CHANGE ON THE HORIZON

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Vice President Case Management
Carolinas HealthCare System
About Us

Carolinas HealthCare System is the largest healthcare system in the Carolinas, and the third largest non-profit public system in the nation. CHS owns, leases or manages 32 hospitals in North and South Carolina, including Levine Children's Hospital in Charlotte and Carolinas Medical Center-NorthEast in Concord, a 457-bed medical center which is home to Jeff Gordon Children's Hospital
CHS's flagship facility is Carolinas Medical Center in Charlotte, an 874-bed hospital with a Level I trauma center, a research institute and a large number of specialty treatment units including heart, cancer, organ transplant and behavioral health. CMC also serves as one of North Carolina's five Academic Medical Center Teaching Hospitals, providing residency training for over 200 physicians in 15 specialties.
CHS employs over 1,400 physicians who practice in more than 275 locations. CHS also operates rehabilitation hospitals, nursing homes, ambulatory surgery centers, home health agencies, radiation therapy centers and physical therapy facilities. Together, these operations comprise nearly 6,000 licensed beds and employ more than 43,000 full-time or part-time employees.
Health Care Form

- HealthCare Reform
- ObamaCare
- Affordable Care Act
- PPACA
- Value Based Purchasing
- Implications for Case Management
Change in the Air

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act. The law puts in place comprehensive health insurance reforms that will roll out over four years and beyond, with most changes taking place by 2014.
Goals Of Health Care Reform

- Bring Stability and Improved Care to Americans by offering consumer protections

- Reduce Cost
  - Harvard researchers found that 62% of all U.S. personal bankruptcies were caused by health problems – 78% of those had insurance

- Protect Choice of provider hospital and payor

- Assure Quality Health Care for All
PPACA

- **Patient Protection and Affordable Care Act**
- PPACA is aimed primarily at decreasing the number of uninsured Americans and reducing the overall costs of health care.
- It provides a number of incentives, including subsidies, tax credits, and fees, to employers and uninsured individuals in order to increase insurance coverage.
- Additional reforms are aimed at improving healthcare outcomes in the United States while updating and streamlining the delivery of health care.
“I have patients every day who must decide whether to purchase medications or eat.” -- Linda McIntosh, RN, MSN, APN
Family Nurse Practitioner, Des Arc, AR
PPACA Highlights

Effective for health plan years beginning on or after September 23, 2010

Under the new law, young adults are allowed to stay on their parent’s plan until they turn 26 years old.
- Unless offered through employer
Case Management

- More young adults with insurance coverage
- Results released by the National Center for Health Statistics show that the dependent coverage provision of the Affordable Care Act has had a significant impact on improving insurance coverage among young adults.
- Data from the National Health Interview Survey (NHIS) show that in the first quarter of 2011, the percentage of adults between the ages of 19 and 25 with health insurance increased to 69.6%, from 66.1% in 2010.
- This 3.5 percentage-point increase represents approximately one million additional young adults with insurance
An analysis of 687,091 patients who visited trauma centers nationwide from 2002 to 2006 found that the odds of dying from injuries were almost twice as high for the uninsured than for patients with private insurance.

- 209,702 trauma patients ages 18 to 30 were less likely to have chronic health conditions that might complicate recovery.
- Among these younger patients, the risk of death was 89% higher for the uninsured, the study found.
Trauma

- Despite the federal law, uninsured patients often wait longer to see doctors in emergency rooms and sometimes visit ERs at several hospitals before finding one that will treat them.
- Other studies show that, once they're admitted, uninsured patients receive fewer services, such as CT and MRI scans, less likely to be transferred to a rehabilitation facility.

- Frequently younger people involved in crime -- were much more likely to die from their wounds than other trauma patients tracked in the study.
- Patients without insurance may have higher rates of untreated underlying conditions that make it harder to recover from trauma injuries,
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 (as under current law undocumented immigrants are not eligible for Medicaid). All newly eligible adults will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges.
Effective April 1, 2010
Medicaid

● **Allowing States to Cover More People on Medicaid**
  ● States are able to receive federal matching funds for covering some additional low-income individuals and families under Medicaid for whom federal funds were not previously available.
  ● This will make it easier for states that choose to do so to cover more of their residents.
  ● Beginning in 2014, most adults under age 65 with individual incomes up to about $15,000 per year will qualify for Medicaid in every state.

● **Help for disabled people:** This expansion helps low-income adults who have disabilities but don’t meet the disability requirements of the SSI program. The expansion also helps those whose income is above their state’s current eligibility levels.
Medicaid

- To finance the coverage for the newly eligible (those who were not previously eligible for at least benchmark equivalent coverage, those who were eligible for a capped program but were not enrolled, or those who were enrolled in state-funded programs), states will 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.
- States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal financing as other states (93% in 2019 and 90% in 2020 and later).
Minimum Wage

- For work performed prior to July 24, 2007, the federal minimum wage is $5.15 per hour.
- For work performed from July 24, 2007 to July 23, 2008, the federal minimum wage is $5.85 per hour.
- For work performed from July 24, 2008 to July 23, 2009, the federal minimum wage is $6.55 per hour.
- For work performed on or after July 24, 2009, the federal minimum wage is $7.25 per hour.
- State dependent
  - Calif $8.00 (San Fran 10.24)
  - Conn $8.25
Minimum Wage
2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family/household</th>
<th>Poverty guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,170 ($15,080)</td>
</tr>
<tr>
<td>2</td>
<td>$15,130 (30,160)</td>
</tr>
<tr>
<td>3</td>
<td>$19,090</td>
</tr>
<tr>
<td>4</td>
<td>$23,050</td>
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<tr>
<td>5</td>
<td>$27,010</td>
</tr>
<tr>
<td>6</td>
<td>$30,970</td>
</tr>
<tr>
<td>7</td>
<td>$34,930</td>
</tr>
<tr>
<td>8</td>
<td>$38,890</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $3,960 for each additional person.
The Affordable Care Act establishes the Patient-Centered Outcomes Research Institute. Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will assist patients, clinicians, purchasers and policy-makers in making informed health decisions by advancing clinical effectiveness research.

The trust fund will be funded in part by fees paid by issuers of health insurance policies and sponsors of self-insured health plans.
A variety of entities are eligible to receive funding contracts, including federal agencies, academic institutions, and private research organizations.

The Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH) receives priority funding consideration. Data collected by the Centers for Medicare and Medicaid Services (CMS) will be made available to contracting research groups, and the Institute may request data from other federal, state, and private entities hosting patient registries and other databases.
Washington, D.C. (June 18, 2012) – The Patient-Centered Outcomes Research Institute (PCORI) has announced the approval of 50 research funding awards, totaling $30 million over two years, through its Pilot Projects Program, which will address a broad range of questions about methods for engaging patients in the health research and dissemination process.

Local Award
- Methods to increase validity of Comparative Effectiveness Research in the Elderly UNC 690K
Small Business Tax Credit

- **Providing Small Business Health Insurance Tax Credits** For tax years 2010 through 2013, the maximum credit is 35 percent for small business employers and 25 percent for small tax-exempt employers such as charities. An enhanced version of the credit will be effective beginning Jan. 1, 2014.

- In general, on Jan. 1, 2014, the rate will increase to 50 percent and 35 percent, respectively.
Here’s what this means for you. If you pay $50,000 a year toward workers’ health care premiums – and if you qualify for a 15 percent credit, you save … $7,500. If you save $7,500 a year from tax year 2010 through 2013, that’s total savings of $30,000.

To be eligible, you must cover at least 50 percent of the cost of single (not family) health care coverage for each of your employees. You must also have fewer than 25 full-time equivalent employees (FTEs). Those employees must have average wages of less than $50,000 a year.
Eliminating Lifetime Limits on Insurance Coverage

Effective for health plan years beginning on or after September 23, 2010

Under the new law, insurance companies are prohibited from imposing lifetime dollar limits on essential benefits, like hospital stays.
What does it mean to Case Management

- The health-care tax credit, however, was only claimed by 170,300 employers in 2010, according to the Government Accountability Office report released 6/2012. That is only a sliver of the 1.4 million to 4 million small businesses that were eligible for the tax credit, according to various estimates.

- Why? It's too complicated and takes too much time to apply for, the report stated. In particular, having to figure out average wages and the full-time equivalency requirement of employees discouraged small business owners.
2010 Expanding Coverage for Early Retirees

- Applications for employers to participate in the program available June 1, 2010.
- Early retirees are individuals age 55 and older who are not yet eligible for Medicare and who are enrolled in health benefits under the employer-sponsored plan.

- To preserve employer coverage for early retirees until more affordable coverage is available through the new Exchanges by 2014, the new law creates a $5 billion program to provide needed financial help for employment-based plans to continue to provide valuable coverage to people who retire between the ages of 55 and 65, as well as their spouses and dependents.
Early Retiree Coverage

- Health insurance premiums for older Americans are over four times more expensive than those for young adults, and the deductible these enrollees pay is, on average, almost four times that in a typical employer-sponsored insurance plan.
- The Affordable Care Act created a new program called the Early Retiree Reinsurance Program to help address this challenge that employers and older employees are facing. The Early Retiree Reinsurance Program (ERRP) provides much-needed financial relief to businesses, schools and other educational institutions, unions, State and local governments, and non-profits, in order to help retirees and their families continue to have quality, affordable health coverage.
The availability of group health insurance coverage for America’s retirees age 55 to 64 has declined significantly over the past 20 years, as the percentage of large employers providing workers with retirement health coverage has dropped from 66 percent to 28 percent.
ERRP

- Program provides $5 billion in financial assistance to employers and unions to help them maintain coverage for early retirees age 55 and older who are not yet eligible for Medicare.
- The Department of Health and Human Services received applications from more than 50 percent of Fortune 500 companies, all major unions, and government entities in all 50 States and the District of Columbia.
In the first few months of the program, nearly 3,000 applications were approved representing a wide range of organizations that are interested in support from the Affordable Care Act to provide health care coverage to their early retirees. Applications have been approved in every State and the District of Columbia.
Participants

- Alexander County
- American Kennel Club
- Arrowood Indemnity Company
- Bank of America Corporation
- BB&T Corporation
- Belk Stores Services, Inc.
- Blue Cross and Blue Shield of North Carolina
- Board of TTEE of Teachers & State Empl Comp Major Med Plan Trust
- Boddie-Noell Enterprises, Inc.
- Boice-Willis Clinic, P.A.
- Brunswick County
- Cape Fear Public Utility Authority
- Catawba County
- Charlotte Pipe and Foundry Company
- Chatham County
As of May 5, 2011, the Department of Health and Human Services is no longer accepting applications for ERRP.
Prohibiting Denying Coverage of Children Based on Pre-Existing Conditions

- Effective for health plan years beginning on or after September 23, 2010 for new plans and existing group plans.
- The new law includes new rules to prevent insurance companies from denying coverage to children under the age of 19 due to a pre-existing condition.
Adoption Credit

The Affordable Care Act raises the maximum adoption credit to $13,360 per child, up from $13,170 in 2010 and $12,150 in 2009. The adoption tax credit is refundable for tax year 2011, meaning that eligible taxpayers received it even if they owe no tax for that year.

In general, the credit is based on the reasonable and necessary expenses related to a legal adoption, including adoption fees, court costs, attorney’s fees and travel expenses. Income limits and other special rules apply.

The adoption credit is per child; thus the amount doubles if you adopt two children in the same year.
In April 2011, the Center for Medicare and Medicaid Services (CMS) announced funding opportunities for acute-care hospitals with high readmission rates that partner with community based organizations (CBOs) or CBOs that provide care transition services to improve a patient’s transition from a hospital to another setting, such as a long-term care facility or the patient’s home. Created by Section 3026 of the Affordable Care Act, the Community-Based Care Transition Program (CCTP) provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients’ transitions effectively. Participants will use process and outcome measures to report on their results.
Community-based organizations (CBOs) will use care transition services to effectively manage Medicare patients' transitions and improve their quality of care. Up to $500 million in total funding is available for 2011 through 2015.

The CBOs will be paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level.
In 2011, seniors who reach the coverage gap received a 50 percent discount when buying Medicare Part D covered brand-name prescription drugs. Over the next ten years, seniors will receive additional savings on brand-name and generic drugs until the coverage gap is closed in 2020.
2010

● Preventing Disease and Illness
  ● Funding began in 2010
  ● A new $15 billion Prevention and Public Health Fund invests in proven prevention and public health programs that can help keep Americans healthy – from smoking cessation to combating obesity.
Rebuilding the Primary Care Workforce

Effective 2010

To strengthen the availability of primary care, there are new incentives in the law to expand the number of primary care doctors, nurses and physician assistants, including funding for scholarships and loan repayments for primary care doctors and nurses working in underserved areas.

Doctors and nurses receiving payments made under any state loan repayment or loan forgiveness program intended to increase the availability of health care services in underserved or health professional shortage areas will not have to pay taxes on those payments.
2011 Medicare Preventative Services

- The law provides certain free preventive services, such as annual wellness visits and personalized prevention plans, for seniors on Medicare

- Flu Shots,
- Mammograms
- Cholesterol screenings
- Pap Smears
- colonoscopies
Bringing Down Health Care Premiums

- Effective January 1, 2011
- To ensure premium dollars are spent primarily on health care, the new law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans are spent on health care services and health care quality improvement. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals because their administrative costs or profits are too high, they must provide rebates to consumers.
Addressing Overpayments to Big Insurance Companies and Strengthening Medicare Advantage

Effective January 1, 2011

Today, Medicare pays Medicare Advantage insurance companies over $1,000 more per person on average than is spent per person in Original Medicare. This results in increased premiums for all Medicare beneficiaries, including the 77% of beneficiaries who are not currently enrolled in a Medicare Advantage plan. The new law levels the playing field by gradually eliminating this discrepancy. People enrolled in a Medicare Advantage plan will still receive all guaranteed Medicare benefits, and the law provides bonus payments to Medicare Advantage plans that provide high quality care.
Effective by August 1, 2012

All new plans must cover certain preventive services such as mammograms and colonoscopies without charging a deductible, co-pay or coinsurance. Women's Preventive Services – including well-woman visits, support for breastfeeding equipment, contraception and domestic violence screening – will be covered without cost sharing. This is also known as the **contraceptive mandate**.
Effective by January 1, 2013 Medicare Tax

- Income from self-employment and wages of single individuals in excess of $200,000 annually will be subject to an additional tax of 0.9%.
- The threshold amount is $250,000 for a married couple filing jointly (threshold applies to joint compensation of the two spouses), or $125,000 for a married person filing separately.
- In addition, an additional Medicare tax of 3.8% will apply to unearned income, specifically the lesser of net investment income or the amount by which adjusted gross income exceeds $200,000 ($250,000 for a married couple filing jointly; $125,000 for a married person filing separately.)
Insurance Exchange 2014

- A health insurance exchange is a set of state-regulated and standardized health care plans in the United States, from which individuals may purchase health insurance eligible for federal subsidies. All exchanges must be fully certified and operational by January 1, 2014 under federal law.\(^1\)

- Calls on states to set up regulated exchanges where an estimated 16 million uninsured Americans are expected to qualify for private health coverage at rates subsidized according to income.

- Many states have done little to prepare as election outcome may lead to appeal.
Insurance Exchange

- Beginning in 2014, Exchanges will serve primarily individuals buying insurance on their own and small businesses with up to 100 employees, though states can choose to include larger employers in the future.
- States are expected to establish Exchanges—which can be a government agency or a non-profit organization—with the federal government stepping in if a state does not set them up. States can create multiple Exchanges, so long as only one serves each geographic area, and can work together to form regional Exchanges.
- The federal government will offer technical assistance to help states set up Exchanges
Exchanges

- States may choose to join together to run multi-state exchanges, or they may opt out of running their own exchange, in which case the federal government will step in to create an exchange for use by their citizens.
- A market where Americans can one-stop shop for a health care plan, compare benefits and prices, and choose the plan that's best for them.
- All of these plans should include an affordable basic benefit package that includes prevention, and protection against catastrophic costs.
2014

- If you aren't covered by insurance by 2014, you need to get it or be subjected to a fine. In 2014, uninsured people will face a fine of $95 or one percent of their income.
  1. The penalty will be phased-in according to the following schedule:
     - $95 in 2014
  2. $325 in 2015
  3. $695 in 2016 or the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.
- In 2014, insurance companies will not be able to exclude or limit coverage to people who have current or past health conditions.
- In 2014, businesses with more than 50 employees will be required to insure their workers or pay a $2,000 fine per uninsured worker. This places more pressure on your employer, but it doesn't necessarily mean the company will comply.
Effective by January 1, 2014

- Maximum Out-of-Pocket Premium Payments Under PPACA by [Family Size](#) and [federal poverty level](#). Insurers are prohibited from discriminating against or charging higher rates for any individuals based on gender or pre-existing medical conditions.
Table 1. Maximum Out-of-Pocket Premium Payments Under PPACA, If Currently Implemented
for the 48 contiguous states and the District of Columbia

<table>
<thead>
<tr>
<th>Federal Poverty Line (FPL)</th>
<th>Maximum Premium as a % of Income (2014)</th>
<th>Maximum Annual Premium (current), by Family Size</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>1</td>
</tr>
<tr>
<td>100%</td>
<td>2.0%</td>
<td>$217</td>
</tr>
<tr>
<td>133.00%</td>
<td>2.0%</td>
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<tr>
<td>133.01%</td>
<td>3.0%</td>
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<tr>
<td>150%</td>
<td>4.0%</td>
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<tr>
<td>200%</td>
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<td>250%</td>
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<td>300%</td>
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</tr>
<tr>
<td>350%</td>
<td>9.5%</td>
<td>$3,601</td>
</tr>
<tr>
<td>400%</td>
<td>9.5%</td>
<td>$4,115</td>
</tr>
</tbody>
</table>

Penalty

- Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment.
- **Exemptions** will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual’s income, and those with incomes **below the tax filing threshold** (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).
Exemptions

- **Members of certain faiths**: Practitioners of certain religions will be free from tax penalties. Under this exception, you must certify you are a member of a recognized religious sect. Who is exempt and what proof is needed are described in Internal Revenue Code Section 1402(g)(1).

- For example, an exempt people must adhere to the established teachings of a sect that has been in continuous existence since 1950. Such people must be "conscientiously opposed" to accepting benefits from any private or public insurance that makes payments in the event of death, disability, old age or retirement, or that makes payments toward the cost of medical care. This includes Social Security.
Exemptions

- For instance, Amish people who are exempt from paying Social Security and Medicare taxes (and therefore do not accept any of their benefits) may be exempt from the health care mandate and tax penalties.
- Tax penalty exemptions will be granted people for whom the lowest-cost plan option exceeds 8 percent of income and for those with incomes below the tax filing threshold.
Hardship

- **Hardships**: Those suffering hardships may be exempt from the tax penalties of the health care law. If the U.S. Department of Health and Human Services determines someone has suffered a hardship that prevents them from obtaining qualified health insurance coverage, he or she may be exempt.
- If the U.S. Department of Health and Human Services determines someone has suffered a hardship that prevents them from obtaining qualified health insurance coverage, he or she may be exempt.
The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.

The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program.
Transitions

- Hospitalizations account for approximately 33 percent of total Medicare expenditures and represent the largest program outlay.
- The Medicare Payment Advisory Commission estimated Medicare costs of approximately $15 billion due to readmissions, $12 billion of which is for cases considered preventable.
- Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible, including the quality of care during the hospitalization and the discharge planning process.
Community-based organizations (CBOs) will use care transition services to effectively manage Medicare patients' transitions and improve their quality of care. Up to $500 million in total funding is available for 2011 through 2015. The CBOs will be paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level.
Long Term Care

- Nationally, $4.3 Billion in New Funds
- to Help Establish and Expand Community-based Alternatives to Institutional Long Term Care
Money Follows the Patient

- The MFP program provides individuals living in a nursing home or other institution new opportunities to live in the community with the services and supports they need. Groups benefiting from these home-and-community based programs include the elderly, persons with intellectual, developmental and/or physical disabilities, mental illness or those diagnosed with several of these conditions.
- States participating in MFP are: AR, CA, CO, CT, DE, FL, GA, HI, IA, ID, IL, IN, KS, KY, LA, MA, MD, ME, MI, MN, MO, MS, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, WI, WV and the District of Columbia.
Goals NC MFP

- Increase the use of home and community based services (HCBS) and reduce the use of institutionally based services;
- Eliminate barriers and mechanisms in state law, state Medicaid plans, or state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;
- Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,
- Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

- Have lived in a hospital, skilled nursing facility or an intermediate care facility for people with developmental disabilities for at least three months
The “Money Follows the Person” Rebalancing Demonstration Program (MFP) helps States rebalance their long-term care systems to transition people with Medicaid from institutions to the community.

From spring 2008 through December 2010, nearly 12,000 people have transitioned back into the community through MFP Programs. The Affordable Care Act of 2010 strengthens and expands the “Money Follows the Person” Program to more States.
MFP Goals

- **MFP Program Goals**
  - Increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services
  - Eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice
  - Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
  - Put procedures in place to provide quality assurance and improvement of HCBS
New Community First Choice Option Available to States

- This option will allow States to receive a six percent increase in federal matching funds for providing community-based attendant services and supports to people with Medicaid.

- Over three years—through 2014—States could see a total of $3.7 billion in new funds to provide these services. States currently receive Federal Medicaid matching funds for these activities at the State’s normal matching rate.

- The demonstration is scheduled to begin on June 1, 2012, and conclude May 31, 2015
Community First

- the first 16 organizations that will participate in the new Independence at Home Demonstration were announced. They will test whether delivering primary care services in the home can improve the quality of care and reduce costs for patients living with chronic illnesses. These 16 organizations were selected from a competitive pool of more than 130 applications representing hundreds of health care providers interested in delivering this new model of care.
Community First

The Independence at Home demonstration, which is voluntary for Medicare beneficiaries, provides chronically ill Medicare beneficiaries with a complete range of in-home primary care services. Under the demonstration, the Centers for Medicare & Medicaid Services (CMS) will partner with primary care practices led by physicians or nurse practitioners to evaluate the extent to which delivering primary care services in a home setting is effective in improving care for Medicare beneficiaries with multiple chronic conditions and reducing costs. Up to 10,000 Medicare patients with chronic conditions will be able to get most of the care they need at home.
Community First

- Home-based primary care allows health care providers to spend more time with their patients, perform assessments in a patient’s home environment, and assume greater accountability for all aspects of the patient’s care.
- This focus on timely and appropriate care is designed to improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings.
Selected

- Boston Medical Center (Boston, Massachusetts)
- Christiana Care Health Services (Wilmington, Delaware)
- Cleveland Clinic Home Care Services: Medical Care at Home Program (Independence, Ohio)
- Comprehensive Geriatric Medicine P.C. (Brooklyn, New York)
- Doctors Making House calls, LLC (Durham, North Carolina)
- Housecall Providers, Inc. (Portland, Oregon)
- MD2U (Louisville, Kentucky)
- National House Call Practitioners Group (Austin, Texas)
- North Shore – Long Island Jewish Health Care Inc.: Physician House Calls Program (Westbury, New York)
Partnership for Patients

- Launched in April 2011, the Partnership for Patients now consists of more than 6,500 partners, including over 3,167 hospitals, along with 2345 physicians, nurses, patient advocates, 892 consumers and consumer groups, and 256 employers and unions. In addition, health plans, Area Agencies on Aging, and state and federal government officials who have pledged to work together to reduce the number of hospital-acquired conditions by 40 percent and reduce hospital readmissions by 20 percent by the end of 2013.
- Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years
Partnership for Patients

- As a part of the Partnership for Patients initiative, a nationwide public-private collaboration to improve the quality, safety, and affordability of health care for all Americans, $218 million will go to 26 state, regional, national, or hospital system organizations.
- As Hospital Engagement Networks, these organizations will help identify solutions already working to reduce healthcare acquired conditions, and work to spread them to other hospitals and health care providers.
Partnership for Patients

- The Hospital Engagement Networks’ will be funded with $500 million from the Centers for Medicare & Medicaid Services Innovation Center, which was established by the Affordable Care Act.
- Hospital Engagement Networks will work to develop learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety.
- They will be required to conduct intensive training programs to teach and support hospitals in making patient care safer, provide technical assistance to hospitals so that hospitals can achieve quality measurement goals, and establish and implement a system to track and monitor hospital progress in meeting quality improvement goals.
HEN

- The activities of the Hospital Engagement Networks will be closely monitored by CMS to ensure that they are improving patient safety

- **Reductions**
  - Adverse drug events
    - Catheter-associated urinary tract infections (CAUTI)
    - Central line-associated blood stream infections (CLABSI)
    - Injuries from falls and immobility
    - Obstetrical adverse events
    - Pressure ulcers
    - Surgical site infections
    - Venous thromboembolism
    - Ventilator-associated pneumonia
    - Preventable readmissions
Partnership for Patients

- **20% Readmission reduction**: Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

- **40% reduction in HACs**: Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
Readmission Penalty

- 1% 2012
- The maximum penalty will increase after this year, to 2 percent of regular payments starting in October 2013 and then to 3 percent the following year. This year, the $280 million in penalties comprise about 0.3 percent of the total amount hospitals are paid by Medicare.
Readmission Penalties

- Some safety-net hospitals that treat large numbers of low-income patients tend to have higher readmission rates, which the hospitals attribute to the lack of access to doctors and medication these patients often experience after discharge.
- The analysis of the penalties shows that 76 percent of the hospitals that have a lot of low-income patients will lose Medicare funds in the fiscal year starting in October. Only 55 percent of the hospitals treating few poor patients are going to be penalized.
Readmissions

Medicare Readmission Penalties

- Max Penalty: 278 Hospitals (8.3%)
- No Penalty: 1,156 Hospitals (34.3%)
- Other Penalty: 1,933 Hospitals (57.4%)

Source: Kaiser Health News analysis of Centers for Medicare & Medicaid Services data
Awards

- American Hospital Association;
  Ascension Health;
  Carolinas HealthCare System;
  Catholic Healthcare West;
  Dallas-Fort Worth Hospital Council Foundation;
  Georgia Hospital Association Research and Education Foundation;
  Healthcare Association of New York State;
  Hospital & Healthsystem Association of Pennsylvania;
  Intermountain Healthcare;
  Iowa Healthcare Collaborative;
  Joint Commission Resources, Inc.;
  Lifepoint Hospitals, Inc.;

- Michigan Health & Hospital Association;
  Minnesota Hospital Association;
  National Public Health and Hospital Institute;
  New Jersey Hospital Association;
  Nevada Hospital Association;
  North Carolina Hospital Association;
  Ohio Children’s Hospital Solutions for Patient Safety;
  Ohio Hospital Association;
  Premier;
  Tennessee Hospital Association;
  Texas Center for Quality & Patient Safety;
  UHC;
  VHA;
  Washington State Hospital Association.
CCTP

● The Community-based Care Transitions Program (CCTP)
● A major component of the Partnership for Patients is the Community-based Care Transitions Program (CCTP). The Center for Medicare and Medicaid Services (CMS) has announced funding opportunities available for Community-based organizations (CBOs) partnering with acute-care hospitals to decrease preventable complications during a transition from one care setting to another
The CCTP program, which was created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. Community-based organizations will use care transition services to effectively manage Medicare patients’ transitions and improve their quality of care.
CCTP

- CBOs must provide care transition services across the continuum of care and have formal relationships with acute care hospitals and other providers along the continuum of care.
- CBO must be physically located in the community it proposes to serve, must be a legal entity that can accept payment for services, and have a governing body with representation from multiple healthcare stakeholders including consumers.
- In selecting CBOs, preference to Administration on Aging (AoA) grantees that provide care transition interventions in conjunction with multiple hospitals and practitioners and/or entities that provide services to medically-underserved populations, small communities, and rural areas.
Transitions of Care

- In addition to the funding to help reduce health care acquired conditions, $500 million has been made available through the Community-Based Care Transitions Program to ensure patients safely transition between settings of care to bring down readmissions. Recently, seven organizations were selected as the first participants for the Community-Based Care Transitions Program.

- The CBOs will be paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level. CBOs will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.
Participants sign two-year program agreements with CMS, with the option to renew each year for the remainder of the program, based on their success.

NORTH CAROLINA

The Northwest Triad Care Transitions Community Program (NTCTCP) will partner with an expansive network of hospitals and other providers to address the care transition needs of urban and rural North Carolina populations. Serving as lead community-based organization (CBO), the Northwest Community Care Network will partner with four additional regional CBOs and seven acute care hospitals including: Forsyth Medical Center, Hugh Chatham Memorial Hospital, Lexington Medical Center, Medical Park Hospital, Northern Hospital of Surry County, Thomasville Medical Center, and Wake Forest Baptist Health.

More announcements 9/20
Beacon

- The Beacon Community Cooperative Agreement Program is part of a larger health care improvement revolution that demonstrates how health IT investments and Meaningful Use of electronic health records (EHR) advance the vision of patient-centered care, while achieving the three-part aim of better health, better care at lower cost.
- The HHS Office of the National Coordinator for Health IT (ONC) is providing $250 million over three years to 17 selected communities throughout the United States that have already made inroads in the development of secure, private, and accurate systems of EHR adoption and health information exchange.
Beacon

- Each of the communities, with its unique population and regional context, is actively pursuing the following areas of focus:
  - Building and strengthening the health IT infrastructure and exchange capabilities within communities
  - Positioning each community to pursue a new level of sustainable health care quality
  - Efficiency over the coming years;
Beacon Communities

- Increase use health information technology, including health information exchange among providers and increased patient access to health records to improve coordination of care, encourage patient involvement in their own medical care, and improve health outcomes while controlling cost.
Southern Piedmont Beacon

- Adding care managers and pharmacists, and mental health counselors to the care team for patients with diabetes, congestive heart failure, hypertension, and other chronic diseases in the area to help establish a more seamless, integrated health care experience
- Expanding opportunities for patient education and involvement through a specialized program and clinics in the community including schools
- Expanding health IT to support increased communication and collaboration among members of the care team including patients
Republican Proposals

Expand Health Savings Accounts
Health Savings Accounts (HSAs) are popular savings accounts that provide cost effective health insurance to those who might otherwise go uninsured. We will improve HSAs by making it easier for patients with high-deductible health plans to use them to obtain access to quality care. We will repeal the new health care law, which prevents the use of these savings accounts to purchase over-the-counter medicine.
Rebulican Proposals

- Ensure Access for Patients with Pre-Existing Conditions
  Health care should be accessible for all, regardless of pre-existing conditions or past illnesses. We will expand state high-risk pools, reinsurance programs and reduce the cost of coverage.
- We will make it illegal for an insurance company to deny coverage to someone with prior coverage on the basis of a pre-existing condition, eliminate annual and lifetime spending caps, and prevent insurers from dropping your coverage just because you get sick.
- We will incentivize states to develop innovative programs that lower premiums and reduce the number of uninsured Americans.
Proposals

- **Purchase Health Insurance across State Lines**
  Americans residing in a state with expensive health insurance plans are locked into those plans and do not currently have an opportunity to choose a lower cost option that best meets their needs. We will allow individuals to buy health care coverage outside of the state in which they live.
Proposals

● Enact Medical Liability Reform
  Skyrocketing medical liability insurance rates have distorted the practice of medicine, routinely forcing doctors to order costly and often unnecessary tests to protect themselves from lawsuits, often referred to as "defensive medicine."

● will enact common-sense medical liability reforms to lower costs, rein in junk lawsuits and curb defensive medicine
Proposals

- A reformed Medicare will give seniors choice, flexibility
- Give older Americans access to the insurance plan Congress has, including medical savings accounts. Build on the strengths of the free market system, offer seniors real choices, and make sure there are incentives for the private sector to develop drugs. No more one-size-fits-all. Medicare also needs new measures of solvency. We must reduce the administrative complexities. A reformed Medicare program will provide reimbursement at levels that will permit providers to continue to care for patients.
Proposals

- Individuals should be free to manage their own health needs through Flexible Savings Accounts (FSAs) and Medical Savings Accounts (MSAs).

- Individuals should be able to roll over excess FSA dollars from one year to the next, instead of losing their unspent money at the end of each year. MSAs should be a permanent part of tax law, offered to all workers without restriction.
Medicaid

- block-granting the Medicaid program.
- Currently, the federal government sets standards for Medicaid eligibility and pays about 60% of the cost of covering those individuals.
- The block grant program would provide each state with a lump sum annual payment in exchange for greater freedom in administering the program.
- The platform says this change would allow "flexibility to design programs that meet the needs of their low income citizens"
Medicare

- The platform also adopts the portion of the Ryan plan which would convert Medicare from a defined-benefit system into a defined contribution system for Americans under the age of 55.
- This is what has come to be known as the voucher system, wherein Medicare beneficiaries would be given the option of traditional Medicare or income-adjusted premium support to purchase their own health insurance.
- The platform also suggests an increase in the age of eligibility "without disadvantaging retirees or those nearing retirement," but does not lay out particulars on when such changes would be implemented or to what age eligibility might be raised.
United States
> Total expenditure on health per capita: $7,960
> Expenditure as % of GDP: 17.4% (the most)
> Annual growth of total health expenditure: +2.2%
> Life expectancy: 78.2 years

The U.S. has, by far, the highest total expenditure on health care per capita. America spends approximately $2,600 more per person annually than Norway, the second-highest spender.

Only 47.7% of this amount is public expenditure — the third-smallest percentage among developed countries. However, the actual amount of public spending, $3,795, is among the highest.

The U.S. also spends the largest amount on pharmaceuticals and other medical nondurables. The country has fairly low rates of doctors and hospital beds relative to its population. It also has the eighth-lowest life expectancy, at 78.2 years.
Questions

- Innovation
- Programs you are participating in?
- Thank you!