health System Changes

Opportunities for Communities

- Workforce/Training
- Community Health Centers
- Community Transformation Grants
- Medicaid health homes
- National Diabetes Prevention Program
- Community health teams to support medical home model
- Uninsured access demonstration
- Community Needs Assessment

Workforce

National Health Care Workforce Commission (§ 5101)

- Develop a national workforce strategy
- Annual recommendations to Congress and the Administration concerning national workforce priorities, goals, and policies

Workforce

- HHS plans to use some Prevention and Public Health Fund money (§ 4002) to support workforce initiatives
 - \$500 million for FY 2010
 - \$750 million for FY 2011
 - \$1 billion for FY 2012
 - \$1.25 billion for FY 2013
 - \$1.5 billion for FY 2014
 - \$2 billion each for FYs 2015 on
- For PHSA prevention, wellness, and public health activities, including: prevention research, health screenings, and other initiatives

Workforce

- Of the \$500 million for FY 2010, HHS to use \$250 million for primary care workforce development
 - \$168 million for training new primary care physicians (see next slide regarding grant announcement)
 - \$32 million for new physician assistants
 - \$30 million for nursing students to attend full-time
 - \$15 million for 10 nurse-managed health clinics
 - \$5 million for innovative state strategies to expand their primary care workforce

Workforce

- \$1.5 billion appropriated for the National Health Service Corps (NHSC) for FYs 2011-2015 (§ 10503)
- Builds on ARRA's \$300 million investment in the NHSC
 - Detailed implementation plan can be found here:
<http://www.hhs.gov/recovery/reports/plans/nhsc.pdf>
- Expected to result in an increase of more than 12,000 additional primary care physicians, nurse practitioners, and physician assistants by 2016

Community Health Centers

- Community Health Center Fund established for expanded and sustained national investment in community health centers.
\$11 billion from 2011-2015
- Establishes prospective payment system for Medicare-covered services furnished by FQHCs
- Qualified teaching health centers (FQHCs and others) are eligible for GME payments for operating primary care residency programs

Community Transformation Grants

- Competitive grant program
- For State and local governmental agencies and community-based organizations
- Implement, evaluate, and disseminate evidence-based community preventive health activities to address chronic disease and health disparities

Medicaid Health Homes

- States can allow Medicaid beneficiaries with chronic conditions to select a “health home” consisting of a designated provider or a team of professionals
- States make Medicaid payments to “health home” using state methodology approved by HHS
- State option begins Jan 1, 2011

National Diabetes Prevention Program

- Establish a network of evidence-based lifestyle intervention programs for those at high risk of developing type 2 diabetes
- Carry out community-based prevention activities, training, outreach, and evaluation

Community Health Teams

- Program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams to support primary care practices
- Communities can partner with the state designated agency to ensure that the agency's health care delivery integrates existing community resources and services

Uninsured Access Demonstration

- 3-year demonstration to provide access to comprehensive health care services to the uninsured
- State-based, nonprofit, public-private partnerships in up to 10 states
- \$2 million per state

Community Needs Assessment

- Applies to all tax-exempt hospitals 501 (c) (3)
- At least once every three years
- Adopt an implementation strategy that must be disclosed on the hospital's 990
- Adopt and widely publicize a financial assistance policy
- Tax of \$50,000 for failure to comply

Opportunities for Communities

Delivery System Transformation – Aligning payment with Quality

- Medicare & Medicaid-Pediatric ACOs.
- Reduce readmissions
- Community-Based Collaborative Care Networks
- CMS Center for Medicare & Medicaid Innovation

ACOs

Medicare

- Fee for service shared savings model
- Groups of Medicare providers and suppliers can share in cost savings above a certain threshold if quality standards are met
- Partner with community stakeholders by having a community stakeholder on the governing body

Medicaid pediatric

- To be determined

Readmissions

Community-based Care Transition Program

- \$500 million available; part of CMS' Partnership for Patient initiative
- Community based organization and/or hospitals with high readmissions rates can apply for funding to improve care transition

Community-Based Collaborative Care Networks

- Grant program for safety net providers to create collaborative care networks to provide low-income patients with comprehensive coordinated care

Center for Medicare and Medicaid Innovation

- Design, implement, test, evaluate and expand payment models & methodologies under Medicare, Medicaid, & CHIP that foster patient-centered care, improve quality, & reduce the cost of care.
- \$10 billion for FY2011-FY2019

Questions?

For more information about NAPH
visit www.naph.org.

Or contact:

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