

**How Safety New Institutions Can Best Leverage Federal and State Health Reform**  
*Health and Medicine Policy Research Group*  
April 25, 2011

**Forum Notes**

Introduction by *Margie Schaps, Executive Director of Health & Medicine Policy Research Group*- Welcomes everyone and introduces *Roberta Rakove, Senior Vice President, Government Affairs, Sinai Health System*, moderator for the day.

**9:35—National Overview, Cathy Hurwit, Chief of Staff to Rep. Jan Schakowsky, (IL-D)**

- It's an important time to be discussing these issues
- Will cover discussions in DC that could change health care, Medicaid, and ACA implementation
- National budget
  - Paul Ryan's "disgusting" budget passed in the House, Senate to enter theirs soon
  - Sentiment is "we won't raise the debt ceiling unless we commit to making reductions in outgoing money"
  - A deficit reduction agreement will probably be released
    - What % will be from cuts, what % from revenue increases?
    - Look at Dave Stockman's article in the Times
    - Spending will be cut, but who will it affect?
    - No spending cuts until 2013 a possibility
- Medicaid
  - It is more efficient than private system
  - Are we cost-shifting?
  - Will it be a block grant?
  - Will be cut in ½ by 2022 and in half again by \_\_?
- The 3 Cs—caps, cuts, cost-sharing
  - Caps
    - Federal spending as a % of GDP will happen
    - Ryan proposes a 19% cap
    - Fiscal Commission says 21%
    - Obama wants a trigger with fail-safe exception for low-income programs, but this is still vague
    - Billions will be cut from Medicaid
    - Aggregate caps, per capita caps, caps on Medicaid, Medicare, and partial for CHIP
    - IPAB—target GDP and 1% growth for Medicaid
    - Bowles-Simpson should be expanded to Medicaid
  - Cuts
    - Watch the numbers—if cuts are over 150 billion, can only get this by using block grants

- Obama’s message, giving states more “flexibility” except for the “most economically vulnerable” people, is unclear. What groups are considered most economically vulnerable, and what about people who are still very economically vulnerable?
    - Cuts in use of provider taxes
    - Duals—putting them in managed care, giving them MSAs that will not be in keeping with costs
    - Cuts in education
    - Use of generics and penalties for high prescribers
    - ACOs supposed to create savings
    - Partnership for Patients supposed to create savings
  - Cost-Sharing
    - Center for Medicare advocacy concerned what will happen to nursing homes
    - Changes to Medicare parts B & D
    - Serious changes in Medicaid—those at upper end will pay more, at lower end, will also pay more, and could be variance depending on provider
    - Public is on our side—people oppose balancing budget if it means cutting Medicare/Medicaid
    - Must find ways to improve efficiency without negatively affecting patients
- Q&A
  - Cuts? In some instances there will be actual cuts, in some caps, like 19% on total spending and DISH. McArthur and Pew study says capping at 21% or higher would be a disaster. Caps are a problem in general.
  - What can we do at the state level to help revenue problems get solved responsibly at the federal level? Support Schakowsky’s HR 1124, includes a tax on incomes over 1 million of 45% and higher. We need more public showings of support for these programs, talk to people.
  - Cook county Medicaid reimbursements? Senate, Grassly, probably not going to block grant, but in House, they want to block grant everything.
  - The public supports Medicare/caid, but who’s going to do the messaging? People sometimes support these things without realizing it. We need to get the word out, have Town Hall meetings. We need to talk to people about what cuts would mean for them. The media should do a better job of presenting the issues and how they affect people. Ms. Hurwit wants to hear ideas. We need to have more meetings like this one and be engaged and involved.

**10:00am- John Holahan, Director, The Urban Institute, Health Policy Center-**  
 PowerPoint: “The Affordable Care Act and Medicaid: The Health Status of New Enrollees”

- Health insurance coverage under the ACA

- Fewer non-exchange employers offering coverage, more employers offering coverage on exchanges – but overall not much change in number of people covered by employer insurance
- Overall, non-group insured pool expands
- Those insured by Medicaid expands
- Number of uninsured (mostly low income) reduced by 27.8 million
- New eligibles are childless adults, younger, male (currently uninsured)
- In general, those currently uninsured (new eligibles) are in better health than those currently covered by Medicaid/Medicare – pattern is true for general health, mental health, chronic conditions, ability to work.
- Therefore, pool we are drawing from for new Medicaid coverage is healthier than those we currently serve.
- If participation rates are low, the newly covered will be the sickest from the pool
- Participation estimated to be 75%
- Conclusions:
  - 80% new Medicaid enrollees will come from the uninsured
  - Higher participation of newly eligible in Medicaid = less adverse selection
- Q&A
  - As a 209B state, will IL have differences in enrollment? Yes. And we can expect between 500,000 and 800,000 new Medicaid enrollees in IL.
  - Could the # uninsured be higher than reported in this study? Yes.
  - Adverse selection—why does it happen and why does it have negative impact? Is auto-enrollment possible to broaden pool of enrollees? 40% of those eligible do not sign up for Medicaid. It's inevitable that those who need health care (are sicker) will sign up, and younger (healthier) will not, and this is expensive.

**11:00am- Gordon Bonnyman, Executive Director, Tennessee Justice Center-  
PowerPoint: “Opportunities for Maximizing Medicaid Match”**

- Maximizing Medicaid match is ultimately a policy choice – it is about getting credit for what states are already doing
- There is still money on the table in Illinois
  - The state is not using money that could be directed to match Medicaid, which in effect is subsidizing the federal program
- Medical inflation is increasing at a higher rate than the growth of everything else
  - Dilemma of states: balanced budget requirements, yet medical inflation
- Medicaid is also a revenue center – there are few cost centers with opportunities for increases in revenue, and Medicaid is one of them
- Matching share in Illinois is 50%, question is where to come up with the match?
- Matching Medicaid = getting credit for expenditures already being made
- There is lots of money left on the table from spending on services that could be getting Medicaid credit/funding
- Better expenditures for tax dollars exist
- Increasing Federal Medicaid revenues:
  - Take back hospital tax exemptions and spend them on Medicaid match

- Not a provider tax, but the same property and sales taxes other businesses pay
- Treat existing expenditures (local public funds) as matching funds
  - IGT: transfer from county to states, reallocate funds to Medicaid program
  - CPE: state auditors account for expenditures, an accounting mechanism, creates a paper trail
  - Go with IGT because can give the full dollar to state Medicaid
  - Check to see if there are CPEs that could be made IGT
- Impose health-care related taxes that are uniform throughout class, but do not have to be broad-based across all classes
  - Benefit: taxes revenue stream inflating at the same rate as expenditures

### Q & A

Has Cook County been following through on this sort of plan?

- Yes, we have been using IGTs since 1991 and draw on every dollar we can
- Bonnyman: need to ask now whether the *state* is exploring such opportunities

How does a property tax on hospitals trickle down? Would the promise of higher rates offset the cost of the tax for poor hospitals?

- It may be that some taxes wouldn't work in some areas, but looking at the big picture
- There is a fear of change, but dire needs open up these conversations

Regarding the Obama plan for Medicaid, have you talked to people about these savings assumptions?

- No. Tennessee saw the opportunity to get hospitals to give money (coverage fees) in order to get a larger share of the Medicaid pool
- The more states use their Medicaid funds, the more they are protected
- Think globally, about rural communities
  - If any of the current proposals take effect, they will be devastated. They rely heavily on Medicaid and hospitals are the largest employers in such areas.

***11:45am- Michael Gelder, Senior Advisor on Health Policy, IL Office of the Governor***

- Want to give the State's perspective
- IL is lucky, have commitment from the public and the governor for Democratic values – governor Quinn has made commitment to health care and social policies
- It is possible that we don't have the money to provide all the care we did in the past
- Message we get from public: people don't want to be taxed, people not covered have to fend for themselves, people do not want their own situation to change
- Like we are on the Titanic: those at the top are worried that they may be inconvenienced, the next few hours could be a disaster
- We need to do a better job with messaging – it is harder defining what the left progressive public thinks, need to be clearer and do this in a way that people

- understand. Technical discussions miss the opportunity to express what is important to us, which is people and improving value of services.
- We need to expand our discussion, cannot let the other side prevail.
  - Challenge of state budget: IL at the point of potential spending caps now. Income tax has increased, and state committed to spending caps – if spending goes over, the tax will be repealed.
    - o This is smart, means we will not spend revenue on new services, which would increase the deficit
    - o Revenue from tax increase is not available to spend on more services, and more coverage – it must be spent on paying back the deficit
  - So, where can the money come from to increase services? Not likely to increase taxes again.
  - Balanced spending vs. expectations
    - o How can we spend more efficiently as a state?
    - o Expectations are way higher than our spending potential
    - o There is no good dialogue yet – must look at different systems now, because we need more efficient spending and continued services
  - Quinn has embraced ACA, established a council, held hearings on various issues (ex. Medicaid expansion, and the need to change eligibility and enrollment systems because they are currently not sufficient to serve all new eligibles).
  - Goals:
    - o We need bridges between those offering coverage on exchanges and through Medicaid
    - o Need more private insurers to offer services in Medicaid and the exchange
    - o Get rid of “separate but equal” in the medical system, and bring access to care for everyone
  - Getting insurance to people could bring revenue to the safety net system.
  - The safety net needs to be seen as a desirable place to get care, not just the only place for some people – focus on value and outcome
  - Delivery system design: how to do more with less, increase case management, comprehensive health care delivery systems (primary, secondary, tertiary, mental, LTC, etc.)
  - Workforce issues: need providers to serve, and well trained providers
  - Health Information Technology – rely on technology to assure accuracy and improve quality.
    - o New federal money for technology investments
    - o Health Information Exchange is new (first meeting is Wednesday)
  - Have an exchange for health benefits, also want cooperatives to build insurance from the bottom-up
  - Accessible coverage without having to go through brokers (requires change to system) – can achieve through technology, online HIE, will hopefully drive down cost of insurance

### Q&A

1. I am concerned because as of July 1 there will be no more YourHealthcare Plus. What is in place for people who relied on these services?

The state needs to show the effectiveness of the care we provide (in terms of disease management). Currently, there are bad results from people on Medicare, with high re-hospitalization rates. We need to look at disease management in a more holistic way, looking at providers, the Department of Health and Human Services, etc.

2. Why has the state chosen not to do an early expansion of Medicaid?

We would consider an early expansion if there were a way to make it work for the state financially.

3. We will not be able to pay for the system you described (case management). Can you comment on that?

We spend a lot of money on care for people who would not require hospitalization if they had gotten good primary care. If we reallocate spending, we could cover disease management, and shift it from a stand-alone service to filling in the cracks before it is needed. We should integrate disease management into care first, through incentives to our doctors and nurses.

Prevention is currently neglected, and we pay the price. We need better primary care and prevention, and the question is how to incentivize?

4. Barrier to disease management is health illiteracy. How can we educate people to seek healthcare before they need emergency care?

We need to engage the healthcare delivery sector; we have to be the messengers. We need the personal and political will to allocate resources.

***12:30, Linda Rae Murray, MD, MPH, Chief Medical Officer, Cook County Dept. of Public Health; President, APHA***

- This is one of many HMPRG forums on the safety-net, past and to come
- Trends in our region, 2010 Census
  - Population decrease, especially for Black people, who are moving to the suburbs and collar counties
  - Amount of poor people is growing and the rich are getting richer
  - Suburbanization of Black and Latino people and poverty are not unique to Chicago area
- APHA is holding it's mid-year meeting on ACA with national speakers
- ACA
  - Be careful about calling it Obamacare, it's subtly racist
  - ACA is at most mild medical insurance reform
  - If ACA works perfectly, it will reduce uninsurance for those here legally by 50%
  - People without documents, who pay taxes like everyone else, are left out of the ACA. It violates the values of most Americans.
  - ACA gives money to some important things, but we will still have a messed up health care system.
  - ACA will not be repealed, but bill is still being killed by parts of it being cut

- The problem with financing medical care is for-profit insurance companies. We need to be able to say what we know, that single-payer is the solution. It is fiscally responsible.
  - In Vermont, there is the political will for single-payer, but still with obstacles, such as having to wait until 2017 to implement it as things stand now under the ACA.
- How do we provide access, address quality, address equity? We have to admit, and state, that we don't have the best health care system in the world.
  - We must ask much more than simply, How do we serve *those* people?
  - The outcomes we get for the money do not add up.
  - If you're poor or even a little poor, you get worse outcomes. The middle-class do worse than the rich, the rich in the U.S. do worse than the rich in other nations.
  - Do we believe that people in the U.S. deserve to be healthy?
- Some in Washington snuck into the ACA "various little pennies" to try to transform the delivery of medical care.
  - Medical homes, watered-down versions of primary care, ACOs that will hopefully be built on an older model of care, but these things might be designed only to control costs.
  - There are a few gifts under the ACA Christmas tree, but this does not change the fact that the system is sick
- Demonstration projects
  - Do teams work better? Does prevention make a difference? Does coordinated care make a difference? We already know they do. Most of these things are ways of saying we didn't have the political power to do the right thing.
  - Yes, we need to know how to hustle for money for our programs, but these hustles are not enough to keep the safety-net collectively alive.
- It's not acceptable that Dr. Murray cannot order colonoscopy or breast cancer screenings. Great racial inequity in breast cancer. Community health centers have to apply for grants in order to pay for care. Everywhere else in the world these things would be crimes.
- Our present health care system and safety-net are killing hundreds of thousands every year "because we're not willing to stand up and tell the truth."
- Safety-net is a wobbly wood structure, especially in IL and some other states. We're adding 500,000-800,000 to a shaky structure with holes in it.
  - Private sector is even less prepared to take on these new people than is the public sector in any kind of culturally competent way.
  - Public services accomplish many things better than private industry
- If you don't ask for what you need, you're never going to get it
- ACAs expansion of CHCs might get us up to 3000 across the country, a goal that was set long ago
- We need money for IT advancement, not just a grant, but to continually support this
- There is a lack of primary care in the U.S., we have 30% primary care, 70% specialists. This is the reverse in the rest of the world.

- Dr. Murray applauds the temporary bump in Medicaid payments
- If we don't address workforce issues we're in trouble, we must connect the issues.
- We can't allow the right things to be off the table.
- We can wage wars without raising taxes, but we can't provide health care?
- Scariest thing about health care is when schools talk about raising class sizes to 45 students. Chicago has a 50% graduation rate.
- The number of Black male medical students is decreasing
- If we continue to fail to invest in our people, we will not be able to produce the kinds of people who can solve our problems,
- *We must speak the truth*
- People in the health care field, whether they are capitalists or not, like Dr. Murray, agree on most things, but we are afraid to talk about them.
- How can we defend a bill (ACA) that we all know will not work?
- Neoliberal ideology has taken over. It twists basic American values. We're supposed to believe that that collective action is futile and that government can't do anything right.
- We've let people believe the medical system is working when it is not
- What can we do locally?
  - We have a public system that's in dire trouble. Imagine what would happen to U of C and Northwestern if the public system disappeared?
  - We can create a county health authority that merges city and county authority and build structures as models for everyone
  - We can transform the organization of medical care, otherwise we're all on our own
  - In bad times, with cuts all over, we often do the *right* thing
- Q&A
  - Raising taxes to raise pensions? We need real pension reform. We need to not just talk to legislatures, it's not enough, talk to the general public about the issues, connect the dots between issues. We must do more than simply talk—boycotts, pickets.
  - The city-county merger? We can remake a better, stronger public county system—create health districts in the county by churches, sororities, workplaces, etc, looking at what communities need, like more grocery stores. Yes it will take a while to work out what this would look like but it must be done.

### **1:30-3:15pm- *Systems Reform Panel***

#### **Karen Batia, Executive Director, Heartland Health Outreach**

- Serve some of the most vulnerable, specialize in homeless (~80,000 in Chicago)
- Supportive housing, allow people to live as autonomously as possible
- 5 basic tenets of Philosophy of Care
  - Human rights
  - Trauma-informed
  - Strength-based assessment intervention

- Harm reduction (acknowledge that people will still engage in high-risk behaviors, work w/ people and manage risks)
- Invite, embrace, and recognize differences (cultural competence)
- First priority for homeless is somewhere to stay, so Heartland provides housing options, build relationships, then offer medical care
- Heartland wants to transform the system, be advocates as well as service providers, want systems of care to work for the people
- Identify gaps, see lessons learned, then develop agenda for policy
- No one funding stream will pay for everything
  - Coordinating care = ability to respond to person, may not have one defined problem
- Service and system integration: if barriers, why are they there and how to break them down so they are no longer in the way of providing care
- There is money in the system that can be reallocated and spent more effectively
- Health homes and care coordination are key
  - What are the “right” health outcomes? Different populations require different outcomes
  - Health home ≠ medical home. Medical home is driven by a physician and is narrow definition, but a health home does include a medical home.
  - Need to look at a more comprehensive network
  - How and where to provide services?
    - Open access (no appt. necessary), makes it difficult to offer services because numbers change daily
    - Take a team to set locations, people will be there waiting and we can serve them.
  - Health records need to be mobile
  - How sickest and poorest not already entitled will get onto benefit rolls?
    - Need to overcome barriers to application and information

**Ray Werntz, Senior Consultant, HPN Worldwide, HMPRG Board Member**

- Employment based-healthcare changes, and implications for safety net
- PPACA seeks to deal with costs, quality, and access, but always seems that only one can really be addressed – as we try to tackle quality, access will become bigger issue
- Last year, many companies raising premiums, despite govt. efforts to curb
- Agree with Linda, we know what works but we lack willpower to make them happen
- ½ coverage financed by government, employers only fund about 25%
- ACA assumption that employment-based coverage will hold
- Breakdown of employment-based coverage:
  - 95% of employers with less than 50 employees
  - Are employers willing to continue to provide coverage? Is it still financially advantageous to provide coverage once exchanges are running?
  - If employers withdraw, adds to burden of the safety net
- Exchanges are not a good way to grow coverage, instead should use community-based health plans

- Community-base health plans:
  - o Coordination of all stakeholders; all are part of conversation, organization and delivery of services in the system
- Cooperative plans:
  - o If done right, serve interests of covered population and structured properly, they can be extremely effective
  - o Another way to finance community-based health plan
- Access Health
  - o Truly innovative
  - o Targets micro-businesses (less than 50 employees), which addresses “hot spot” of 95% of businesses not under the mandate to provide coverage
  - o Health Advisors take all determinants of health into consideration, focus on people not just problems
  - o Health advisors are total-person oriented, not just direct health services
- AFSCME Council 31: typical cost-increase problem, tried launching a health benefit plan with two plans similar to Access Health (one with higher premiums and deductibles)
  - o 95% choose the better plan, currently in 52<sup>nd</sup> month, costs are lower
- Access Health vs. Council 31
  - o Participant agrees to work harder to improve health, emphasis on health self management
  - o Both see costs lower

**Tina Spector, Vice President for Quality, Sinai Health System**

- CMS/Premier Demonstration Project
  - o 6-year project, focus on 5 clinical conditions
  - o Incentive payments to hospitals in top 10% and 20%, penalties for hospitals below threshold
  - o Project expanded after 3 years, add more measures
  - o “Go-green dashboard”: Sinai managed to improve in many areas
- Framework for leadership of quality
  - o Board commitment to quality
- Quality strategic plan – work on important areas, annually updated, every department has a plan that flows from this overall plan
- Build the will – understand performance compared to best practices, basic classes about quality, train people to look at data in statistically important way
- Use dashboards on all levels – to understand performance
- Dashboards show that pay-for-performance areas match up with services our patients need
- “Simply the Best” (HCAPS training) now required for every new employee
- Project RED – looks to reduce readmissions by managing heart failure patients across the continuum of care
- Teams working on reducing infections, working to zero

QUESTIONS:

1. Are the models you described replicable for other institutions?
  - Karen: Yes, however have to have a large enough organization to sustain the work and have a workforce willing to manage a culture of change
  - Tina: Everything we have done can be done by another safety net hospital, we learned from others so it is all very possible, all about leadership and willingness to change
  - Ray: employers can influence their health plan (see it as a way to change interaction between hospitals and patients); it is doable. Community health plans require architecture that brings patient more into relationship with doctor and others involved, changes expectations of patient in this relationship
  
2. Clarify \$1,800 per person statistic you used?  
For one person per year
  
3. Incentives and disincentives for participants in the program you described? What types of employers are we talking about?
  - Two different plans, incentives are similar
  - One better plan – the individual evaluates the differences, understands that for a better low cost plan they have to work harder or choose more expensive plan if they don't want to work more.
  - Only do the things you can control, a teaching plan for consumers, teach them to think about their role in health care in a new way – make choice to change (stop smoking, be more active)
  - Consumers not held accountable for failing, we have learned that we can be just as effective this way. Got a large number of people to change their behavior just be reminding them to keep trying.
  - Teaching people the skills to gain respect in their own health care.
  
4. Is it impossible to imagine community based health plans on an exchange? Does it have to be either-or?
  - Exchanges are highly regulated in terms of what they can provide etc.
  - Cooperative plan done right can be more flexible, more realistic
  - In exchange plans, some things are unrealistic

Closing:

**Margie Schaps, Executive Director, HMPRG**

Thanks to speakers, and to Roberta for being our facilitator

- We are in a new world
- I hope speakers have provided us with lots of ideas for this new landscape
- We have to think about new alliances, really thinking about communities, how we can improve health and quality of services
- Something for all to think about
- For me, this conference has raised new questions and ideas
- If you want to stay engaged in this discussion, there is a website – IL Health Matters (5 orgs, and HMPRG involved)
  - o Robust place, dialogue about IL health reform

- If you have questions or ideas to throw out, go to the facebook page and post
- Please fill out the evaluation forms