From Capitol Hill to Your Community – What Health Reform May Mean for Community Health Systems

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Presentation Outline

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

I. Health Reform Overview

II. Health System Improvements

III. Public Health and Prevention Investments

The Big Picture –

The Patient Protection and Affordable Care Act became law March 23, 2010.

- Coverage for 32 million uninsured
- Broad insurance reforms
- Major new investments in public health.

Key Provisions for MCH

- Approximately 9 million children and 12 million women of reproductive age gain coverage in 2014.
- Insurance reforms provide new protections, particularly for CYSHCN.
- Expands and strengthens coverage of clinical preventive services

Impacts Continued

- New sections of Title V provide $1.5 billion for home visiting, $375 million for PREP (teen pregnancy prevention), and $15 million for post-partum depression services.
- Shift towards primary care with $11 billion expansion of health centers
- Provisions to promote medical home

Key Challenges

- Can states afford new costs in out years?
- Lawsuits to block or repeal
- Upgrading and coordinating eligibility and enrollment systems
- Assuring health system capacity to absorb newly insured and pent up demand
- Who and what is not covered

AMCHP's Aim

- Provide state MCH leaders and their partners with information, tools and resources to optimize opportunities throughout implementation to improve services, systems, and outcomes for MCH populations.

- Focus on immediate, intermediate, and long term phases .

Coverage Basics

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- Expands Medicaid to all under 133% of poverty

- Preserves Medicaid & CHIP coverage for children above 133% of FPL.

- Creates state-based Exchanges to provide coverage and provides tax credits to help people with income up to 400% of FPL

Coverage Continued

- Establishes mandate that people obtain insurance or face a tax penalty.
- Requires employers with 50 or more full-time workers to pay penalties for employees who receive coverage through exchange.
- Provides tax credits to small businesses to purchase coverage for their employees.

Medicaid Financing

- Sates receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years.
- Expansion states receive phased-in increase in FMAP for non-pregnant childless adults - by 2019 receive same financing as other states (93% in 2019 and 90% in 2020 and later).
- States option to expand Medicaid eligibility to childless adults beginning April 1, 2010, but with regular FMAP until 2014.

CHIP Financing

- Beginning in 2015, states will receive a 23 % point increase in the CHIP match rate up to a cap of 100%.

- CHIP-eligible children who are unable to enroll in the program due to enrollment caps will be eligible for tax credits in the state Exchanges.

Medicaid Primary Care Payment Increase

- Medicaid payments for primary care services provided by primary care doctors increase to 100% of the Medicare payment rates for 2013 and 2014.

- States will receive 100% federal financing for the increased payment rates

- What happens in 2015?

Key Opportunities for State MCH Programs

Key Questions

Benefits

- Extends Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) to all children gaining coverage via Medicaid

- Assures continuation of CHIP benefits package to eligible children until 2019.

Benefits Continued

- Establishes four benefit packages available within Exchanges - Bronze, Silver, Gold, and Platinum will vary by actuarial value.
- Creates a catastrophic category for the under 30 “young invincible.”
- Bronze plan to provide minimum essential coverage at actuarial value of 60%; Platinum at 90%.

Essential Health Benefits Package
Plans in the Exchange must include:

- ambulatory services,
- emergency services,
- hospitalization,
- maternity & newborn care,
- mental health & substance use disorder services, including behavioral health treatment,
- prescription drugs,
- rehabilitative & habilitative services and devices,.
- laboratory services,
- preventive & wellness services and chronic disease management, and
- pediatric services, including oral and vision care.

Coverage of Clinical Preventive Services

- Eliminates co-pays for services recommended by USPSTF and immunizations recommended by CDC.
- Provides a 1% increase in FMAP for states that provide Medicaid coverage and remove cost-sharing for recommended preventive services
- New plans must cover services recommended by Bright Futures guidelines
- HRSA directed to create Bright Futures for Women to also be covered by new plans

New Medicaid Benefits

- Requires coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.

- State option to cover family planning services without waiver.

Insurance Reforms

- Prohibit pre-existing condition exclusions for children. (Effective six months following enactment)

- No annual or lifetime limits. Prior to January 2014, plans may only impose annual limits on coverage as determined by the Secretary.

- Guaranteed issue and renewal with rating variation limits in the individual, small group market and the Exchange.

- Prohibition on rescinding coverage except in cases of fraud.

Insurance Reforms Continued

- Grandfather existing individual and group plans with respect to new benefit standards, but require these grandfathered plans to extend dependent coverage to adult children up to age 26, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.
- Require grandfathered group plans to eliminate annual lifetime limits on coverage and beginning in 2014.
- Require grandfathered group plans to eliminate pre-existing condition exclusions for children within six months of enactment and by 2014 for adults.

Insurance Reforms Continued

- Require all new policies (except stand-alone dental, vision, and long-term care insurance plans) to comply with one of the four benefit categories. Existing individual and employer-sponsored plans do not have to meet the new benefit standards.
- Limit deductibles for health plans in the small group market to $2,000 for individuals and $4,000 for families
- Limit any waiting periods for coverage to 90 days.
- Allow states the option of merging the individual and small group markets. (All above effective January 1, 2014)

Consumer Protections

- Establish internet website to help identify health coverage options (effective July 1, 2010) with standard format for presenting information on coverage options.

- Develop standards for insurers to use in providing information on benefits and coverage.

Promoting Medical Homes & Integrated Systems

- **Health Homes in Medicaid:** $25 million in planning grants to states to develop a state plan amendment to provide health homes.

- **CMS Center for Medicare and Medicaid Innovation**: “Test innovative payment and service delivery models for Medicare, Medicaid, and CHIP programs.” Mandatory appropriation of $10 billion over the next ten years for implementation.

Medical Homes Continued

- **Accountable Care Organization Demonstration Project**: Recognizes pediatric medical providers as an accountable care organization (ACO)

- **State Grants to Promote Community Health Teams that support the Patient-Centered Medical Home**: Grants for community-based interdisciplinary teams which will provide support services to primary care practices, including OBGYN practices
- **Establish 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.

Community Health Center Expansion

- **Community Health Centers and National Health Service Corps Trust Fund –** Creates $11 Billion for Health Center Program Expansion to expand capacity to serve nearly 20 million new patients; $1.5 billion for capital needs to expand and improve existing facilities and constructing new sites.

- **$1.5 Billion for the National Health Service Corps –** support an estimated 15,000 primary care providers in shortage areas.

Community Health Center Fund

Fund is in addition to annual CHC discretionary funding, which was $2.19 billion in FY 2010. Annual allocations for the operations dollars are as follows:

FY 2011 - $1 Billion

FY 2012 - $1.2 Billion ($200 million increase)

FY 2013 - $1.5 Billion ($300 million increase)

FY 2014 - $2.2 Billion ($700 million increase)

FY 2015 - $3.6 Billion ($1.4 billion increase)

CHC Payment Provisions

- Requires that health centers receive no less than their **Medicaid PPS rate from private insurers** offering plans through the new health insurance exchanges and requires that these plans contract with health centers.

- **Adds preventative services** to the Federally-Qualified Health Center (FQHC) Medicare payment rate and eliminates the outdated Medicare payment cap on FQHC payments.

- **Teaching Health Centers** - Authorizes a new grant program for the development of residency programs at health centers and establishes a new program to provide payments to community-based entities that operate teaching programs. Directly appropriates $230 million over 5 years for the payments.

Key Challenges

- Forced state Medicaid or CHIP cuts
- Capital needs for infrastructure
- Reimbursement policies that undervalue primary care
- Recruitment and retention of providers
- Lack of specialists willing to see uninsured
- Limited health IT adoption

Many will be ameliorated by health reform

Key Opportunities for State MCH Programs

Key Questions

Prevention and Public Health Investments

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- Prevention and Public Health Fund provides mandatory funding of $7 billion over 5 years

- Purpose - “To provide for an expanded and sustained national investment in prevention and public health programs (over the FY 2008 level). The Fund will support programs authorized by the Public Health Service Act, for prevention wellness and public health activities….”

Prevention Fund Levels

- FY 2010 - $500 million
- FY 2011- $750 million
- FY 2012 - $1 billion
- FY 2013 - $1.25 billion
- FY 2014 - $1.5 billion
- FY 2015 and each fiscal year thereafter- $2 billion.

New MCH Investments

- **Maternal, Infant, and Early Childhood Home Visiting Programs -** Creates a new section in Title V to provide mandatory $1.5 billion appropriation over five years to States, tribes, and territories to develop and implement one or more evidence-based home visiting model(s).
- **Personal Responsibility Education.** Another new section of Title V provides $75 million per year through FY2014 for grants to States for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS.
- **Restoration of Funding For Abstinence Education.** Appropriates $50 million per year through FY 2014 for abstinence education.

MCH Provisions

- **Support, Education, and Research for Postpartum Depression -** Amends Title V to authorize $3 million for new grants to states to provide services to at risk or affected individuals.
- **School Based Health Centers -** provides mandatory $50 million appropriation to establish school-based health clinics; authorizes but does not appropriate funds for operations.
- **Reasonable Break Time for Nursing Mothers -** Require that employers provide a reasonable break time breastfeeding mothers.

MCH Provisions

- **Pregnancy Assistance Fund.** Appropriates $25 million annually for ten years to establish programs to meet the specified needs (housing, childcare, parenting education, post-partum counseling) of pregnant or parenting students.
- **EMSC Program -** Reauthorizes Wakefield Emergency Medical Services for Children Program at $25 million for fiscal year 2010 going up to $30.8 million for fiscal year 2014.
- **Family to Family Health Information Centers -** extends centers through FY2012 at current funding level.

Other Key Prevention Provisions

- Establishes National Prevention, Health Promotion & Public Health Council
- Authorizes Prevention and Health Promotion Outreach and Education Campaign “to raise public awareness of health improvement across the lifespan. “
- Funds Childhood Obesity Demonstration Project at $25 million
- Authorizes Oral Healthcare Prevention and Education.
- Authorizes Community Transformation Grants

Workplace Wellness

- Provide grants for up to five years to small employers that establish 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—in the form of 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.

Menu Labeling

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- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

- Proposed regulations issued within one year of enactment

New Requirements for Non-Profit Hospitals

- Imposes new requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet identified needs.

Quality

- 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. (National strategy due to Congress by January 1, 2011)
- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations. Also require collection of access and treatment data for people with disabilities. (Effective two years following enactment)

Health Care and Public Health Workforce

- Extensive provisions authorized but not appropriated

Key State Roles

- Create Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchanges
- Provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes, define rating areas, etc.
- Enroll newly eligible Medicaid beneficiaries into the Medicaid program no later than January 2014 (states have the option to expand enrollment beginning in 2011), coordinate enrollment with the new Exchanges, and implement other specified changes to the Medicaid program.
- Maintain current Medicaid and CHIP eligibility levels for children until 2019 and maintain current Medicaid eligibility levels for adults until the Exchange is fully operational.

State Roles

- Establish an office of health insurance consumer assistance or an ombudsman program
- Consider creation of Basic Health Plan for uninsured individuals with incomes between 133% and 200% FPL in lieu of these individuals receiving premium subsidies to purchase coverage in the Exchanges
- Permits states to obtain a five-year waiver of certain new health insurance requirements if the state can demonstrate that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit. (Effective January 1, 2017)

Key Dates – 2010

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- States must maintain Medicaid/CHIP eligibility levels and enrollment procedures in effect on March 23, 2010 (until 2014, with some exceptions, for adults and 2019 for children).
- States can continue to expand eligibility or simplify enrollment in Medicaid and CHIP.
- Small employers receive tax credits to purchase employee health care premiums.
- States have option (under certain conditions) to provide CHIP to children of state employees.
- By July 1, 2010, a temporary, high-risk pool is established for qualified uninsured persons with pre-existing conditions (in place until 2014).
- Seniors begin to receive rebates/discounts toward drug coverage (with elimination of the “doughnut hole” by 2020).

- After September 23, 2010 (as a new health plan year begins):

  o Young adults can remain on their parents' health plan until age 26.

  o Children with insurance can no longer be denied coverage for pre-existing conditions.

  o Insurance plans can no longer impose lifetime caps or restrictive annual limits on coverage, and cannot rescind coverage when a person becomes sick.

  o New plans must provide free preventive services to all enrollees.

Key Dates 2011-2013

- By March 23, 2011, states provided federal grants to plan for and establish Exchanges.
- Medicaid physician payments increased, at federal cost, to Medicare levels for primary care services (for 2013 and 2014).
- Medicare beneficiaries receive annual exams and other preventive services at no cost.

Key Dates - 2014

- Most people required to purchase coverage or pay tax penalty.
- New federal Medicaid floor of 133% of the FPL (based on adjusted gross income with 5 percent disregard) for adults and children. Medicaid and CHIP coverage for children still maintained.
- Enhanced federal financial assistance for states covering newly-eligible adults and for expansion states (those that already cover adults up to or above 100% of the FPL) covering childless adults.)
- Individuals (including lawfully residing immigrants) and small businesses can purchase affordable coverage through state-based Exchanges; low- to moderate-income families receive premium tax credits and cost sharing subsidies.

Key Dates 2014

- Children up to age 26 who "age-out" of foster care are eligible to continue receiving Medicaid.
- Insurance companies must cover the care of pre-existing conditions for both adults and children, can no longer set annual coverage limits (in addition to lifetime limits), and cannot deny coverage or charge higher premiums based on health status.
- Exchanges must be financially self-sustaining by end of 2014.

Key Dates 2015

- CHIP funded through September 30, 2015. If state runs out of federal funding, children can be enrolled in comparable Exchange plans.
- States receive a 23 percentage points increase in CHIP federal match rate (effective October 1, 2015).

Sources and for More Information

- **Public Law 111-148, Patient Protection and Affordable Care Act - http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf**
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