Implications of the ACA for physicians: Understanding its context and key elements

Bill Hayes
Director, Health Reform Strategy
Office of Health Sciences
The Ohio State University Wexner Medical Center

Coverage before the ACA

- Increasing number of uninsured 18-64 year olds
  - For Ohio from 15.0% in 2004 to 18.8% in 2010
- Decreasing percent of getting coverage through employers between 2004 and 2010
  - For Ohio 18-64 year olds from 66.3% to 57.4%
  - For Ohio children from 61.9% to 48.5%
- Employer coverage lowest among smaller firms and getting lower between 2004 and 2010
  - Firms with less 10 workers from 23.5% to 19.1%
  - Firms 10 to 24 workers from 42.7% to 32.1%
  - Firms 25 to 49 from 52.2% to 47.5%

Coverage before the ACA

- Total premiums increasing, with employee share significantly outpacing growth in wages
  - For family coverage total premium cost increased by 81.6% between 2002 and 2010 while employee premium cost increased by 142.0% vs. a 23.2% increase for CPI
  - For individual coverage total premium increased by 67.5% and employee cost increased by 67.9% between 2002 and 2010
- Growing out-of-pocket burden and plans with less rich benefits leading to an increase in people being underinsured

Coverage before the ACA

- Only people getting taxpayer support for their health coverage are those with employer-based insurance and those with public insurance (Medicaid, Medicare), not people buying coverage on the individual market or the uninsured

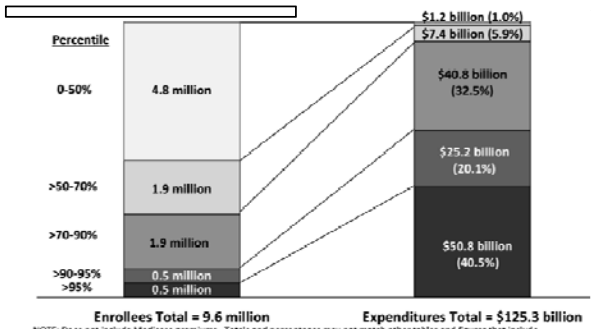
Coverage before the ACA

- Insurance underwriting practices prevent individuals with existing health conditions from effectively obtaining coverage on individual market, e.g.
  - Preexisting conditions
  - Refusal to write coverage at all
  - Recission actions by insurers
  - Annual and lifetime limits on policies
  - Significant premium differences between young and healthy vs older and/or sicker and between men and women independent of health status

Health spending before the ACA

- Total health spending was growing faster than GDP and considered unsustainable
- Around 80% of spending occurs among 10-20% of the population, usually for people with chronic health conditions

Dual Eligible Enrollment and Medicaid Spending by Per Enrollee Spending Percentile, FY 2010



NOTE: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WY, and then adjusted to 2010 CMS-64 spending levels.

Health spending before the ACA

- Payment system based on fee-for-service (FFS)
- Cost containment strategies focus mostly on cutting provider rates or increasing patient cost share
- Experiments were beginning to test out:
  - Payment alternatives to FFS
  - Chronic care management strategies (e.g. Aligning Forces for Quality; Bridges to Excellence)
  - Transparency of information on prices and quality to help patients as they seek out care options
  - Patient engagement strategies
  - Patient-centered medical home

Health system effectiveness before the ACA

- **Multiple studies suggest that 30% or more of health spending (roughly $750 billion) is wasted, adding no value or creating negative value, due to:**
  - **Overuse**
  - **Underuse**
  - **Misuse**
  - **Administrative waste**

  (e.g. see IOM's Best Care at Lower Cost, September 2012 http://www.advisory.com/Daily-Briefing/2012/09/07/IOM-report)
- **Spending varies across the country and within states with lower spending regions typically showing same or better levels of outcomes**

How much is Ohio spending?

Total Medicare Reimbursements per Enrollee (Part A and B) 2005	
Area	Rates
*National Average	7964.40
*Ohio Average	7893.18
*Oregon Average	6038.81
*New York Average	9384.27
Elyria , OH	9432.82
Akron , OH	8447.21
Youngstown , OH	8008.76
Cleveland , OH	8002.50
Toledo , OH	7923.45
Columbus , OH	7862.06
Kettering , OH	7730.93
Dayton , OH	7568.91
Cincinnati , OH	7555.70
Canton , OH	7356.07

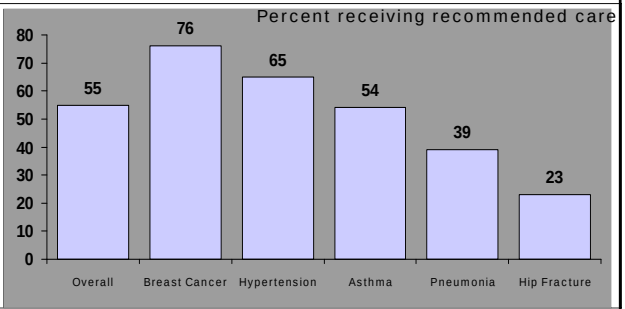
From presentation by Julie Lewis of the Dartmouth Institute for Health Policy and Clinical Practice. August 14, 2008. For forum sponsored by the Health Policy Institute of Ohio

Health system effectiveness before the ACA

- **Lack of adoption of electronic health records and exchange of health information**
- **Examples of poor system performance**
  - **30 day hospital readmissions**
  - **ER use for basic care**
  - **Preventable hospitalizations**
  - **Hospital-acquired infections**
  - **Drug-drug interactions**
  - **Difficulty in tracking and preventing drug seeking behavior**
  - **Documented lack of providers following best practices**

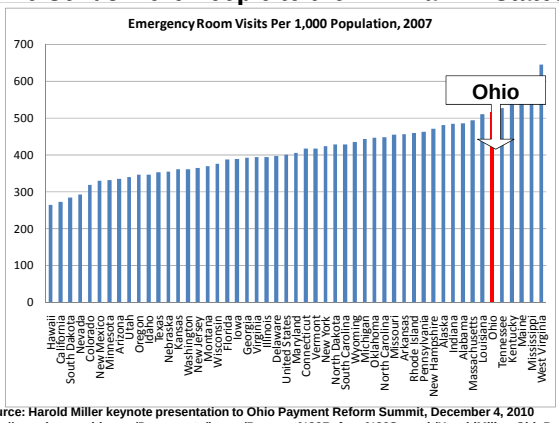
About Half of U.S. Adults Receive Recommended Care

Adherence to Quality Indicators Varies Significantly by Medical Condition



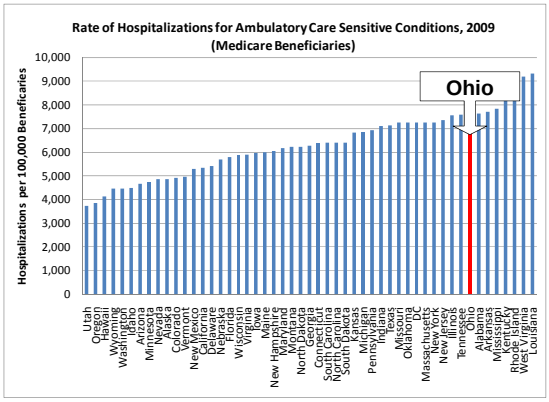
Source: E.A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 348 (June 26, 2003): 2635–45.
Slide borrowed from the Commonwealth Foundation

Ohio Sends More People to the ER Than 44 States



Source: Harold Miller keynote presentation to Ohio Payment Reform Summit, December 4, 2010
http://www.hccqc.ohio.gov/Documents/hccqc/Payment%20Reform%20Summit/HaroldMiller_OhioPaymentReformSummit_12-04-10.pdf

Ohio Has the 8th Highest Rate of Preventable Hospitalizations



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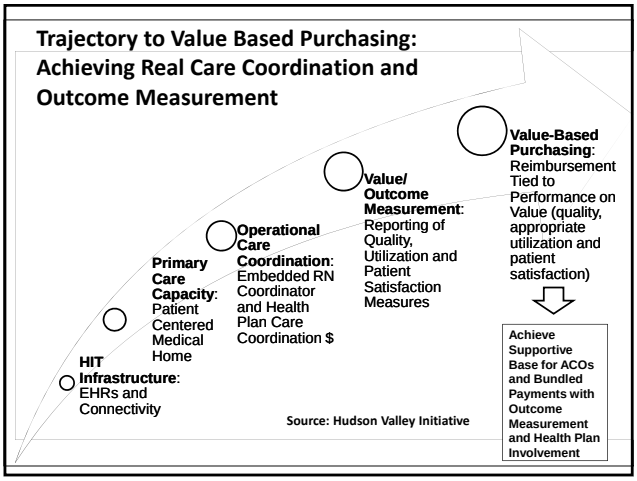
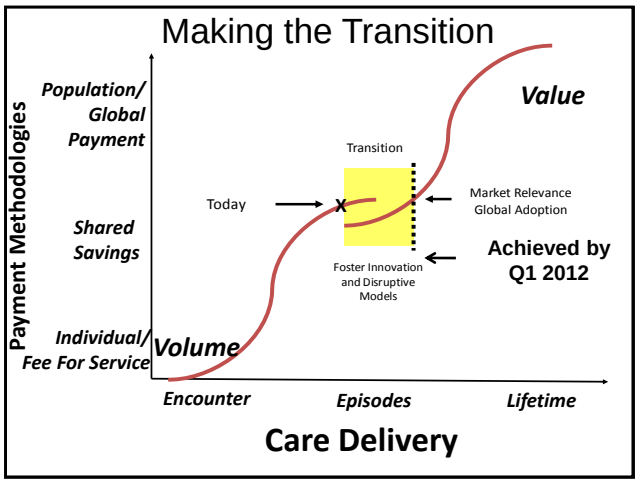
If Ohio's performance improved to the level of the best-performing state for this indicator:	2007 Number	2007 $ saved	2009 Number	2009 $ saved
fewer preventable hospitalizations for ambulatory care sensitive conditions would occur among Medicare beneficiaries (65+)	54,822	$256,621,000	44,865	$276,103,274
fewer hospital readmissions would occur among Medicare beneficiaries (ages 65 +)	9,794	$93,701,000	13,124	$162,254,116
fewer long-stay nursing home residents would be hospitalized	7,394	$60,763,000	6,630	$49,213,233
fewer premature deaths (before age 75) might occur from causes that are potentially treatable or preventable with timely and appropriate health care.	4,495		4,385	
more adults (ages 18 +) would have a usual source of care to help ensure that care is coordinated and accessible when needed.	409,691		404,013	
more adults (ages 18 +)/diabetes would receive 3 recommended services (eye exam, foot exam, and hemoglobin A1c test) to help prevent or delay disease complications	177,454		200,731	

From the Commonwealth Fund's State Scorecard on Health System Performance, 2007 and 2009
http://www.hpio.net/pdf/OhioHCQualityBrief.July2007.pdf and http://www.commonwealthfund.org/Charts-and-Maps/State-Scorecard-2009/DataByState/State.aspx?state=OH

Trajectory to Value Based Purchasing: Achieving Real Care Coordination and Outcome Measurement





ACA Elements to deal with coverage

- Allow children to stay on parents policy until age 26
- State run or federal run high risk pools until January 1, 2014
- Elimination of certain insurance writing practices
- Reduction in allowed premium rating difference to 3:1
- Creation of essential benefit package that plans are to adhere to
- Required that plans cover all Schedule A and B preventive services with no cost sharing

ACA Elements to deal with coverage

- Ability to purchase insurance on a new state or federally run health insurance marketplace with
  - premium sharing subsidies for those with incomes between 100% and 400% of poverty and
  - cost sharing subsidies for those with incomes to 250% of poverty
- Medicaid expansion option for 19 to 64 year olds with incomes at or below 138% of poverty
- Individual mandate, with exemptions
- Employer mandate on firms with more than 50 full time employees (delayed until 2015)

2010 Federal Poverty Guidelines*
(Before any tax and withholdings)

Annual Income*				
Family Size	**100% FPL**	**138% FPL**	**200% FPL**	**300% FPL**
1	$10,830 ($902.5 monthly)	$14,498 ($1,245.45 monthly)	$21,600 ($1,805 monthly)	$32,490 ($2,707.5 monthly)
2	$14,570 ($1,214.17 monthly)	$20,107 ($1675.55 monthly)	$29,140 ($2428.33 monthly)	$43,710 ($3,642.51 monthly)
3	$18,310 ($1,525.83 monthly)	$25,267.8 ($2105.65 monthly)	$36,620 ($3,051.67 monthly)	$54,930 ($4,577.49 monthly)
4	$22,050 ($1,837.5 monthly)	$30,429 ($2535.75 monthly)	$40,792.5 ($3,675 monthly)	$66,150 ($5,512.5 monthly)

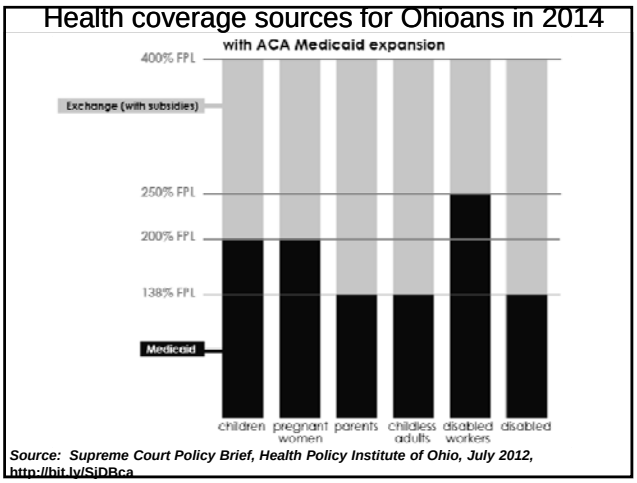
$15,184 - annual income for full time worker (2080 hours/year) at $7.30 per hour (minimum wage)

$20,800 - annual income if working full time at $10 per hour

$899 and $3,907- 2010 average worker annual premium cost for single and for family coverage**

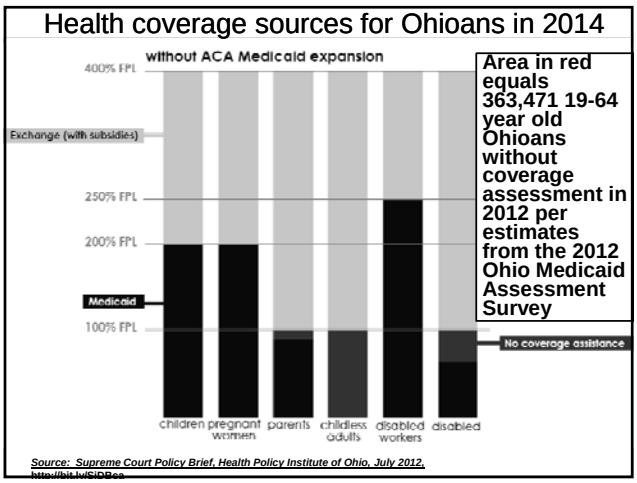
*Source: *https://www.cms.gov/MedicaidEligibility/downloads/POV10Combo.pdf*
***Employer Health Benefits 2010: Summary of Findings, Kaiser Family Foundation http://ehbs.kff.org/pdf/2010/8086.pdf*

Health coverage sources for Ohioans in 2014



Source: Supreme Court Policy Brief, Health Policy Institute of Ohio, July 2012, http://bit.ly/SjDBca

Health coverage sources for Ohioans in 2014



Area in red equals 363,471 19-64 year old Ohioans without coverage assessment in 2012 per estimates from the 2012 Ohio Medicaid Assessment Survey

Source: Supreme Court Policy Brief, Health Policy Institute of Ohio, July 2012, http://bit.ly/SjDBca

ACA elements to deal with health spending and effectiveness

- **Part of Medicare hospital payment tied to performance, such as the rate of hospital readmissions**
- **Creation of Center for Medicare and Medicaid Innovation to sponsor different models for health system improvement, including:**
  - **Episode of care and bundled payments**
  - **Accountable care organizations**
  - **Chronic care management initiatives**
  - **Patient-centered medical home**

ACA elements to deal with health spending and health system effectiveness

- **Support for value-based purchasing efforts, e.g.:**
  - **incentives for employer wellness programs and**
  - **premium differences for people who smoke**
- **Encourage Medicaid innovation through:**
  - **Medicaid health home opportunity**
  - **Expanded use of home and community based services**
  - **Medicare-Medicaid dual integration**
- **Reductions in hospital payments not tied to performance**
  - **Cuts in DSH payments (with expected decreased in uninsured)**
  - **Cut in hospital payment rates not tied to performance**

ACA elements to deal with health spending and health system effectiveness

- **Independent Payment Advisory Board**
- **Comparative Effectiveness Research**
- **Required reporting of hospital acquired infections**
- **Increased capacity of Federally Qualified Health Centers to serve more patients**
- **Focus on training more primary care providers and auxiliary staff to support primary care providers**
- **Increased investment in public health**

The ACA is Here? Now What?

Randy Wexler, MD, MPH, FAAFP
Associate Professor and Clinical Vice Chair
Department of Family Medicine
The Ohio State University Wexner Medical Center

Payment Changes

Episodic Payments

An episode of care may extend from the time of admission to days or weeks after discharge.
An episode of care includes home health, a stay at an extended care facility, as well as ancillary services such as physical therapy or occupational therapy.

Groups of providers work together to care for all of a patient's needs and are paid a set fee that will be distributed amongst all care givers.

Payment Changes

Prospective Payment

In this mechanism reimbursement for inpatient hospital services is based on a prepayment amount covering a defined period (some of which are familiar to physicians as a Diagnostic Related Group or DRG).

Payment Changes

Pay-for-Performance
In pay for performance, reimbursement is tied to achieving certain mutually agreed upon metrics, such as level of patients immunized for a specific disease, achievement of a particular biometric outcome such as lower blood pressure, or increased patient satisfaction.

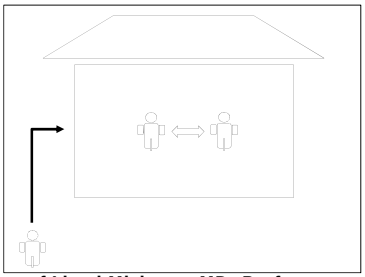
Payment Changes

Hospital-Physician Bundling
One example is combining the cost of a procedure or diagnosis to include both the hospital as well as the physician component for the service into one payment for the totality of services provided.

Patient Centered Medical Home

1. **Access During Office Hours.**
2. **Use Data for Population Management**
3. **Care Management**
4. **Support Self-Care Process**
5. **Referral Tracking and Follow-Up**
6. **Implement Continuous Quality Improvement**

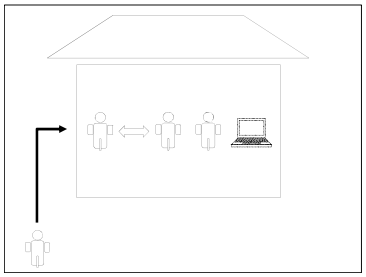
Traditional Health Care
Focus: Individual Patients
Care Location: Offices
IT: Minor
Provider: Physicians



- **Courtesy of Lloyd Michener MD- Professor and Chair of Community and Family Medicine, Duke University**

Medical Home Version 1

Focus: Improved outcomes for patients seen in office
Care Location: Offices and hospitals
IT: Minimal
Provider: Physicians and Office team



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Team-Based Care

- **Pharmacists**
- **Advanced Practice Nurses**
- **Physician Assistants**
- **Registered Dietitians**
- **Social Workers**
- **Others**

Access to Care

- **Same Day appointments**
- **Sick Call**
- **Advanced Access**
- **Every patient is offered an appointment on the day they call regardless of the reason.**

Population Management

- **Proactive delivery of evidence-based care to specific groups based on guideline recommended care**
- **Elderly**
- **Diabetics**
- **Heart Failure**
- **COPD**
- **Immunizations**
- **Age appropriate screenings**

Population Management

- **Disease Registries**
  - **A population-based database that contains the names of people with a specific condition as well as information related to that condition a population-based database that contains the names of people with a specific condition as well as information related to that condition.**

Population Management

- **Dashboards**
  - **A computer based snapshot assessment of a particular disease or process. Similar to a disease registry but may also be presented in per cent level achieved or per cent change from previous.**

Planning and Managing Care *Using Evidence Based Guidelines to manage a patient's chronic disease care*

- **Lack of guideline use by physicians**
  - **1) lack of knowledge or familiarity with guidelines**
  - **2) lack of physician agreement with guidelines**
  - **3) lack of physician self-efficacy**
  - **4) organizational issues (staff, facilities)**
  - **5) patient-related factors**
  - **6) ease of guideline use**
  - **7) cost**
  - **8) clinical Inertia**

Planning and Managing Care

- **Conduct pre-visit preparations**
- **Collaborate with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit**
- **Give the patient/family a written plan of care**
- **Assess and address barriers when the patient has not met treatment goals (i.e. social, educational, financial)**

Planning and Managing Care

- **Give the patient/family a clinical summary at each relevant visit. Identify patients/families who might benefit from additional care management support**
- **Follow up with patients/families who have not kept important appointments**

Self Management Support

- **Patients spend only a few hours a year with a physician. Therefore, to maximize care it is important for patients to learn to manage their own disease.**
- **Many patients do not understand what they have been told about their care and rarely make specific inquiries about it.**
- **Poor communication between patients and physicians is often a contributing factor.**

Self Management Support

- **Improved communication with patients allows physicians to better understand what patients need and want. Without direct patient involvement health outcomes of patient-centered care will be suboptimal, and lack of patient involvement will not motivate nor activate patients for success to the degree necessary.**

Track and Coordinate Care

- **One of the most perilous times for patients is the transition from one health care setting to another.**
- **This transition can occur between an office and a hospital, from a primary care doctor to a specialist, or anywhere in which the transfer of a patient and the medical information about them leaves one location and moves to another.**

Track and Coordinate Care

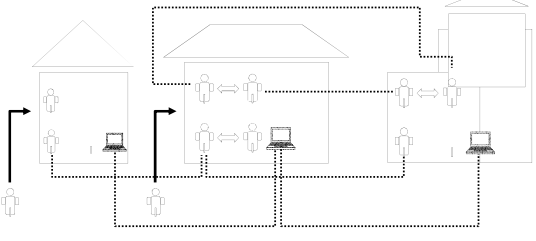
- **The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as *"the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."***

Track and Coordinate Care

- **Factors contributing to care coordination problems include poor communication, incorrectly completed forms, and lack of a physician relationship.**
- **Between 1995 and 2006, communication breakdown was the leading cause of sentinel events reported to the Joint Commission on Accreditation of Hospitals.**
- **The World Health Organization lists "communication during patient care handovers" as one of its top 5 safety initiatives.**

Medical Home Version 2

Focus: Improved outcomes for patients seen across the spectrum of care
Care Location: Offices and hospitals
IT: Somewhat integrated
Provider: Physicians, Office team, and Community team



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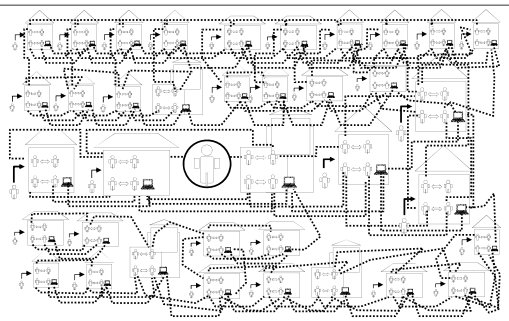
Community Team
Office Team
Patients
Physicians
Office
Hospital
Anywhere
IT

Medical Home Version 3

Focus: Improved outcomes for all
Care Location: Anywhere
IT: Highly integrated
Provider: Network



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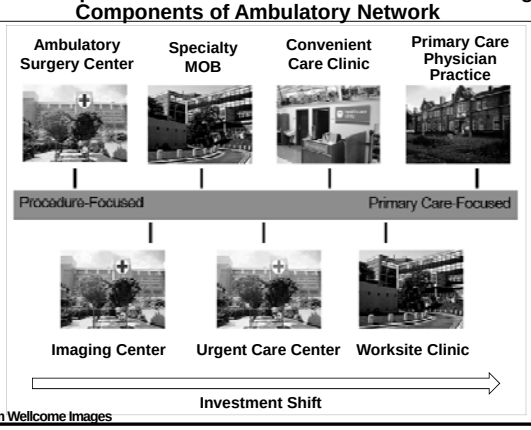
Community Team
Office Team
Patients
Physicians
Office
Hospital
Anywhere
IT

PCMH is the Foundation of an ACO

Access Expansion Needed Most in E/M Oriented Settings

Components of Ambulatory Network



Images from Wellcome Images