HEALTH CARE REFORM IN THE U.S.
A LOOK AT THE PAST, PRESENT AND FUTURE
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Health care reform in the U.S. has been an ongoing process for decades.

2008: Democrats won the Presidency and controlled both Chambers of Congress.

Health care reform was a priority but a complicated task.

Affordable Care Act was not a holistic plan. Leadership gathered individual bills and policy ideas from Republicans and Democrats.
• Five Congressional Committees drafted health care reform legislation
  – U.S. House: Energy & Commerce; Ways & Means; Appropriations
  – U.S. Senate: Health, Education, Labor & Pension (HELP); Finance
• Separate drafts resulted in difficulty reconciling the different versions
• Lack of committee hearings and transparency increased political criticism
• Ultimately, one bill passed the House and one bill passed the Senate
• Bills were merged into one giant bill spanning over 2,000 pages
• President Obama signed the legislation and an amendment to the legislation into law
• 2010: The *Patient Protection and Affordable Care Act of 2010* was born
LEGAL CHALLENGES
SURVIVAL OF THE AFFORDABLE CARE ACT

• States
  – Proposed legislation to nullify provisions
  – Statutory bans to prohibit implementation
  – Lawsuits against the Individual Mandate
  – Declining to expand Medicaid
LEGAL CHALLENGES
SURVIVAL OF THE AFFORDABLE CARE ACT

• U.S. Supreme Court
  – Individual Mandate: Court upheld penalty on individuals without insurance coverage because it is a tax
  – Medicaid Expansion: Court determined the federal ultimatum to withhold federal funds if a state does not expand Medicaid was unconstitutional
  – Tax Credits: Individuals living in states that use the federal Health Insurance Marketplace can still receive subsidies
  – Contraception: Ongoing battle between religious freedom and requirements under the ACA for health insurance coverage
Health Insurance Marketplace

- ACA established new Federally Facilitated Exchanges (FFE) and State-Based Exchanges (SBE)
  - SBE: 14 states and DC
  - FFE: 36 states
- Significant administrative costs to support running the FFE
  - $456M for FY2010 - FY2012
  - Projected $1.8B for FY2015
• **Health Insurance Coverage**
  – Requirements for essential health benefits coverage
    • Ambulatory patient services
    • Emergency services
    • Hospitalization
    • Maternity and newborn care
    • Mental health and substance use disorder services, including behavioral health treatment
    • Prescription drugs
    • Rehabilitative and habilitative services and devices
    • Laboratory services
    • Preventive and wellness services and chronic disease management
    • Pediatric services, including oral and vision care
Medicaid Expansion

- 30 States and Washington, DC have expanded Medicaid coverage to a greater population of individuals
- 4 states are considering Medicaid expansion
- 16 states have declined Medicaid expansion
- Medicaid 1115 Waiver was created under the ACA
  - Goal is to design and implement changes to the health care delivery system to improve access to care and cost savings
  - Houston Methodist participating with mental health transition of care project
• Health Care Delivery Reform
  – Accountable Care Organizations (ACOs)
    • Providers agree to collectively take responsibility for the quality and total costs of care for each patient
    • Medicare Shared Savings Program: Reward for quality-based performance
  – Medical Homes
    • Comprehensive, coordinated and accessible primary care can improve patient outcomes and reduce costs
  – Comprehensive Primary Care (CPC) Initiative
    • Multi-payer initiative to strengthen primary care
    • Health insurance companies pay monthly care management fees for each patient member
  – Multi-Payer Advanced Primary Care Practice Demonstration
    • Pilot model to test and support physician practices as medical homes
24 percent (52 ACOs) earned shared savings bonus

3 percent (6 ACOs) achieved savings, but did not successfully report quality

27 percent (60 ACOs) reduced spending, but not enough to earn shared savings bonus

46 percent (102 ACOs) did not achieve

### Comprehensive Primary Care Initiative
- **Patients**: 2,534,506
- **Total patients to date**: $153.2M
- **Early results**: In year 1, initiative generated nearly enough savings to cover $20 care management fee paid, although not enough for net savings. Across all seven regions, emergency department visits decreased by 3% and hospital admissions by 2%. Quality results mixed.

### Multi-Payer Advanced Primary Care Practice Demonstration
- **Patients**: 2,225,537
- **Total payments to date**: $99.2M
- **Early results**: Generated $4.5 million in savings across eight states.

### FQHC Medical Home Demonstration
- **Patients**: Total N/A; 207,000 Medicare beneficiaries
- **Total payments to date**: $41.7M
- **Early results**: 73% of 492 participating health centers achieved Level 3 Patient-Centered Medical Home recognition based on standards set by National Committee for Quality Assurance, short of 90% goal set in 2011.

### Independence at Home
- **Patients**: 8,300
- **Total patients to date**: N/A
- **Early results**: Have not issued payments

### Total
- **Total patients to date**: $294.1M

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**Note:** The table above provides a summary of key initiatives under the Affordable Care Act, focusing on various aspects of primary care and medical home demonstrations.
# Health Care Reform Today

## CMS Focus Areas and Select Initiatives

### Accountable Care Organizations
- Pioneer ACOs
- Advance Payment ACOs

### Bundled Payment for Care Improvement
- Model 1: Retrospective Acute Care
- Model 2: Retrospective Acute and Postacute Care Episode
- Model 3: Retrospective Postacute Care
- Model 4: Prospective Acute Care

### Primary Care Transformation
- Comprehensive Primary Care Initiative
- Advanced Primary Care Practice Demonstration (Federally Qualified Health Centers)
- Independence at Home Demonstration
- Multi-Payer Advanced Primary Care Practice Demonstration

### Initiatives to Speed the Adoption of Best Practices
- Innovation Advisors Program
- Partnership for Patients

### Initiatives Focused on the Medicaid and CHIP Population
- Medicaid Emergency Psychiatric Demonstration
- Medicaid Innovation Accelerator Program
- Strong Start for Mothers and Newborns
- Medicaid Incentives for Prevention of Chronic Diseases

### Initiatives Focused on Medicare-Medicaid Enrollees
- Financial Alignment Initiative
- Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents

### Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
- Health Care Innovation Awards
- State Innovation Models Initiative
• **Provider Payment Reform**
  
  – Shift from Fee-For-Service payments based on volume to Quality-based payment
    
    • Hospital-Acquired Conditions: Financial penalty for performance on key procedures
    
    • Hospital Readmissions Reduction Program: Financial penalty for a patient’s readmission to the hospital
    
    • Other quality-based metrics
HEALTH CARE REFORM TODAY
CHANGE IN ALL-CAUSE 30-DAY HOSPITAL READMISSION RATES

Source: Patrick Conway, Office of Information Products and Data Analytics, Centers for Medicare and Medicaid Services
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Did not meet benchmark</th>
<th>Met minimum quality benchmark</th>
<th>Met maximum quality benchmark</th>
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</thead>
<tbody>
<tr>
<td>Getting timely care</td>
<td>7</td>
<td>93</td>
<td>17</td>
</tr>
<tr>
<td>How well doctors communicate</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Shared decision-making</td>
<td>21</td>
<td>62</td>
<td>17</td>
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<tr>
<td>Risk-standardized all-condition readmission</td>
<td>18</td>
<td>81</td>
<td>17</td>
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<tr>
<td>ACS admissions for heart failure</td>
<td></td>
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<tr>
<td>% of PCPs qualified for EHR incentive</td>
<td>24</td>
<td>69</td>
<td>7</td>
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<tr>
<td>Medication reconciliation</td>
<td>12</td>
<td>45</td>
<td>7</td>
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<tr>
<td>Screening for fall risk</td>
<td>25</td>
<td>67</td>
<td>8</td>
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<tr>
<td>Pneumococcal vaccination</td>
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<td>91</td>
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<tr>
<td>Depression screening</td>
<td>21</td>
<td>59</td>
<td>20</td>
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<tr>
<td>Colorectal cancer screening</td>
<td>4</td>
<td>96</td>
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<td>Adults with BP screening in past 2 years</td>
<td>5</td>
<td>56</td>
<td>39</td>
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<tr>
<td>Diabetes composite</td>
<td>34</td>
<td>58</td>
<td>8</td>
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<tr>
<td>% with hypertension with BP &lt;140/90</td>
<td>15</td>
<td>80</td>
<td>5</td>
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<tr>
<td>Coronary artery disease composite</td>
<td>28</td>
<td>62</td>
<td>10</td>
</tr>
</tbody>
</table>

Notes: Benchmarks are set based on the performance of Medicare providers not participating in the Shared Savings Program. ACS = ambulatory care-sensitive. Source: Centers for Medicare and Medicaid Services.
HEALTH CARE REFORM TODAY
IMPLEMENTATION OF PAYMENT REFORM PROVISIONS

Hospital Value-Based Purchasing

- 2010–2012
  - Builds on measures used in Inpatient & Quality Reporting (IQR) and Hospital Compare programs

- 2013
  - 1% of hospital payments affected

- 2014–2017
  - Incremental increase to 2% of hospital payments affected in 2017 and beyond

Hospital Readmissions Reduction Program

- 2010–2012
  - Builds on the measures used in IQR and Hospital Compare programs

- 2013
  - Up to 1% of hospital payments affected. Based on readmissions for heart attack, heart failure, pneumonia.

- 2014–2015
  - Incremental increase to 3% of hospital payments affected in 2015 and beyond. Additional conditions included COPD and elective hip & knee replacements
• **Provider Payment Reform**
  
  – Bundled Payments
    
    • Single reimbursement split among health care providers for every service rendered for a given medical condition or procedure
    
    • Incentivizes efficient coordination during and after an episode of care
  
  – HHS goal to have at least 90% of traditional Medicare payments linked to some form of ACO, medical home, bundled payment, or other value-based payment method by 2018
• Assessing the law’s success
• Enrollment status: 16.4M individuals insured
• Improvements to quality, coordination, access and cost of health care
• Noncompliance with Individual Mandate
• Health Insurance Exchanges
  – Insurance companies uncertain about future participation
  – Reduced provider networks
• U.S. House has voted 56 times to repeal or undermine the ACA (as of August 18, 2015)
• Continuing legal challenges