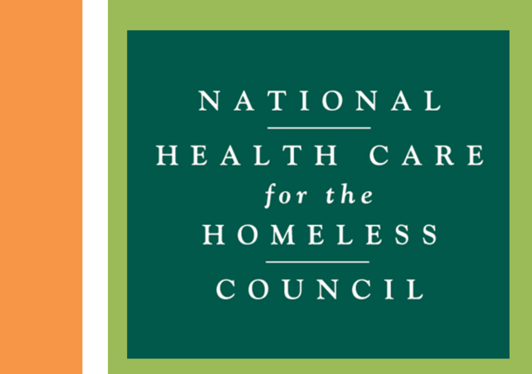
Preparing for Health Reform:
- Educate
- Engage
- Excel

March 14, 2013



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National Goals of Health Reform

- Increase access to care
- Improve health outcomes
- Lower costs to individuals
- Reduce total spending
- Improve quality of care

The Affordable Care Act (ACA)

- P.L. 111-148 as amended by P.L. 111-152
- 8 Major Components:
  - Private insurance reforms (includes Exchanges)
  - Medicaid reforms
  - Quality improvements
  - Prevention of chronic disease/public health
  - Strengthening health care workforce
  - Improve transparency and accountability
  - Improve access to medical technologies
  - Revenue provisions

Reduces Deficit by $73 Billion (2010-2019)

- **Costs:**
  - Subsidies/exchanges: $464B
  - Medicaid expansion: $434B
  - Employer tax credits: $40B
  - **Total: $938B**

$938b – ($441b + $570b) = -$73B

- **Program Savings:**
  - Less Medicare Advantage: $136B
  - Adjust Medicare payments: $196B
  - Reduce Medicaid drug costs: $38B
  - Reduce DSH/hospitals: $36B
  - Increase Medicare premiums for affluent: $36B
  - **Total: $441B**

- **Additional Revenues:**
  - Medicare tax on high-income: $210B
  - Health industry fees: $107B
  - Penalties/ind. Mandate: $69B
  - Excise tax on high-cost insurance plans: $32B
  - Other revenue: $152B
  - **Total: $570B**

Source: CBO, March 20, 2010.

The Biggest Changes

1. State Exchanges
2. Medicaid expansion (optional)
3. Enrollment improvements (required)
4. Additional health center revenue
5. New demonstrations
6. Payment/delivery system changes
7. Focus on data, quality & outcomes
8. New insurance protections
9. New partnerships
10. Revitalized health care discussions

Current Status

- ~3 years since legislation signed into law; major provisions not active until January 1, 2014
- *Public unaware:* 78% uninsured adults do not know of new options (83% of Medicaid expansion group)
- *Administration:* Full speed ahead
- *Congress:* Focused on larger budget reductions
- *Judicial:* Supreme Court upheld law, makes Medicaid expansion optional
- *States:* Where many decisions are being made now

Priorities for HCH Grantees

Medicaid Expansion

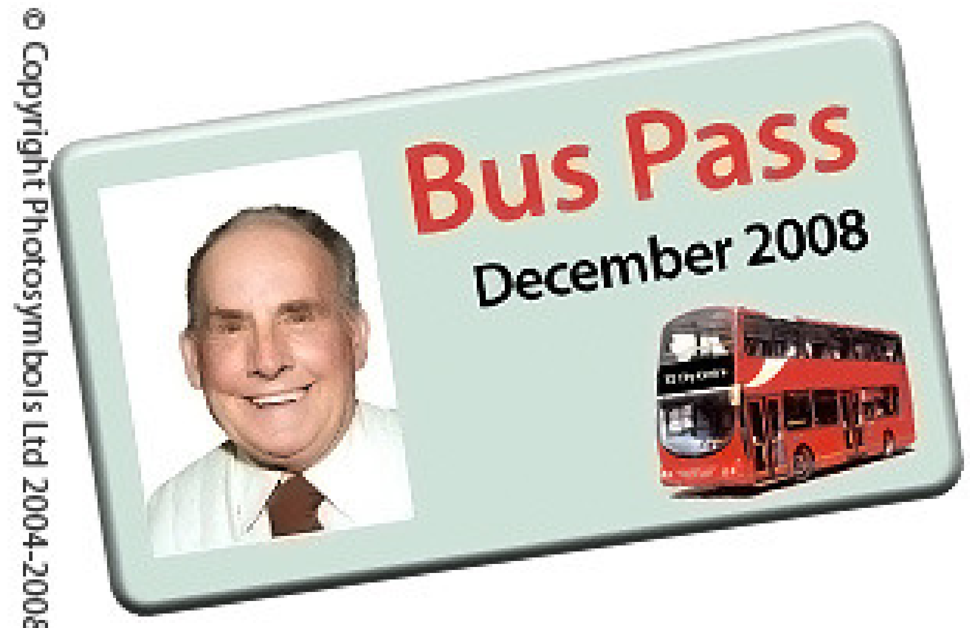
Health Center Expansion

Workforce Expansion

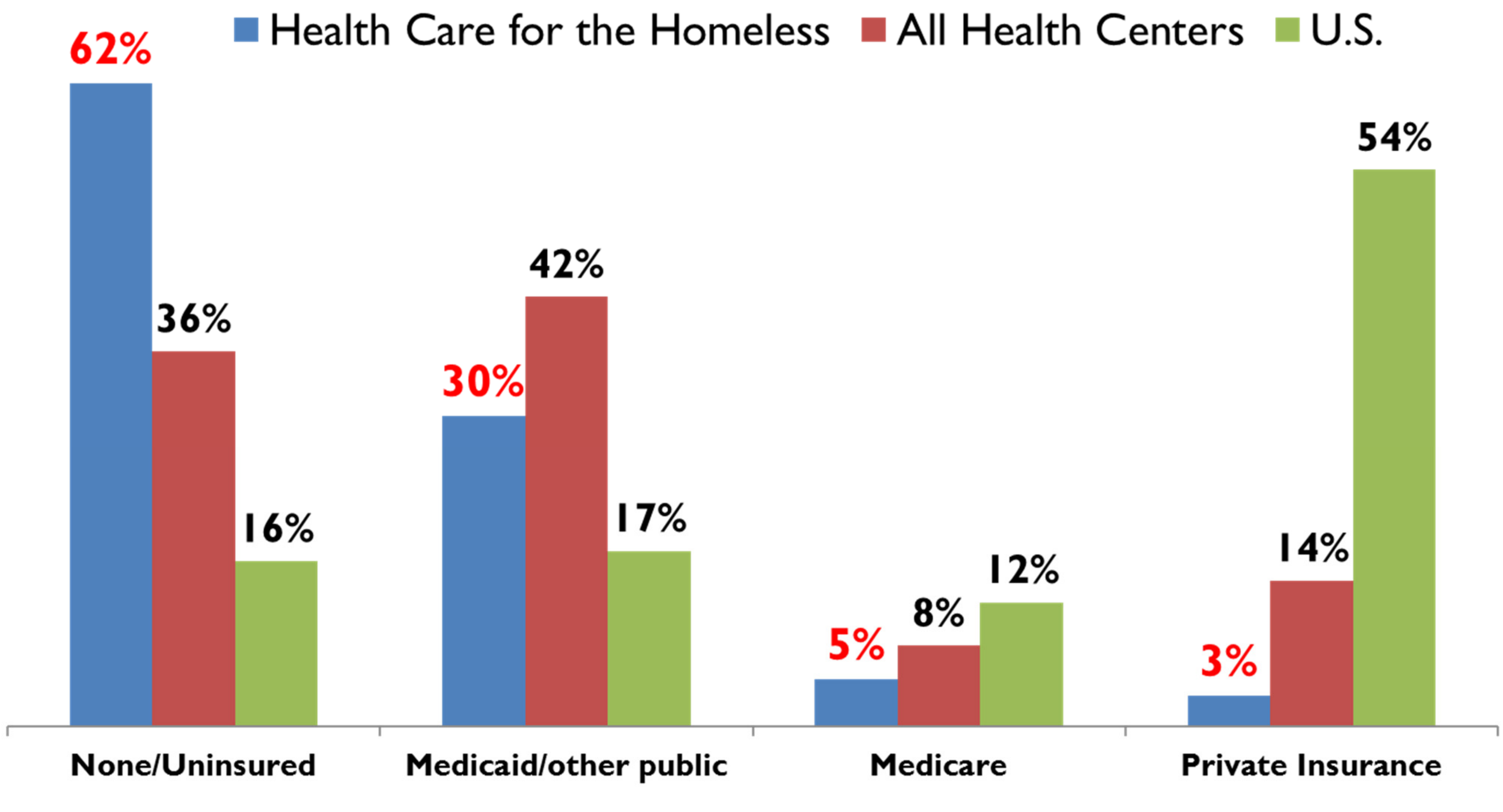
Care Delivery Models

Parameters of Law; Opportunities & Challenges

Medicaid Expansion: The Bus Pass



2011 Insurance Status: HCH v. All Health Centers v. U.S.



Sources: 2011 UDS Data, HRSA; 2011 Census Data

Median Medicaid/CHIP Eligibility Thresholds, January 2012

Minimum Medicaid Eligibility under Health Reform - 133% FPL
($25,390 for a family of 3 in 2012)

Children	Pregnant Women	Working Parents	Jobless Parents	Childless Adults
250%	185%	63%	37%	0%

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2012.

Where the States Stand: March 1, 2013

24 Governors Support Medicaid Expansion

NH VT MA CT RI DE MD NJ

- Participating 24
- Leaning Toward Participating 4
- Undecided/ No Comment 5
- Leaning Toward Not Participating 3
- Will Not Participate 14

- State-Run Exchange.............. 17
- Partnership Exchange..................7
- Federal-Run Exchange...............26

Note: Based on literature review as of 3/1/13. All policies possible to change without notice.
The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

Source: American Health Line, http://ahlalerts.com/2012/07/03/medicaid-where-each-state-stands-on-the-medicaid-expansion/, accessed 3/1/13.

Learn more about the impact of the Supreme Court ruling at **advisory.com/MedicaidMap**

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As of Sept. 2012: 10 yes 6 no

Where the States Stand

What are the States Saying about ACA Medicaid Expansion?

- Participating
- Leaning Toward Participating
- Undecided/ No Comment
- Leaning Toward Not Participating
- Will Not Participate
- ACA Lawsuit Participant

Note: Based on literature review as of 9/12/12. All policies possible to change without notice.

Source: American Health Line, http://ahlalerts.com/2012/07/03/medicaid-where-each-state-stands-on-the-medicaid-expansion/, accessed 9/12/12.

Learn more about the impact of the Supreme Court ruling at advisory.com/MedicaidMap

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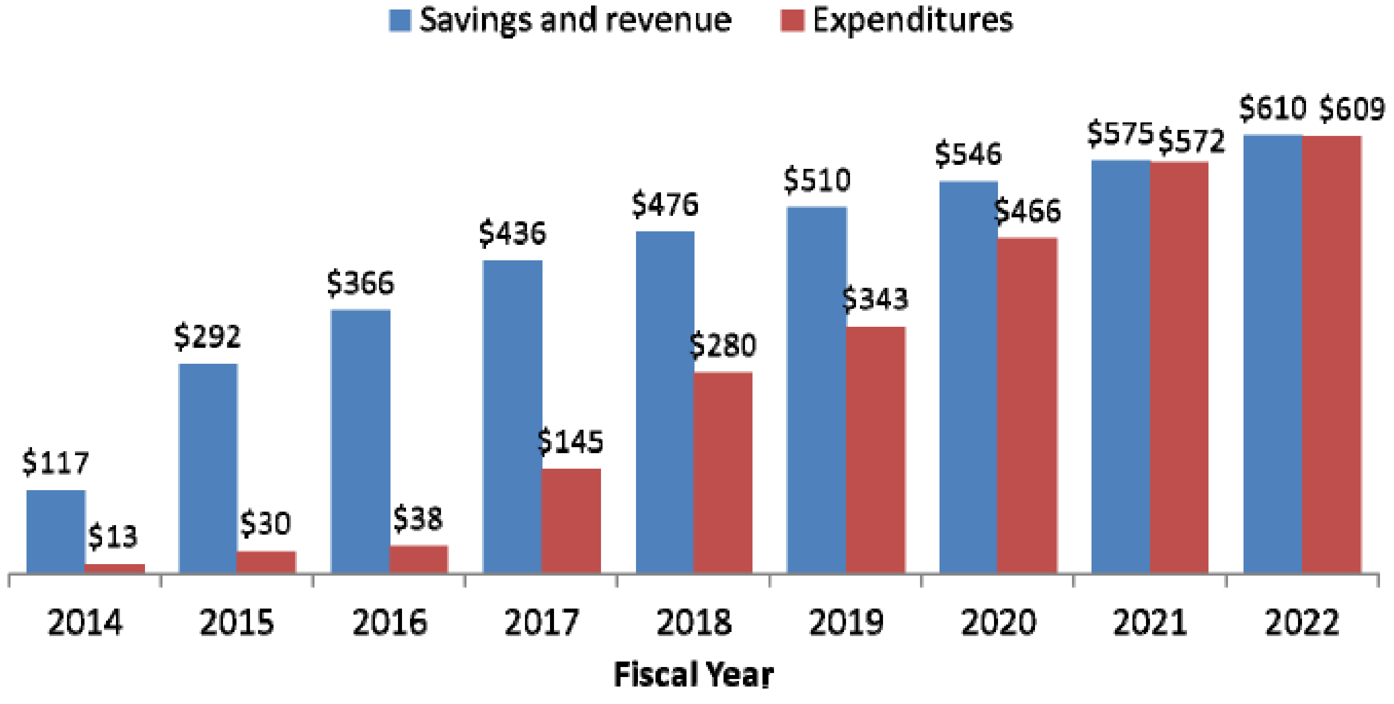
Examples of State Savings

- **Florida:** $100 million a year net savings
- **Ohio:** $1.4 billion net savings 2014-2022
- **Pennsylvania:** $400 million in mental health and general assistance savings per year
- **North Carolina:** $1-2 billion in uncompensated care savings 2014-19
- **Michigan:** $3.2 billion in state savings 2014-2023

Documentation available at http://www.nhchc.org/policy-advocacy/reform/state-medicaid-expansion-advocacy/

Total Savings and Costs: Ohio



Based on Study by Regional Economic Models, Inc., the Urban Institute, Ohio State University and Health Policy Institute of Ohio

Increased Economic Activity: Multipliers

Injection of $ → Direct Effect + Indirect Effect + Induced Effect → Total Impact (Output)

Medicaid Expansion → Health Sector Expands; Business Cost Savings; Household Income Increases → Buy More Health Goods; Produce More Products & Service; Buy More Household Goods → New Jobs; New Income → Higher State Output; Higher Tax Revenue for State Government and Higher Spending on Medicaid

+ Jobs Created Through 2020

- 24,000 jobs in MO
- 20,000 jobs in TN
- 32,000 jobs in OH
- 70,000 jobs in GA
- 30,000 jobs in IN
- 9,000 jobs in MS
- 31,000 jobs in VA

Documentation available at http://www.nhchc.org/policy-advocacy/reform/state-medicaid-expansion-advocacy/

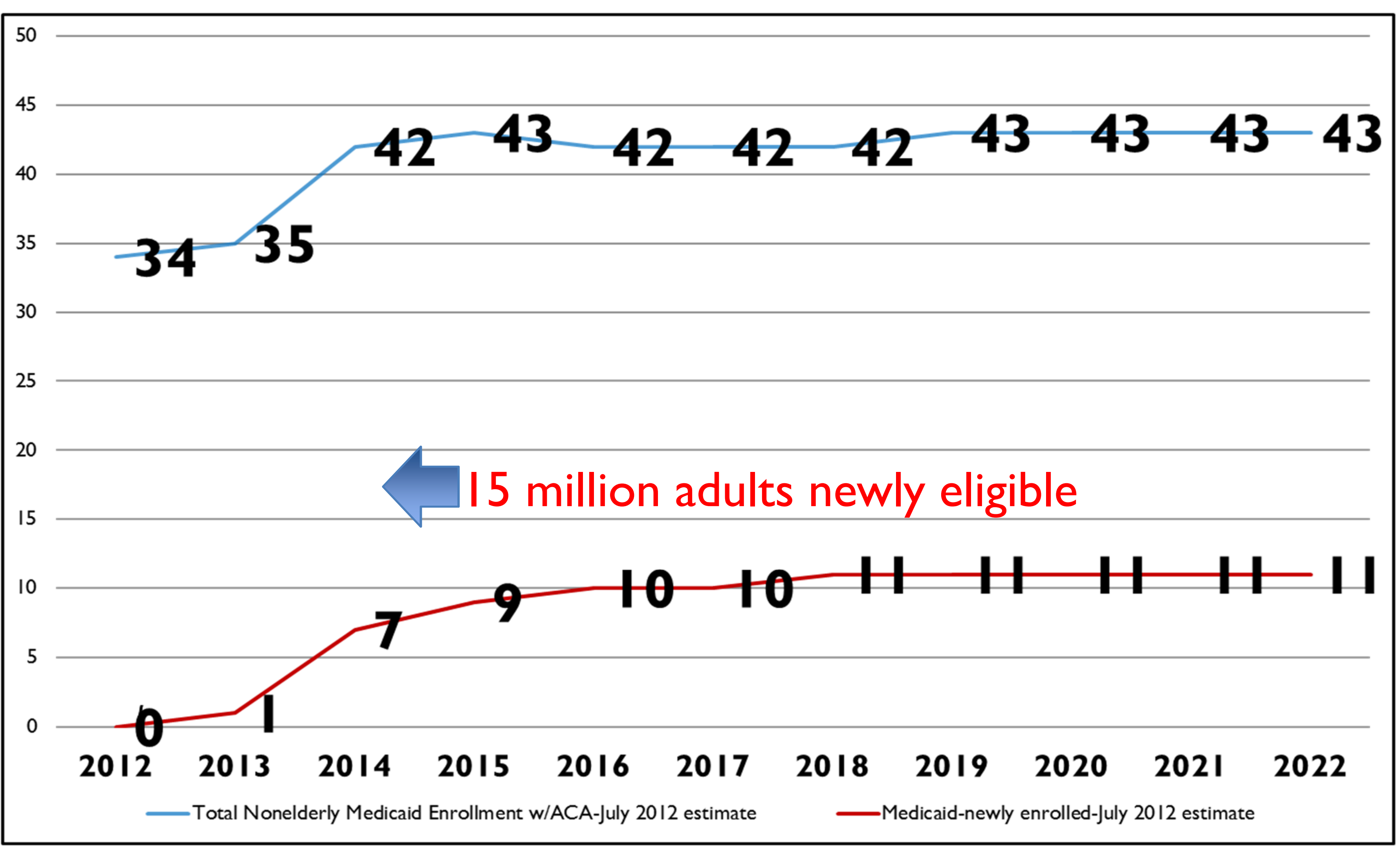
ELIGIBILITY OPTION

- **63 million currently enrolled:** children, pregnant women, disabled, and some parents of children
- **15 million newly eligible (starting January 1, 2014):** Law gives states option to expand Medicaid to non-disabled adults earning ≤138% FPL
  - About $15,000/year for singles
  - About $25,500/year for family of 3
- **7.3 million currently eligible, un-enrolled:**
  - 4.4 million adults (67% take-up rate)
  - 2.9 million children (84% take up rate)
- **85 million possible Medicaid enrollees** (1in 4)

ENROLLMENT REQUIREMENTS

- No wrong door (online, phone, mail, in person)
- Electronic verification of income & identity
  - *No paper documentation*
- Coordinated Exchange, Medicaid & CHIP
- Timely processing
- Single, streamlined application
- No in-person interviews
- Automatic renewals every 12 months
- Use of modified adjusted gross income (MAGI)
- Enrollment assistance available

CBO PROJECTED MEDICAID ENROLLMENT (NON-ELDERLY)



+ OUTREACH & ENROLLMENT

Law **requires** states "establish procedures for outreach and enrollment activities to vulnerable & underserved populations" (ACA § 2201)

- Children
- Unaccompanied homeless youth
- Children and youth with special health care needs
- Pregnant women
- Racial and ethnic minorities
- Rural populations
- Victims of abuse or trauma
- Individuals with mental health or substance-related disorders
- Individuals with HIV/AIDS

Essential Health Benefits

- 10 Categories are required:
  - Ambulatory services
  - Emergency services
  - Hospitalization
  - Maternity/newborn care
  - Mental health, substance use disorder & behavioral health treatment
  - Prescription drugs
  - Rehabilitative/habilitative services
  - Laboratory services
  - Preventive/wellness services
  - Pediatric services, to include oral and vision care

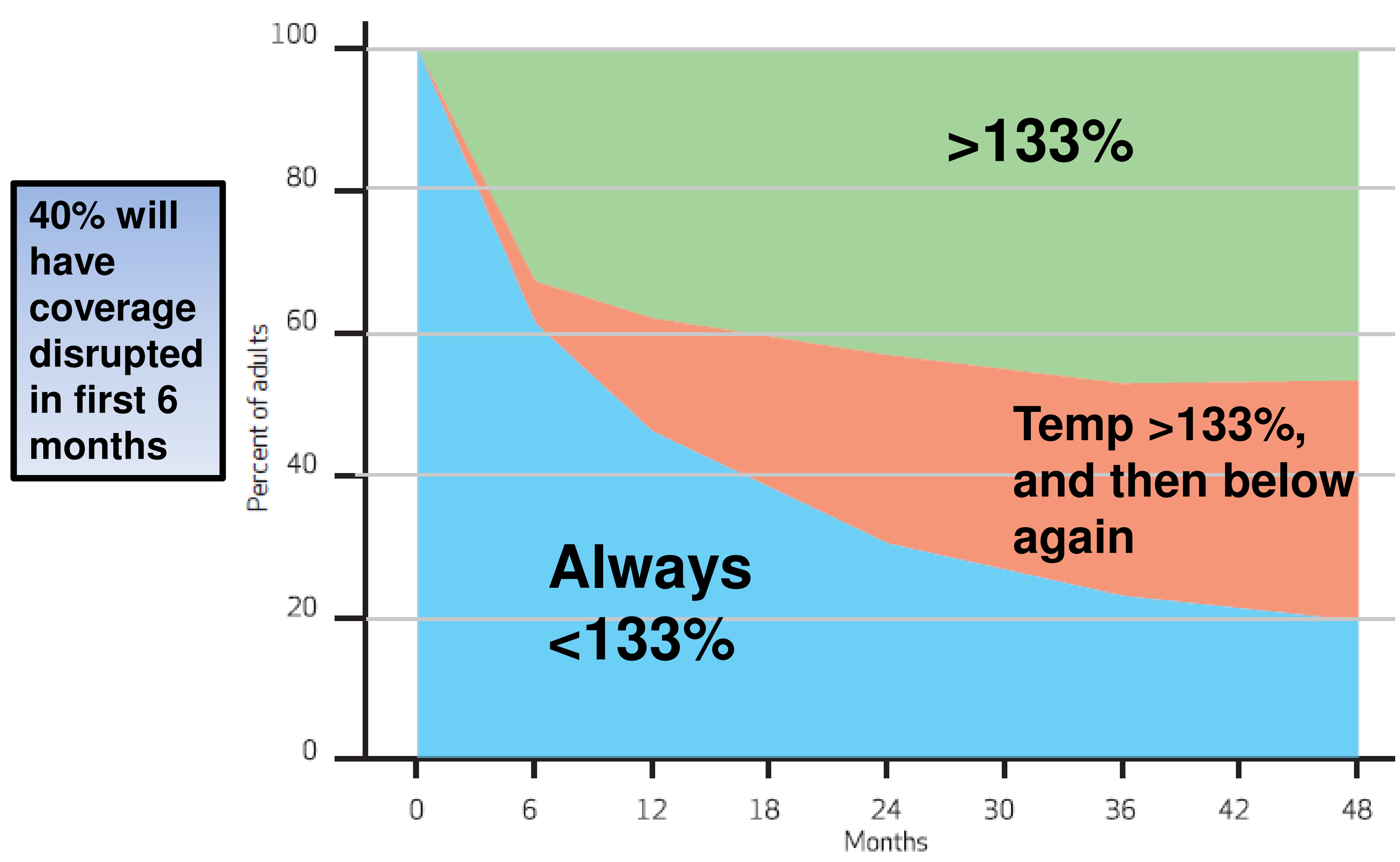
New Requirements for EHB

- No annual/lifetime limits on coverage
- No discrimination based on gender, age, disability, life expectancy, health status
- Behavioral health services must be in parity with medical services (Mental Health Parity and Addiction Equity Act)
- Apply to all private plans inside and outside Exchange and those newly Medicaid eligible
  - Does not apply to current Medicaid groups or private self-insured plans
- Unsure scope, amount, duration of services
- Gaps remain: dental, vision, case management, etc.

12 Reasons Why Medicaid Expansion is Critical

1. Improves access to care
2. Improves financial stability
3. Improves health status/reduces mortality
4. Patient satisfaction is high
5. Improves local and state economy
6. Maximizes federal funding
7. Reduces current state spending
8. Reduces ER & hospital utilization
9. Ensures healthier workforce
10. Helps low-income veterans
11. Helps children & families
12. Reduces health disparities

Income Changes For Those Starting <133% FPL



Source: Sommers & Rosenbaum (Feb. 2011). Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges. Health Affairs 30 (2).

A Word on the State "Marketplaces"

- Exchanges are "shopping centers" for health insurance for individuals and small employers
- Must be implemented by January 1, 2014
- **Subsidies and credits, based on income (100%-400% FPL)**
- Focused on individual and small group markets
- Must contain insurance with "Essential Health Benefits"
- Anticipate covering 9 million in 2014
  - 23 million in 2016

+ Subsidies for those 133-400% FPL

Single Person FPL %	Annual Income	Maximum Premium (as a % of income)	Enrollee Monthly Share
133%	$14,483.70	3.0%	$36.21
150%	$16,335.00	4.0%	$54.45
200%	$21,780.00	6.3%	$114.35
250%	$27,225.00	8.05%	$182.63
300%	$32,670.00	9.5%	$258.64
350%	$38,115.00	9.5%	$301.74
400%	$43,560.00	9.5%	$344.85

Eligibility Between Two Systems

Medicaid

(0-138% FPL)

100-138%

Exchange

(100%+)

Subsidies/credits:
100-400% FPL

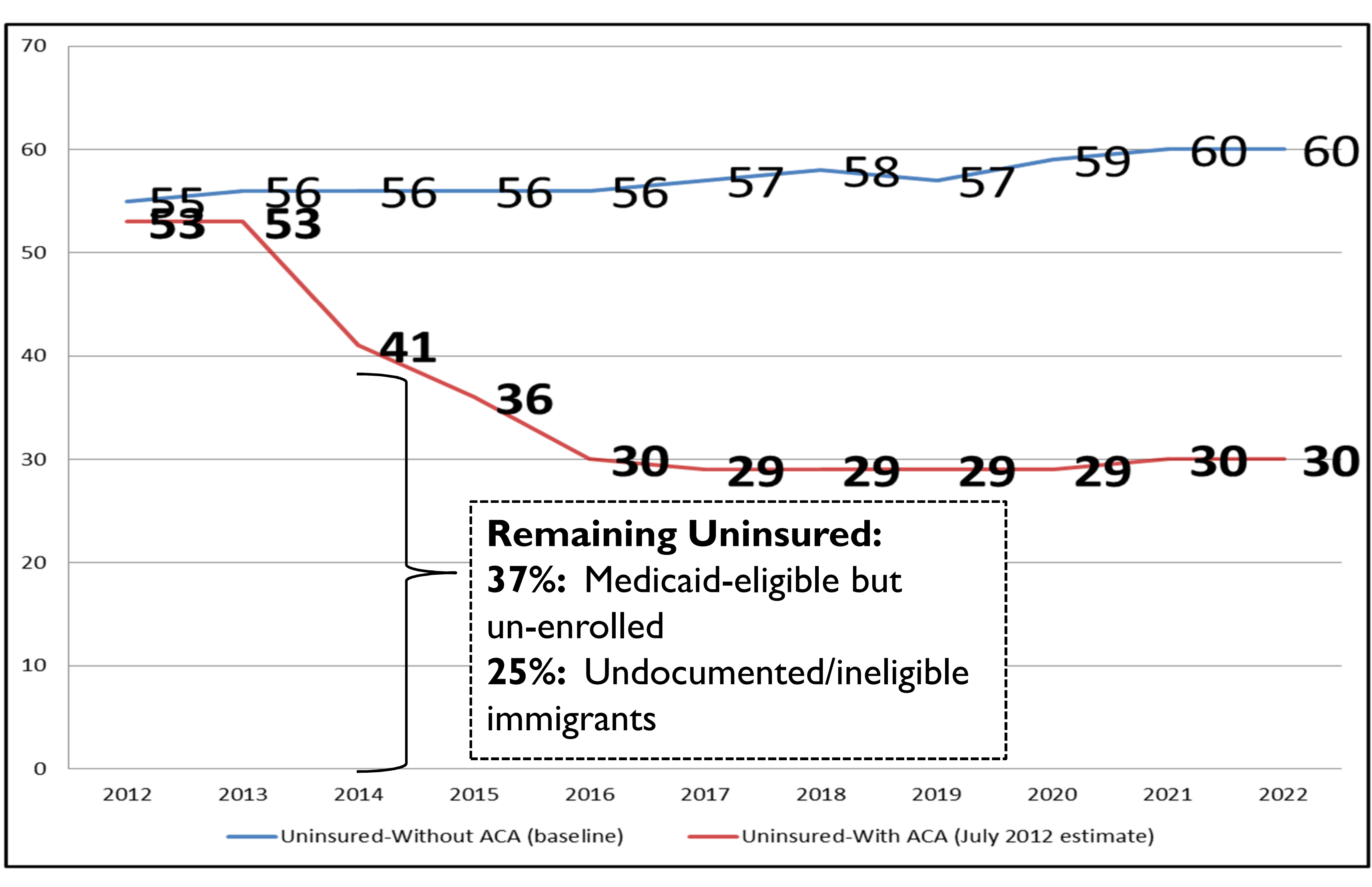
REMEMBER:

The Affordable Care Act is a solid step in the right direction *but*…it **does not** establish a right to health care

&

does not establish universal coverage

CBO THOSE REMAINING UNINSURED



Those Exempt from the Mandate

- Religious conscience (member recognized religious sect)
- Health care sharing ministry
- **Individuals not lawfully present**
- **Incarcerated individuals**
- **Individuals who cannot afford coverage/hardships**
  - **(>8% of household income)**
- **Taxpayers with income below filing threshold**
- Members of Indian tribes
- Months during short coverage gaps

+ State Level Actions
(Part I)

- Ensure states expand Medicaid
- Coordinate Medicaid, Exchanges and CHIP
- Ensure assertive, tailored outreach targeted to vulnerable
- Provide training to wide range of CBOs on enrollment
  - Both new and currently eligible
- Track enrollment by FPL
- Ensure application works well for vulnerable
- Oversee MCO protocols to ensure fairness, equity
- Raise reimbursement rates
- Design comprehensive plans, fill service gaps, provide for remaining uninsured
- Waive/remove out of pocket costs for newly eligible

Health Centers: The Bus

Health Center Expansion

- **$11 billion** in new funding (in addition to annual funding) + creation of Trust Fund

- Funding for New Services and Locations: $9.5 billion total
  - FY2011: $1 billion (final: no increase)
  - FY2012: $1.2 billion (final: +$200M)
  - FY2013: $1.5 billion (final: TBD)
  - FY2014: $2.2 billion (final: TBD)
  - FY2015: $3.6 billion (final: TBD)

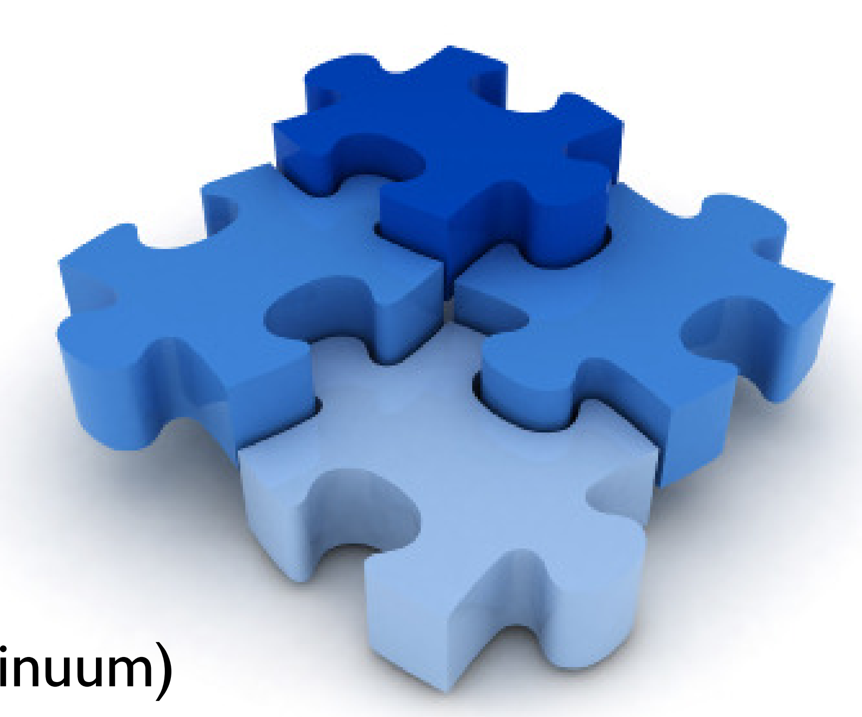
HCHs get 8.7% of funding!

Largely depends on related Congressional decisions

- Funding for New Buildings: $1.5 billion total

Identify Key Service Needs

- Primary care
- Oral health
- Addictions
- Mental health
- Outreach
- Specialty care
- Housing (full continuum)
- Medical respite care
- Employment
- Transportation



Identify Key Relationships

- Local hospital
- Discharge planning sources
- Referral sources
- Jail administrators
- Political leaders
- Shelter and housing providers
- All health care providers
- Business community
- Emergency responders – police & fire
- Continuum of Care
- Local health officer/social services director

Match Resources to Needs

- Who provides the services in each area of identified need, and how will health care reform impact them?
- How will the state of the current economy impact any of these service providers?
- What are the greatest service gaps?
  - What is your role in filling them?
  - What collaborations/partnerships are possible?
  - How are needs being communicated to state/county policymakers?

1
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State Level Actions

Part II

- Maximize relationships between Medicaid directors and health centers (& other health providers)
- Link objectives and goals to larger community health initiatives
- Facilitate data availability and exchange
- Negotiate rates using broad range of factors
  - Social determinants of health
  - Health status
  - Quality outcomes
- Facilitate partnerships where possible

Workforce: The Bus Driver

WORKFORCE

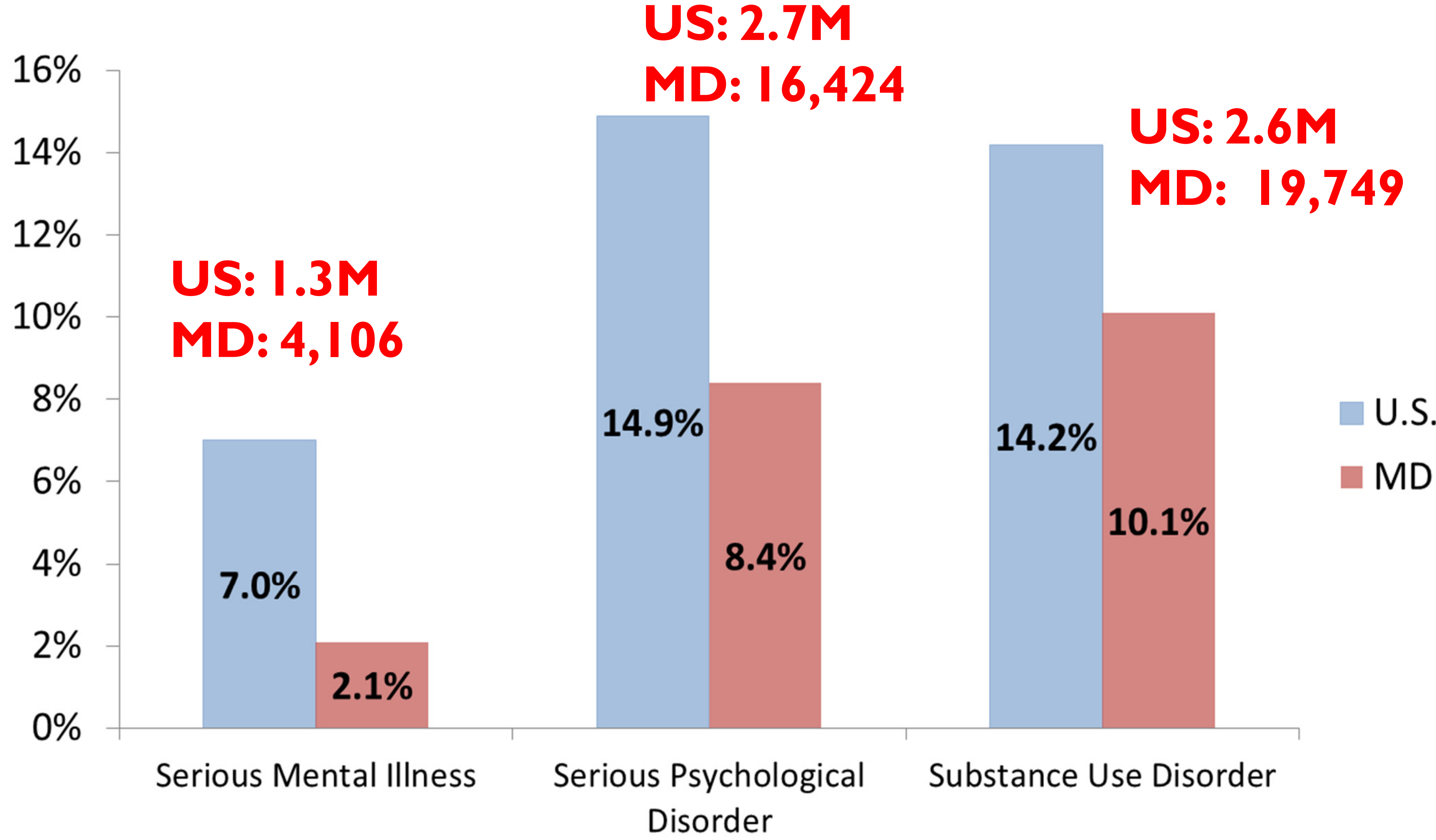
- 7,200 new primary care providers needed (2.5% of the current supply)
  - Geographic disparities in level of disruption
  - 44 million (14%) live in areas where 5%+ increase in demand
  - 7 million (2%) live in areas where 10%+ increase in demand

Source: Huang and Finegold. (March 2013.) Seven Million Americans Live in Areas Where Demand For Primary Care May Exceed Supply by More than 10%. Health Affairs. http://content.healthaffairs.org/content/early/2013/02/19/hlthaff.2012.0913.full.pdf+html.

- 96% physician practices accepting new patients
  - 31% unwilling to accept Medicaid
  - Increases in reimbursements help

Source: Decker, S. (August 2012). In 2011, Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help. *Health Affairs* 31 (8): 1673-1679.

Characteristics of 18-64 Year-Olds Projected in Medicaid Expansion Population



Source: SAMHSA, 2013. Available at: http://www.samhsa.gov/healthReform/enrollment.aspx.

State Level Actions

Part III

- Ensuring sufficient primary care & behavioral health providers
  - New opportunities for criminal justice population
- Staffing case managers & benefits coordinators
- Training (and revitalizing) burned out workforce
  - EBPs, new approaches to care
  - Treating intense needs
- Absorbing local gaps in care
- Recruiting/retaining best skills
- Adapting clinical curricula to include social determinants of health, working with homeless population

Care Delivery Models: Bus Maintenance

Health Care & Housing Are Human Rights

MODELS OF CARE

- Integrated, team-based care (mental health, addictions, medical)
- Focus on quality and outcomes, not quantity of procedures
- Patient-centered medical homes
- Electronic health records
- Coordinated care across multiple venues
- Collect data, eliminate disparities
- Coordinated care entities/accountable care organizations, etc.
- Health care viewed in a wider perspective
  - Renewed attention to social determinants of health

State Level Actions

Part IV

- Consider Medicaid options
  - "Health Homes"
  - Waivers to target benefit packages to specific groups
  - Billable providers
- Create incentives for quality (not quantity) of care
- Re-assess scope of practice laws, data sharing limitations
- Active participant in system of change, check/prevent abuses
- Include housing as a health care intervention in state plans (track homeless measures in health system)

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Action Steps for the HCH Community: What to do NOW

- **Educate** clients, staff, family, friends…everyone
- Hold **site visit/meeting** with:
  - Your state's Medicaid director & health reform lead
  - Your PCO/PCA
  - Your state and local health officer & local DSS director
  - Legislative leadership for health issues
- **Attend health reform stakeholder meetings**
  - **Find/bolster the coalitions that do exist**
- Ensure strong strategic plan/needs assessment is in place
- Form PCMH workgroup internally
- **Partner** with your fellow service providers (shelters, behavioral health care, others)

Key Advocacy Messages for Medicaid

- Free for the first 3 years
- A great deal after that
- Medicaid saves money—*for everyone*
- Good for the economy, creates jobs
- Best coverage & most affordable for low-income folks
- Saves lives, bolsters employment
- Stabilizes families, makes better parents

+

OPPORTUNITIES	RISKS
Improved individual & public health	Fail to reach newly eligible (lack of outreach)
Reduced personal bankruptcy & poverty	Continued barriers to enrollment
Increased individual & family stability	Inability to find provider(s)
Increased employment & productivity	Difficulty engaging in care
Reduced recidivism to criminal justice	Ongoing housing instability risks engagement in care
Preventing & ending homelessness	Poor transition to exchange jeopardizes gains in health, income
	Ongoing homelessness & poor health

+ HCH Leadership – *Managing Change*

HISTORIC	CURRENT / FUTURE
▪ Third decade in…	▪ New facilities
▪ Retirement, leadership change…	▪ New delivery models
▪ Growth in homelessness…	▪ Limitations of "homeless only" approach
▪ Persistence of poverty…	▪ Health reform / Medicaid expansion
▪ Formalization of projects	
▪ Paradigmatic shift – "housing readiness" to "housing first"	

Role of HCH Leadership

INTERNAL	EXTERNAL
1. Strategic planning	7. Relationship building
2. Financial assessment & billing capacity	8. Partnerships
3. Staffing (re)organization	9. Formal participation
4. Board engagement	10. PCA partnership
5. Staff education & training	
6. Consumer education	

Strategic Planning

- **Preliminary Steps**
  - Environmental assessment
  - Stakeholder input
  - Composition of planning committee
- **New Approaches**
- **Strategic Goals**
  - Investment in staff
  - Financial stability
  - Integrated health care services
  - Affordable housing
  - Community engagement

Financial Assessment & Billing Capacity

- Re-assess entire billing & finance system
  - Revisit policies & procedures, staff roles
  - Implement new data measures & work flow
  - Conduct internal audit/external review
- Ensure all systems flow well
- New revenue as a result of Medicaid expansion
  - Anticipate 25% billable visits → 80% billable
- Ensure nothing is left on the table

Staffing (Re)Organization

- Clinical teams
  - Patient-centered medical home (PCMH)
  - Medical
  - Behavioral Health
- Support teams
  - Intake, unit clerks
  - Benefits
  - Case management
- Administrative teams
  - Information technology
  - Performance improvement

Break down "silos"

Board Engagement

- Regular Board meeting discussions
  - Involvement in strategic plan
  - Transparency & involvement in change processes
  - Review of Board composition
  - Use of community relationships

+

Staff Education and Training

- Re-assessed functions and re-organized teams
- Re-assessing job descriptions
- Strategic plan task forces – finance, access, HR, volunteer
- Challenges:
  - Change management – enough info, not too much…
  - Waiting for further state decisions to determine next steps
  - Application format, training resources, enrollment certification requirements
- Summer 2013: Bulk of activity
- **October 1, 2013: Open enrollment begins**

HEALTH CARE for the HOMELESS INC.

Consumer Education

- Obtaining consumer feedback and input
  - Consumer board members
  - Consumer Relations Committee (CAB)
  - Focus groups
  - Consumer satisfaction surveys

- In development: health reform materials
- Valuable perspective on your operations (and required)

External:
Relationship Building w/ Policymakers

- Governor's Office staff
- State Medicaid Director
- State Public Health Officer
- State Health Insurance Exchange board/staff
- City Health Officer, Social Services Director
- Legislative allies

External:
Partnerships with Key Organizations

- Health Care Access Maryland (state's enrollment/navigator entity)
- Managed Care Organizations
- Hospitals & emergency departments
- MedChi (state's physician's association) & other professional associations

- Others?

+ External:

Formal Participation

- Medicaid Advisory Committee
- Behavioral Health Integration
- Health Care Reform Coordinating Committee
- Essential Health Benefits Committee

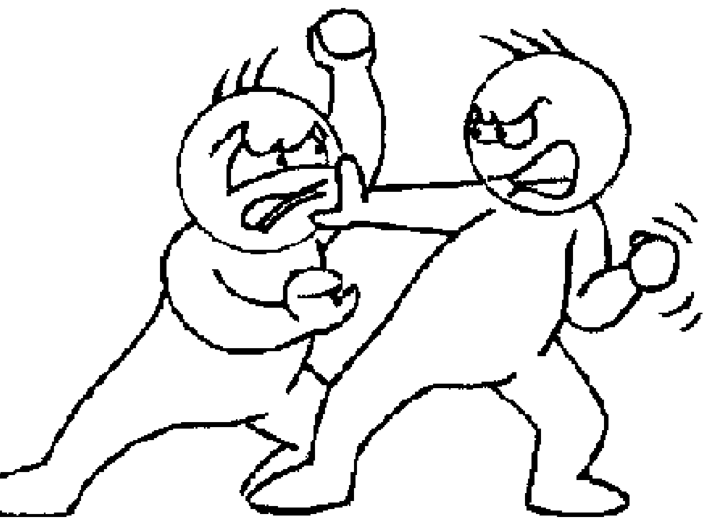
- Others?

External: PCA Collaboration

- Membership
- Training and TA
- Advocacy
- Bridging relationships

A Final Note:
Competition, Really?

- **If yes:**
  - Prepare internally
  - Ensure quality of care
  - Prepare service capacity
  - Bolster "HCH" model of care



- **If no:**
  - Status quo, no change
  - MCO economic incentive to enroll, but not serve
  - Prepare to re-assign clients as needed

Questions?

- Provisions of law
- State role and/or actions
- Role of HCH Community
  - Administrators
  - Clinicians
  - Consumers
  - Other stakeholders
- Internal HCH activities
- External HCH activities

+ About Us

- *Health Care for the Homeless of Maryland:* Prevents and ends homelessness for vulnerable adults & families by providing quality, integrated health care & promoting access to affordable housing and sustainable incomes through direct service, advocacy, and community engagement. www.hchmd.org *@hchomeless*

- *National Health Care for the Homeless Council:* Bring about reform of the health care system to best serve the needs of people who are homeless, to work in alliance with others whose broader purpose is to eliminate homelessness, and to provide support to Council members. www.nhchc.org *@NatlHCHCouncil*

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