“Health Reform and the Health Care Safety Net: Challenges and Opportunities”
Health and Medicine Policy Research Group
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Health Reform in Illinois

Michael McRaith
Director, Illinois Department of Insurance

- System dysfunctional, does not serve consumers or providers well
- Some baseline consumer protection now after health care reform
- Major questions:
  (1) What can we expect in terms of the rollout of health insurance reform?
  (2) What are the challenges to implementation?
- High risk pool
  - Commence enrollment in mid-August
  - Coverage as early as September 1
  - Available if uninsured for 6 months, have a pre-existing condition, and can afford to pay
- $196 million dollars plus premiums will be the entire financial support for the program until 2014
  - Maybe 4,000-6,000 people will be able to be enrolled in Illinois
  - Number eligible to be enrolled will be in the tens of thousands
  - More information: http://Insurance.illinois.gov
- Loss-ratio
  - When I pay a dollar, how much goes to healthcare? To executives? And so forth.
  - Insurance companies want the definition of healthcare to include fees, cost of running the insurance company, and anti-fraud.
  - National definition of what constitutes health care in the loss-ratio will be much more narrow
- Insurance company rates
  - Currently no regulatory oversight on the rates set by the insurance companies
  - All of the rate increases will become public discussion (expect public attention toward how companies are “milking golden goose”)
  - Companies are milking the golden goose while its still breathing, getting everything they can out of it
  - Premiums increasing, will draw attention
- Two challenges
  1) Education: State has a responsibility to educate the public on the implications of reform (Example: People still call to ask about “death panels”).
  2) Implementation (cultural shift): Some Medicaid recipients will be able to purchase private insurance with a subsidy, but will have monthly obligations and access care in the insurance system.

Julie Hamos
Director, Illinois Department of Healthcare and Family Services

- It is one thing to give everyone insurance; it is another to reform health care.
- How do we incorporate the newly eligible Medicaid clients?
    - $14,000 income for a single person (more for a family)
    - 650,000 more people added to the Medicaid rolls (currently 2.4 million)
- Inconsistent eligibility: how do we ensure continuity of care?
- Challenges
    - Ensuring primary care physicians for everyone
        - Not only physicians, but also nurses and others to staff these offices
    - Providing coordinated care for people
        - Illinois Connect
            - Everyone is assigned to an office
            - Full network for coordinated care is not in place
        - About to launch an integrated care pilot program for the aged, blind, and disabled
    - Integrating new technology, including electronic medical records (EMRs) and telemedicine
        - EMRs have a lot of promise for quality care,
    - Creating a collective vision of where we are going to go and how we are going to get there
        - Bringing all of the stakeholders to the table
        - Thinking about reforms throughout the healthcare community
        - Invites attendees to take part in shaping this vision

<u>*Question/Answer Session*</u>

Q: I'm a physician and I often have to negotiate reimbursements with insurance companies. Does health reform or the state plan on providing any type of oversight to the way insurance companies handle reimbursements/payments?
A: Provider and payer have to work together to solve some of the payment issues, e.g. not putting the burden on the patient when, say, an anesthesiologist not part of the payer's network treats the patient and charges him 20,000 dollars. Health reform does not necessarily address these issues.

Q: How do we make sure that through the health insurance exchanges people will get the breadth of coverage they need at affordable rates?
A: Important component is the Medicaid side. Big policy issue: what is the standard benefit package for the exchange? One of the things health reform doesn't really do is address affordability.

Q: (unintelligible)
A: (Hamos) We need to pay incentives for health care providers to keep people healthy rather than just pay for curing their illness.

Q: Can you please explain the loss ratio a little more?
A: (McRaith) The Affordable Care Act requires that individual and small group plans have to spend 80 cents on the dollar on health care while larger plans have to spend 85 cents on the dollar on health care. The insurance industry needs to know the definition of what counts as health care. Companies will of course take advantage of everything and any loophole they can.

Q: A vision for health/wellness care over sick care. When can we move on that?
A: (Hamos) Our goal is to figure out how to structure these kinds of discussions as plans are not in place yet. We will work on this when creating our vision for Illinois.

Q: As a provider, we have to make decisions now due to large Medicaid population. The sooner we can do this, the better.
A: (Hamos) It's a process of building a coalition, spending time with providers to get the vision on the table so they can work with it, building a team in the department.
(McRaith) More payments to providers in capitation arrangements, a.k.a. "global payment". What we now understand to be HMO or PPO will be very different. A lot of providers will establish their own system.
(Hamos) Capitation is a form of asking providers to take on risk, to keep people healthy.

Q: Why is there not more oversight written into the bill? Why was all of the responsibility given to the states? What are the prospects of having decent regulation in Illinois?
A: (McRaith) They will push legislatively and every place possible for improvements in regulations.

Q: What about consumers? It's all about the insurance company making a profit.
A: (Hamos) Other models are being examined, including models by consumers, providers, and non-profit organizations.

A National Look and a Focus on Massachusetts

Claudine Swartz
Assistant Vice President for Policy, National Association of Public Hospitals and Health Systems (NAPH)

- National Association of Public Hospitals and Health Systems: Who are they?
  - 27 years old
  - Represents 140 urban safety net systems
  - Partner with national community of health systems
  - Serves patients "about the patients"
  - Typical NAPH members receive most of the money to pay for patients come from state and federal funds
- Politics of Health Reform
  - Combination of two bills: Patient Protection and Affordable Care Act
  - Reconciliation Bill followed
  - Total cost: $930 billion
  - Provides coverage to 94% of legal us residents
  - Referred to as Health Insurance reform but it has a lot of delivery system reform (different from Massachusetts reform)
  - Implementation
    - Estimates that there are 40 mandatory regulations as a result of the bill
    - Health and Human Services expected to create guidance, request proposals and create commissions/panels/boards
  - Coverage Expansion: Components of the Bill
    - Pre-2014 (Immediate)
      - Important for elections, for consumer education
      - Many consumers believe nothing will happen before 2014
      - High risk pool receives pre-existing Condition Health plan
      - Medicaid for childless adults up to 133% FPL
      - Dependents 26 and below
      - No pre-existing exclusions for children
      - No rescissions except in case of fraud
      - Rate review where necessary
      - Immediate effects important during wake of recession, BP oil spill
    - Beyond 2014
      - Guaranteed issues
      - Enroll 10 million by 2019
        - How do we actually care for these people?
      - Must optimally organize the health care system
        - Example: Primary care physicians that will accept insurance
      - All legal residents must have insurance or there will be a penalty

            - Basic health plan options for states
        - Exchanges
            - Clearing house for vetting of health insurance plans
            - Debate in Washington about state or regional exchanges
            - Each state required to have an exchange
            - Exchange both for individuals and small businesses (i.e. SHOP, more likely they will merge)
            - 2017: States can open up to other business
            - Co-op plans can be offered in exchange
            - At least 2 multi-state plans negotiated by Federal government
            - Plans must contract with central community providers, flexibility for the states
    - Key Questions for Safety Net Health Systems
        - How much is Medicaid going to expand?
        - Will Illinois expand Medicaid early?
        - How many people will be covered via the exchange? (1 million)
        - How will safety net facilitate enrollment?
            - Must set up the exchange
        - How do we facilitate enrollment?
            - Safety net enrolls people for coverage. This will intensify over time.
            - Many believe that safety net won't be needed because everyone will be covered. However, in Massachusetts (after reform) there was an increase in low income patients.
    - Provider payment changes
        - Focus on safety net hospitals
        - Medicaid payment rates and disproportionate share hospital dollars
            - Need less disproportionate share hospital dollars after everyone is covered, so DSH will recline.
        - Medicaid and Medicare payments are reducing as a result of the bill.
            - Problematic because Medicaid and Medicare payments support safety net hospitals
            - If safety net institutions serve mostly low-income patients, are getting paid lower costs for all individuals, and face low DSH, how will safety net facilities keep going?
                - Issue in Massachusetts where cannot keep some hospitals open.
        - Increase in primary care payments over short period of time
        - Adding 16 million people to Medicaid and Medicare
            - MACPAC commission created in legislation prior to health care reform

        - Will try to sort out Medicaid and Medicare, figure out way to provide sustainable Medicare rates to providers
        - Can make recommendations to congress, made up of experts across country (including safety net hospital representatives)
    - We are moving to payment structure where quality intersects with cost, with special attention to admissions, and with penalizations
    - Medicaid DSH payments:
      - Due to high Medicaid and uninsured volumes
      - States regulate
      - Ratio of DSH payments and uninsured patients are different state by state
        - Secretary's discretion in implementing DSH reductions, must consider the ratio of uninsured
      - Medicare DSH payments:
        - Much less targeted throughout country but needs more focus
        - Safety net hospitals trying to plan, do not know how many Medicare DSH payments will be received
- Innovations and Funding Opportunities
  - Funding is the wildcard
    - $105 billion worth of programs require Congressional appropriations
    - Appropriation bills are a mess this year
      - Programs will not receive the funding this year.
    - Elections might impact health reform funding
      - Republican wins may mean inadequate health care funding
    - Innovation Center to figure out which programs work, disseminate money quickly
    - Medicaid Global Payment system demonstration experiments with funding source to streamline payments
    - Accountable Care Organizations (ACOs)
      - Networks of providers with shared risk and savings
      - Run by Medicare
      - DC doesn't know what it is exactly
  - Key Concerns for Safety Net Health Systems
    - Which delivery system reforms and funding opportunities makes sense for your community?
      - Internal strengths and weakness, costs, collaboration with state
    - How can we collaborate with the state?
    - Department of Health and Human Services Organization
      - Office of Consumer Information being established, working on exchange issues
    - CMS Reorganization

- Implementation challenges
    - Enormity of changes
    - Payment changes
    - Establishing state collaborations
    - November elections
    - Pending law suits from across the country
    - Many unresolved issues
- DOC FIX: AMA had a deal not to address the health reform bill, deal with it later
- Massachusetts example
  - Private employer premiums increased 6% in Massachusetts
    - Some people covered, but people continue to suffer
  - Boston Medical Center (large hospital in Massachusetts)
    - Before health reform, received $12,000 per patient (from insured, Medicare, uninsured patients and DSH payments)
    - After health reform, $9,000 per patient (often less than cost of patients)
  - State used stimulus dollars to prop up the stimulus hospitals

Questions

Q: What are your thoughts on the impact of health reform on long term care?
A: Long-term care provisions were in and out, now it is voluntary. It came down to cost in the end.

Q: What is the Demonstration for Uninsured?
A: Enrolling everyone eligible for Medicare in 2014 is not a good idea. How can we cover them now? Need to move slowly to enroll coverage. This program is an attempt to cover uninsured to 2014 through waiver proposals.

What Can We Anticipate on the Ground?

Philippe Largent
VP Government Affair, Illinois Primary Healthcare Association

- Federal Qualified Health Center (FQHC) vs. Community Health Center
    - Some CHCs look, act like FQHCs but do not receive federal funding
    - Community health centers started in 1960s in East to empower communities to resolve own healthcare access issues
    - Community Health Center network large (1700+)
    - Serve 20 million patients
        - More than a million served in Illinois
        - 500,000 in Cook County
    - Can provide primary care, dental services, ambulatory care, and social connecting services as well as transportation, translation, day care, and nutrition services
    - Emphasis on providing culturally competent care
    - Have to be governed have to be users (at least 50% of Board)
    - Doubled in size under Bush administration
    - FY 2010 federal budget (entire program): $2.1 billion
- Federal Health Reform
    - $11 billion to support community health network (October 2010-2015)
    - More than double
    - Tremendous opportunity to add onto existing health center network
    - Expect 40 million patients to be cared by community health centers
    - A number of studies highlight cost effectiveness of community health centers
        - 2009 by GWU
            - Difference between annual total expenditures by a patient seen in community health center versus patients not being seen in a community health center = $ 1100 per annum
            - Billions if extrapolated to larger system
    - Goals of health center system
        - Extending access
            - Why PPACA problematic without funds toward community health centers
            - Managed care saves money, lives in long run
- PPACA is a major step forward in primary care and access
    - Illinois in a good position to double capacity of community health system

<u>Questions</u>

Q: How does or how might health reform bridge gap between preventive care and critical care?

A: Hopefully plans under reform will provide coverage to spectrum of services.

Q: How do we find appropriate providers?

A: Shortage of primary care physicians, in high demand (especially bilingual doctors). Solution not known.

Q: Difference between CHC vs. FQHC?
A: FQHC receive grant money from HIRSA for the uninsured.
Resources available to fill in gap in care.

Bill Foley
CEO, Cook County Health & Hospitals System

Major Effects of Health Reform on CCHS

- CCHS: One of largest public hospital systems in nation
- Implications for Healthcare Reform
  - Hundreds of thousands remain without access to healthcare services
  - Potential opportunities to keep CCHHS patient population, attract new populations
  - Providers and payers adapting aggressive strategies to capture populations
  - Medicaid expansion: $3-4 billion to providers
  - More than 500,000 new enrollees
  - Medicaid and DSH reductions begin
- The Impact of Healthcare Reform
  - The Uninsured
    - 800,000+ before reform
    - 200,000+ after reform
- CCHS Uninsured vs. Other Hospitals
  - $496,500,000
  - More than any other hospital in Illinois
- Strategic Plan- Vision 2015: The Road Ahead
  - Process Change, System Alignment, Training and Cult Change, and other considerations
  - Trying to be more patient-centered
    - Currently not (location, service accessibility, IT challenges, scheduling challenges, waiting times)
    - Changes will include focus on access- geographic and otherwise
    - Cultural change in putting customer service high in priorities
  - Health reform allows for choice. CCHHS must change.
  - Strategic Plan will be presented to County Commissioners soon
    - Strategic Plan must account for reform-related changes
  - Current State Assessment Key System Issues
    - Unmet healthcare needs
    - Disparities in access to healthcare and location of services
    - Disproportionately centered around inpatient environment
    - Misalignment among providers
- Guiding Principles for Strategic Plan

- Population-centered model (vs. hospital centered)
- Accessibility to services
- Align service delivery with population demand
- Build specialty care capability
- Extend primary care services through partnerships
- Provide quality cost-effective healthcare
- Focus on service excellence, employee satisfaction , and leadership development
- Strengthen CCHHS image in the market
    - Tell stories of what happens at County Health System

- Core Goals
    - Access to Health Services
    - Quality, Service Excellence, and Cultural Competence
    - Especially because diverse patient population
    - Service Line Strength
        - ID program, HIV center (one of largest in nation)
    - Staff Development
        - Investing in employees, staff
    - Leadership Stewardship
- Patient-Centered Accountability Across the Continuum of Care
    - System wide care management program
        - Ready access to full continuum of services
        - Top-quartile quality and service excellence
        - System-wide care management and care coordination
        - Integrated patient records
        - Provider Partnerships
- Expanded Outpatient Locations
    - Including Ambulatory Community Health Network, Comprehensive Community Health Center, Regional Outpatient Centers
    - ACHN will remain, will buffet new locations
    - Oak Forest
        - Regional Outpatient Center
            - Primary care
            - Specialty services
            - Urgent care
        - Large facility with tiny inpatient population
        - Prudent to invest in development of outpatient center
        - Serve south and southwest cook county
    - Provident
        - Downsize inpatient
        - Maintain active ED
        - Another Regional Outpatient Center
    - Stroger
        - FANTUS clinic
            - Plan to rebuild, replace

        - Establish 3rd
    - Vista Health
        - Arlington Heights in northwest has growing needs
    - Want Comprehensive Community Health Center
        - Larger than clinic, smaller than regional care centers
        - Expect to expand a clinic in Cicero area and Cottage Grove
- Forecast for Primary Care and Specialty Visits
    - 2006-2015 will see 50% increase
    - Points to high need for primary care providers
        - Will require collaboration, partnerships
- Expected Benefits
    - Improved access
    - Better patient experiences
    - Growth in services to 900,000 outpatient visits by 2015
    - Patient centric workforce
    - Performance driven leadership and stewardship
    - Improved infrastructure

Roberta Rakove
Senior Vice President, Government Affairs, Sinai Health System

- The degree to which you as a provider are excited about health care reform is directly proportional to the amount of uninsured patients you see.
    - 13% uninsured, a lot of charity care, compromises their ability to provide good care, to pay for the technology, etc
    - Undocumented are not being covered
        - Number of undocumented patients unknown
        - Third of uninsured in the metro area are undocumented Hispanics
- We should be offering primary care wherever patients come in, not just at FQHCs, at a reasonable rate.
- Readmissions
    - Penalized for too many readmissions
    - Problem is nobody pays for those interventions
    - Interventions need to be worked into the Medicaid program
    - Need more primary care to prevent readmissions
    - The in-patient safety net is largely unaddressed

Linda Murray
Chief Medical Officer, Cook County Department of Public Health
President-Elect American Public Health Association

- Workforce issues
    - Healthcare workers make up 12% of the entire US workforce
    - 3.8 annual medical visits per capita per year, lower than other nations

    - Low numbers of practicing physicians compared to other nations
        - More specialists, fewer primary care physicians
- Flexner Report – 1910
    - Revolutionary report on the training of physicians
    - required that physicians learn the germ theory of disease, make sure they wash their hands, put the training of physicians on a scientific basis
    - Flexner successfully decreased number of medical schools by 50 %
    - National Workforce Commission
        - Supposed to handle all of the problems the bill didn't cover
        - Figure out where people are needed
        - Needed because Commission has money to try and increase certain specialties that are needed (e.g. support for training in many settings)
- Why are we in trouble and what do we have to do?
    - Disparities in the workforce need to be addressed.
        - Dr. Cornely, leader in public health, first Black to get a doctorate in public health, anatomy
        - Assessment of black physicians in the 1930s revealed losing more physicians than gaining
        - In 1920, 2.6% of physicians were black, we're at 4 % now
        - Graphs on the racial profile of physicians over time
        - Black women are the only women who graduate at a greater rate than men
    - Culturally competent care in underserved communities is lacking
        - Patient-centered medical home is an inadequate version of primary care
    - Workforce crisis
        - Shortages of primary care.
        - No way we can keep up with newly insured.
- Reform will not accomplish what it set out to accomplish. We have to make sure that the safety net doesn't collapse in the face of health care reform.

Questions

Q: "Pay for performance can exacerbate health disparities." What are your views?
A: Study about Pay for Performance: incentives offered showed higher quality. Not necessarily raising outcomes but are giving positive measures. Concept of doctors can do whatever they want is bad. Pay for Performance is attempting to constantly raise floor of what is acceptable in medical care. If hospital really couldn't meet the needs of patients they shouldn't even be open.

Q: Subsidized health insurance and reduced DSH: If patients can't pay deductibles what will happen?
A: Mammograms have no more deductibles. Deductibles only deter people from care. There should not be deductibles. One of flaws of the bill is affordability.

Q (from former Cook County hospital nurse and consumer of health care): What does the consumer say about the plans to changes in Cook County? Have we asked the consumers about what would be important to them?
A: Yes, town hall meetings were conducted throughout the county. At the meetings, the purpose was to ask people about what they thought about the county health system. Also, questionnaires were distributed. Few months later, another round of town hall meetings, were visions and plans were shared with the public. These meetings were very lively. A conclusion was based on where in the county the meeting was. The major theme was access. Cook County's health care was not accessible to a lot of people in the county.

Q: Disparities in females and males and medical providers: how can we try to decrease the disparities?
A: Goal of 12% minority position by 1970s. This was not met. We cannot separate what is going on in elementary schools to medical school and the health reform and health disparities. There are many recommendations to make sure kids of all nationalities and genders have opportunities to pursue their dreams. We must change how to train people, how doctors practice, and how skills and competencies are met.

Q: Nationally there are 8 million people who are uninsured who go to free clinics. There was no mention of this part of the safety net. What do you see the relationship between reform and free clinics?
A: There are many places where people receive primary care. We should not be limiting what we are doing to insure primary care. Our focus should be on how do we look at the entire network of care to patients to low income populations? How do we guarantee that proper care is available to these clinics?

Q: Advocacy: How does advocacy develop role so that we can collectively move on this health reform? What is our agenda?
A: We should be inspired to act. The problem we have is to communicate. We must come together and find ways with resources we have to draw important lessons.