Health Care Law and You: Providers

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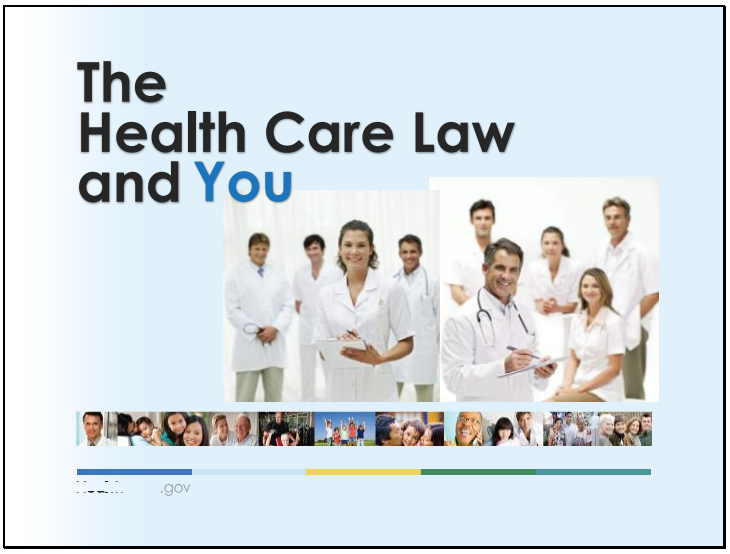

Hello, my name is XXX. And I'm glad to be with you today to talk about the health care law, the Affordable Care Act – and what it means for you, your patients, and your practice.

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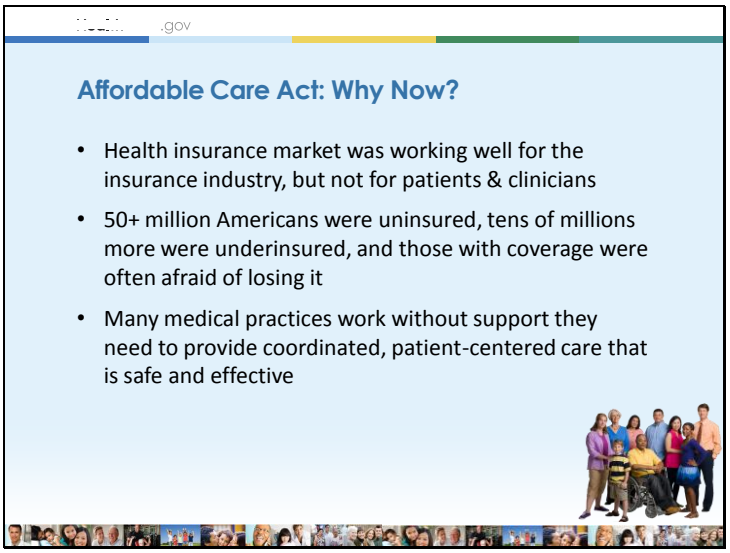
Health Care Law and You: Providers

Slide 2



The Affordable Care Act (ACA) was signed into law in March 2010. You may have concerns about how ACA will affect you and your practice – your reimbursement, your independence, and the welfare of your patients.

The first question is: why did we need the health care law? The answer is that we had a health insurance market that worked very well for big insurance companies, but not so well for patients and providers. Insurers premiums were skyrocketing even as insurers made record profits. Fifty million Americans were uninsured and tens of millions more had coverage that didn't cover critical treatments and preventive care.

Our health care system is full of barriers, roadblocks, and red-tape—ranging from the way we pay for health care services to a lack of usable, reliable information for patients and clinicians alike—that often keep health care professionals from practicing medicine in a collegial, evidence-based, and patient-centered manner.

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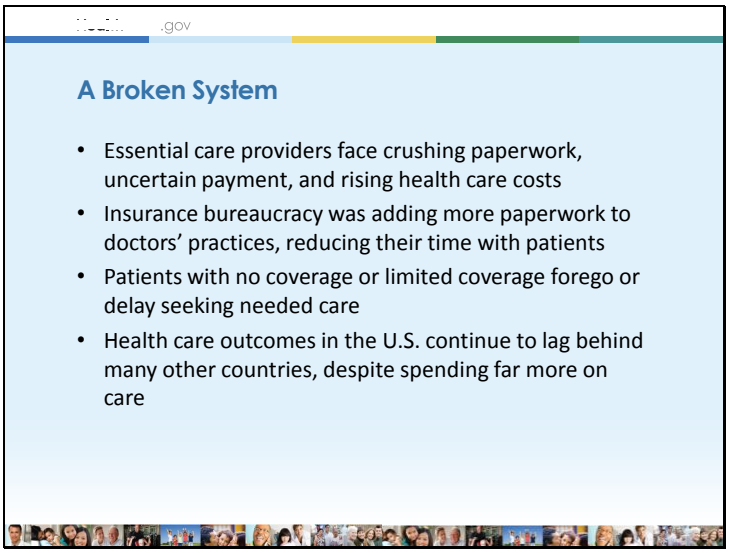


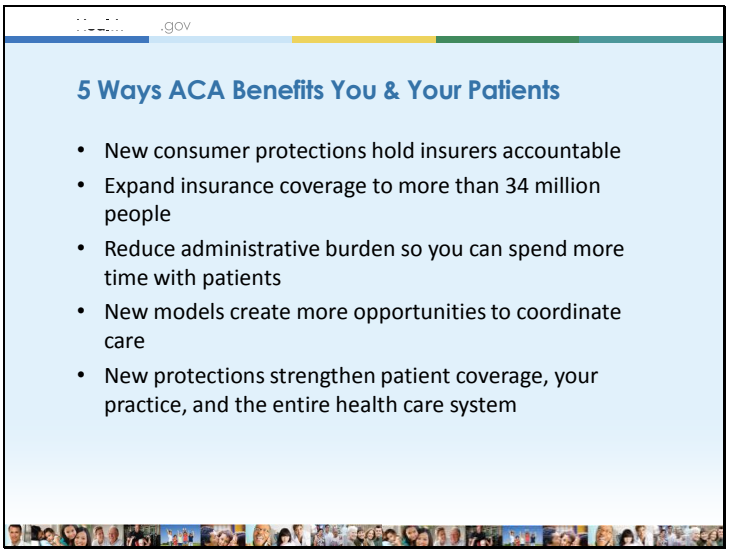
Despite having the world's best trained doctors and nurses, the most advanced medical technology, and the finest hospitals, Americans continue to live sicker and die sooner than our peers around the world.

Too many patients have been harmed by a health care system that's supposed to help them get well and stay healthy. Too many doctors and nurses have seen their best intentions frustrated by a fragmented system with backward incentives.

Each year, health care costs consume a greater share of our paychecks, corporate balance sheets, and local, state, and federal budgets with no signs of slowing down.

Health Care Law and You: Providers

Slide 4



The law replaces some of the worst excesses and abuses of the health insurance industry with strong consumer protections and administrative simplification provisions, and has the potential to bring considerable financial and clinical benefits for providers across the health care spectrum.

The law enacts comprehensive reforms that will hold health insurance companies accountable, protect you and your patients, and guarantee choice and control.

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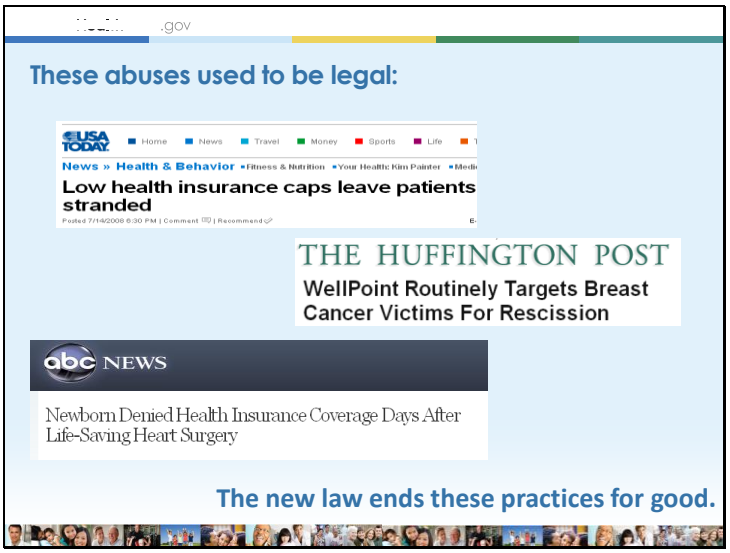
Health Care Law and You: Providers

Slide 5



I'm sure you've all heard stories like these.

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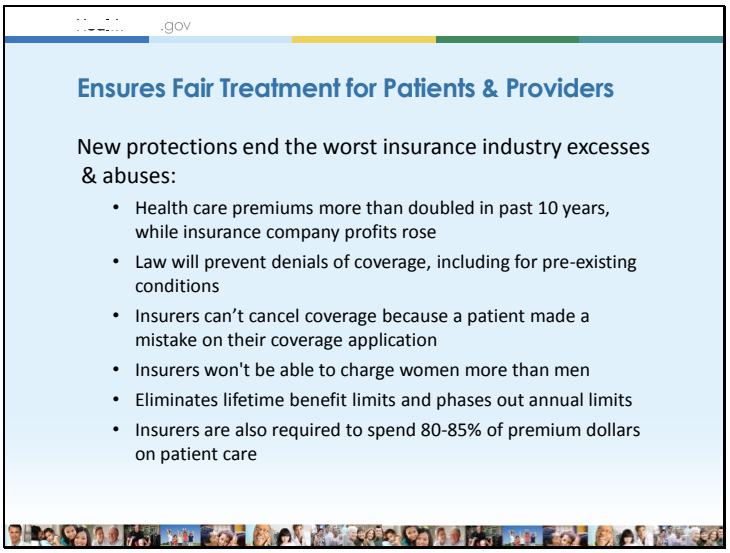
Slide 6



It is now illegal for insurance companies to:

- Deny coverage to children because of a pre-existing condition like asthma and diabetes.
- Put a lifetime cap on coverage
- Cancel coverage because of paperwork mistakes

Other consumer protections in law include:

- Annual limits to coverage are being phased out and will be banned in 2014.
- Consumer access to an independent appeals process for insurance company disputes
- Insurers can't charge an extra co-pay for an out of network emergency room.
- Consumers can choose their own primary care physician in your insurers network, and can see a pediatrician or an OB-GYN without a referral.

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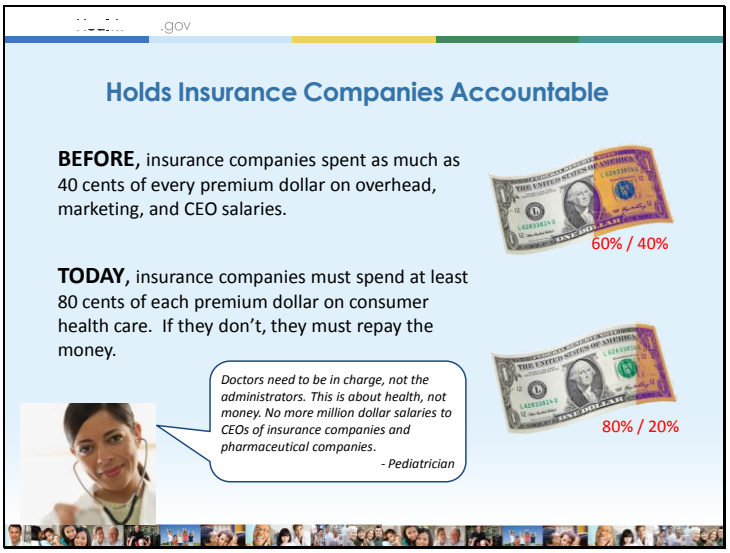

The law brings down health care costs and makes sure health care dollars are spent wisely. Before, some private insurance companies spent almost half of premiums on overhead, leaving only 60 cents of every premium dollar to spend on care.

The health care law mandates that insurers must now spend at least 80 percent of premiums on health care services or improving care, or they must repay the money.

The law also has new rules that require insurance companies to publicly justify any rate increase of 10 percent or more. And it gives states new resources to review and block these premium hikes.

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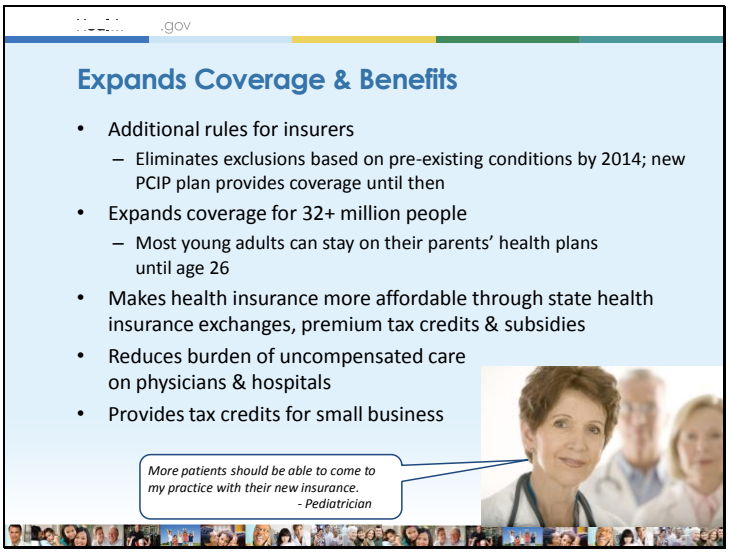

Each of these improvements helps fill gaps in the health care system. But these changes are just the beginning. In 2014, a new marketplace called an Affordable Insurance Exchange will be created in every state for families and small business owners who buy their own health insurance.

These marketplaces will function like Expedia or Orbitz for health coverage. Consumers will be able to go to a website and easily compare coverage options. And the law includes a few important rules set up to protect consumers. No turning people away because of pre-existing conditions. No charging women more just because they're women. There are significant tax credits on a sliding scale for middle class families. There will be better access to Medicaid. And Members of Congress have to get their coverage in the exact same marketplace your patients do.

[*FOR THE SPEAKER'S REFERENCE:*
Medicaid is expanded up to 133% of the federal poverty level – about $15,000 for and individual or $30,000 for a family of 4.
Tax credits are available for those under 400% of the federal poverty level who are not eligible for other affordable coverage – about $45,000 for an individual or $90,000 for a family of 4.]

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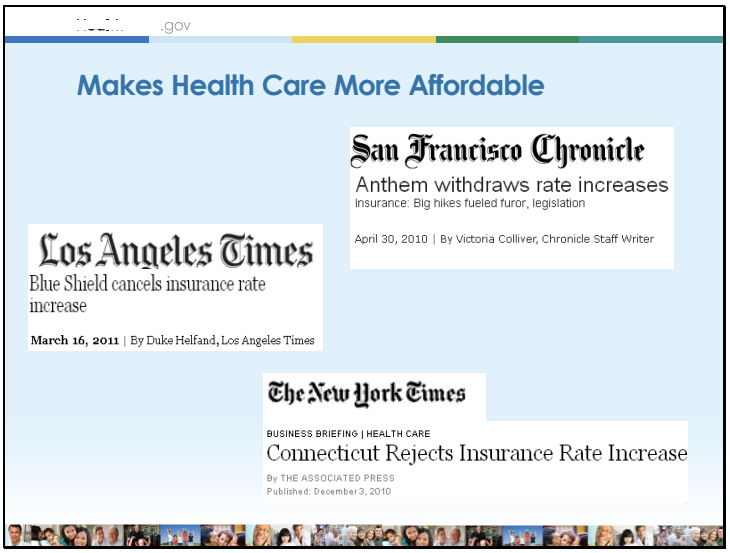

And we're already seeing these rules pay off across the country.

[FOR THE SPEAKER'S REFERENCE:
Additional rate review success stories include:

- Connecticut's Insurance Department rejected a proposed 20% rate hike by one of the state's major insurers.
- In August 2010, a major insurer in Massachusetts agreed to a significant reduction of proposed increases – less than 13% instead of the nearly 23% they initially requested.
- In 2010, Oregon disapproved health insurance premium requests of 10%, 18%, and 20% in the individual market.
- Rhode Island's Insurance Commissioner used his rate review authority to reduce a proposed rate increase by a major insurer in that state from 7.9% to 1.9%.
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7% cut to 14% following a public outcry.
- In 2010, Californians were saved from rate increases totaling as high as 87% after a California insurer withdrew its proposed increase after scrutiny by the State Insurance Commissioner.

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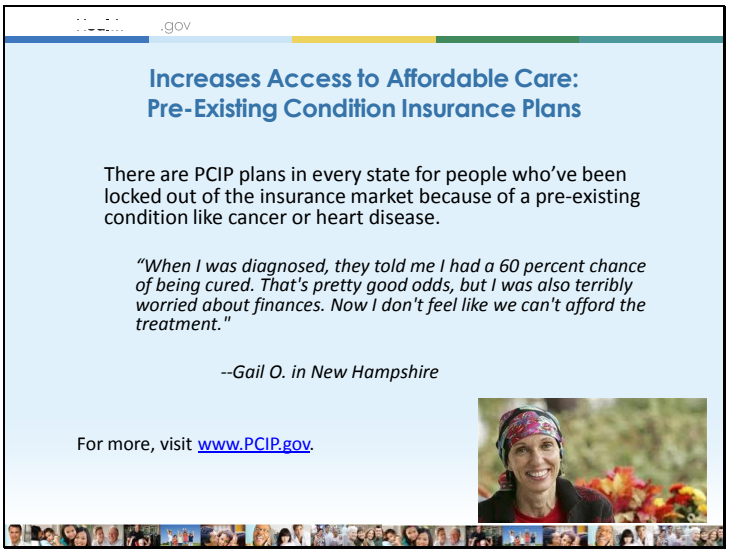
Slide 10

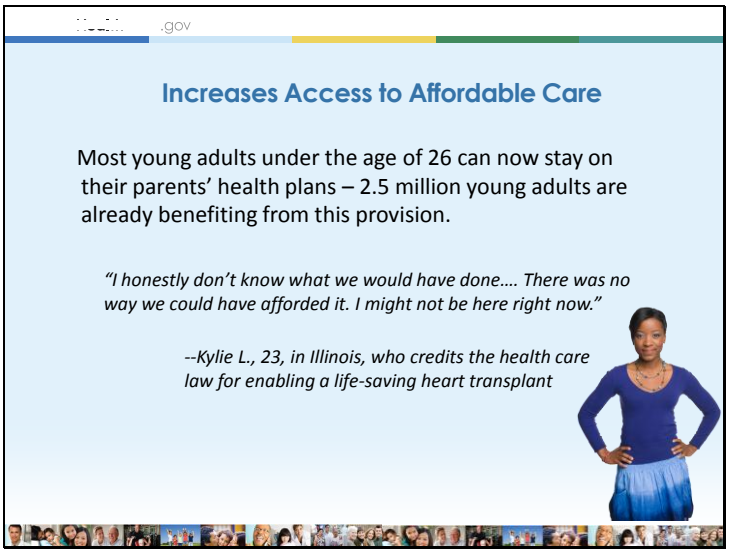


Under the old system, no one got a worse deal than the 129 million Americans with pre-existing conditions. When buying coverage on their own, insurance companies could hike their rates, carve out needed benefits, and, in many cases, lock them out of the insurance market altogether. For people with potentially fatal conditions like cancer, this often meant they couldn't afford the treatments that could save their lives.

The health care law has given Americans who've been locked out of the market for their pre-existing conditions a new coverage option. As a result, tens of thousands of Americans with serious health conditions across the country are now getting the health insurance they need.

You may already know this, as doctors have been a top source of referrals for people eligible for PCIP.

Slide 11



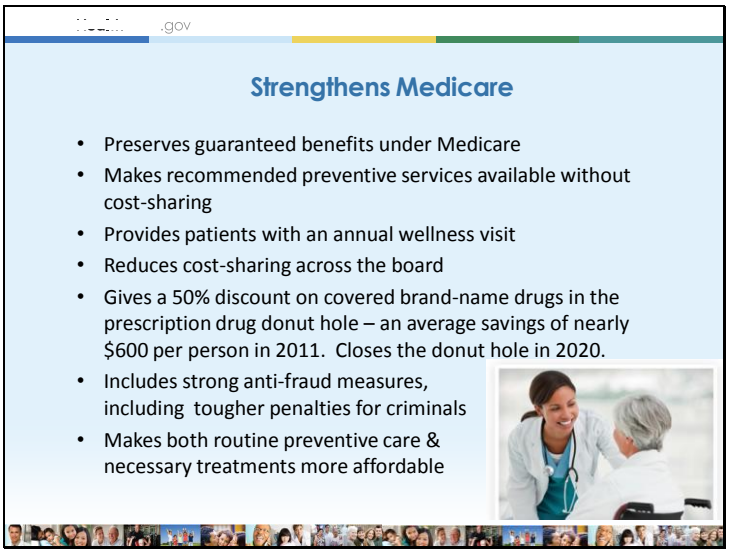
The third key part of the law is a set of improvements that increases access to affordable care. For years, young adults have had some of the highest rates of being uninsured.

Most young people lost their family coverage when they graduated high school or college and it was often a few years before they got a job that offered good health coverage. Even then, they could lose their coverage if they lost their job. That meant that if they had a car accident or an unexpected diagnosis during this period, they could go broke or their families could go broke – or worse, they might not be able to afford the care they needed.

Now, under the law, young adults who don't get coverage through their jobs can stay on their parents' plans until age 26 – a change that has already allowed 2.5 million young adults to get health coverage and given their families peace of mind.

Health Care Law and You: Providers

Slide 12



You got into the health care profession to serve patients — ACA protections are designed to help you keep serving them.

Nearly 50 million older Americans and Americans with disabilities rely on Medicare each year. First, the law makes key preventive services free so no senior ever has to skip a potentially life-saving cancer screenings because they can't afford it.

Second, it gives beneficiaries in the donut hole a 50 percent discount on their covered brand-name medications. In the past, as many as one in four seniors went without a prescription every year because they couldn't afford it. Now, the seniors with the highest out-of-pocket prescription drug costs are getting an average of nearly $600 in relief, and the law will close the donut hole by 2020.

Third, the law provides a historic boost to efforts to crack down on Medicare fraud. In 2010, those efforts returned a record $4 billion, and the law gives law enforcement even more tools to go after those who steal from Medicare.

Fourth, the law contains changes that will make it easier for you to deliver the care that works best for patients. We know that a person with Medicare who has multiple chronic conditions may see as many as 14 doctors in a year. The law will help you spend more time with patients, focus on prevention, and work closely with your colleagues to coordinate care.

And since the law passed, Medicare costs have actually been going down. This year *[2012]*, average premiums for the Part D standard benefit and Medicare Advantage plans will be lower than they were in 2011. And Part B premiums will go up far less than was predicted.

What this means for seniors overall is a stronger Medicare program that better meets their needs.

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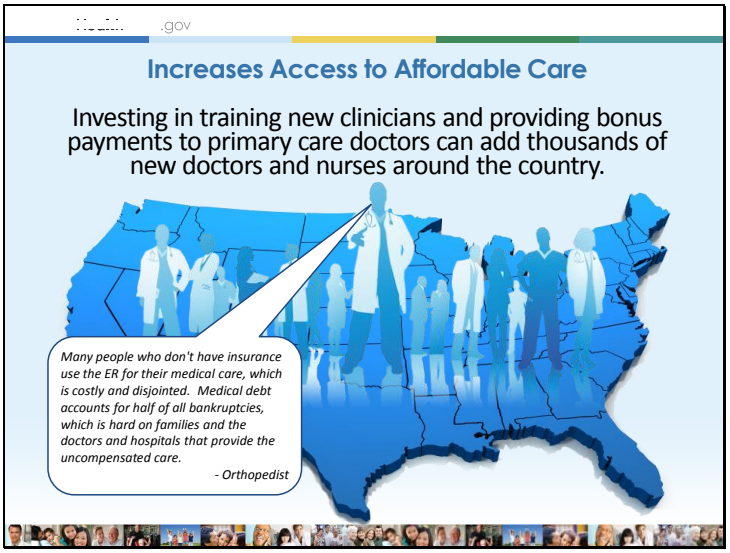

But we all know that health insurance wasn't the only obstacle to care.

That's why the health care law also invests in training and placing thousands of new doctors and nurses, and it provides bonus payments to primary care doctors. The law is also creating and expanding health centers across the country.

As a provider, this will help you see and spend more time with your patients.

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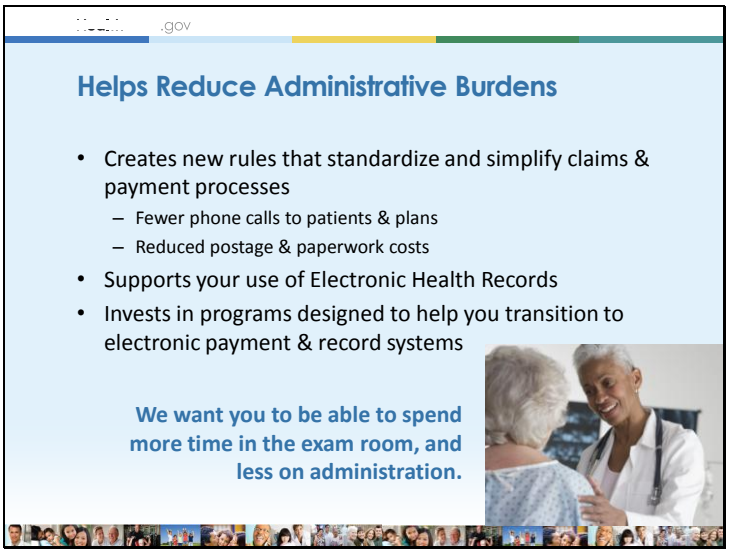

<u>We are taking new steps to simplify paperwork , eliminate red tape and support use of electronic health records.</u>

New rules make it easier for providers to determine whether a patient is eligible for coverage and the status of a health care claim submitted to a health plan.

The new rules save an estimated $12 billion for physicians, other health care providers, and health plans by reducing transaction costs in the form of fewer phone calls between physicians and health plans, lower postage and paperwork costs, fewer denied claims for physicians, and a greater ability to automate health care administrative processes.

Patients benefit from more accurate information about their out-of-pocket costs at the time of service, and expanded access to care as clinicians will have more time to spend treating patients by spending less time calling health plans.

Additional rules to be implemented between 2012 and 2016 will be adopted for electronic funds transfers, payment and remittance advice, claims, health plan premium payments, referral and certification, and enrollment and disenrollment. Physicians should benefit from the changes, which will make it easier to track claims and, in many cases, should improve physician revenue cycles and reduce overhead costs.

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Health Care Law and You: Providers

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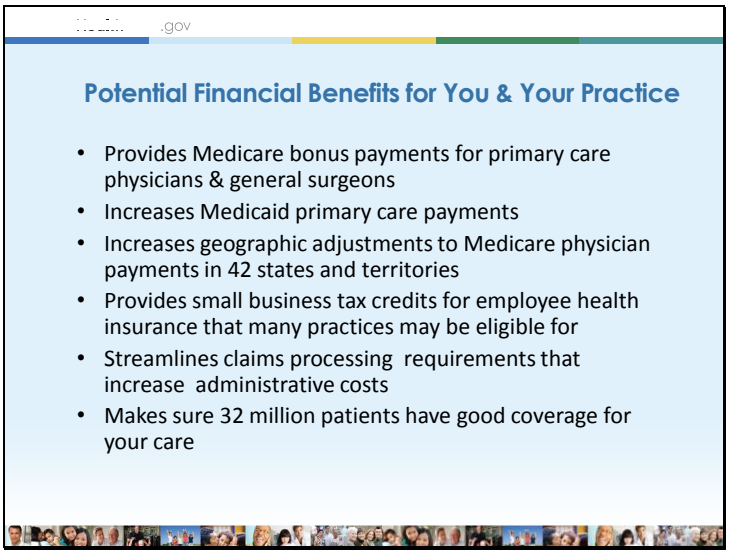

The Affordable Care Act also has the potential to bring considerable financial benefits for providers across the health care spectrum.

Medicare Payment Changes
•10 percent incentive payments for primary care services furnished by primary care physicians.
•10 percent incentive payments for general surgeons performing major surgery in health professional shortage areas.
•5 percent incentive payment for mental health services.
•Increased geographic payment adjustments.
•New funding for doctors in primarily rural and low-cost payment areas
•Extended Medicare quality reporting incentive payments.

Medicaid Payment Changes
•Raises Medicaid payments to family medicine physicians, general internists and pediatricians for evaluation and management services and immunizations to at least Medicare rates in 2013 and 2014.
•Provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

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Health Care Law and You: Providers

Slide 16

NEW PAYMENT AND DELIVERY REFORM MODELS

The Affordable Care Act also created a new Innovation Center in the Centers for Medicare and Medicaid Services –specifically designed to identify and test new care and payment models to deliver greater value for our health system and then to rapidly spread what works. Thanks to input from hundreds of outside innovators we've developed a menu of initiatives that engage different types of providers and payers. Each initiative holds the promise of reducing health care costs, improving quality, and improving health care.

The law includes several demonstration programs to test and evaluate a variety of new voluntary payments models.

Looking Forward

The Innovation Center is not only testing new models of care delivery and payment, it's also changing the way we partner with providers and conduct demonstration projects. The Innovation Center is committed to providing participants with more timely and useful data to improve and coordinate care, rapid-cycle evaluations on their performance, and new opportunities to learn from each other -- so that success is not just a report—but tangible to providers and patients across the country.

Providers will have tools and resources available to them to help spread best practices, lessons learned, and improved care strategies so that innovation is not limited to a demonstration site or only one particular community.

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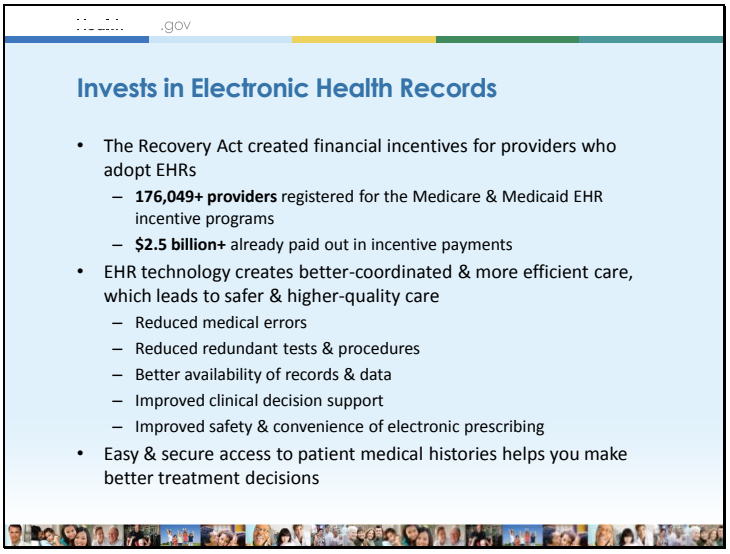
Health Care Law and You: Providers

Slide 17



Meaningful use of EHRs leads to improvements in patient and quality care, including reduced medical errors, increased availability of records and data, improved clinical decision support, and the improved safety and convenience of electronic prescribing.

E-prescribing can improve patient safety by reducing the possibility of a medication error due to various causes, such as poor handwriting.

Laboratory tests or x-rays downloaded and stored in the patient's EHR make it easier to track and share results.

Automatic alerts built into EHR systems direct attention to possible drug interactions or warning signs of serious health conditions.

E-prescribing also lets providers send prescriptions electronically to the pharmacy, so medications can be ready and waiting for the patient.

Slide 18

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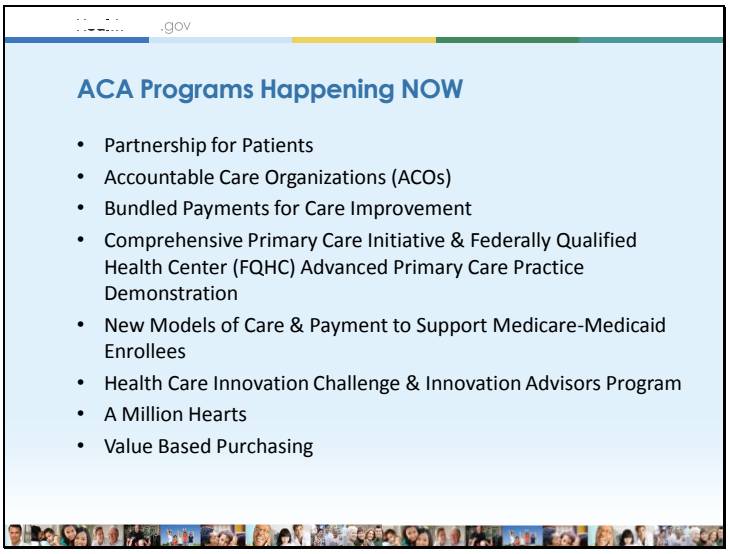
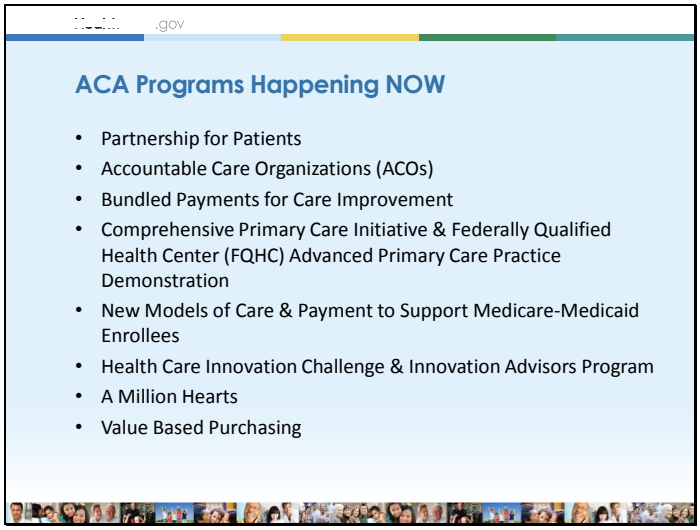


These are just some of the initiatives launched to date as a result of the Affordable Care Act:
Partnership for Patients: The Partnership for Patients initiative is a public-private partnership with hospitals, physicians, nurses, other clinicians, consumer groups, and employers to reduce hospital-acquired conditions and preventable hospital readmissions. The Partnership's two goals: **to reduce preventable harm in hospitals by 40% and readmissions to hospitals within 30 days of discharge by 20% in the next 3 years**. Over 7,100 organizations participating as of January 2012, including more than 3,200 hospitals. The Partnership is investing up to $500 million in public private engagement networks that will help hospitals adopt proven strategies to reduce hospital-acquired conditions in their own facilities and systems. The Community-based Transitions Program, is a $500 million initiative to reward hospitals, physicians, and others who partner together to keep patients out of the hospital after discharge. Taken together, the Partnership has the potential to save 60,000 lives, reduce millions of preventable injuries and complications in patient care and, by meeting its goals, save our health care system as much as $50 billion over 10 years, according to the CMS Office of the Actuary.

Accountable Care Organizations (ACO): The **Pioneer ACO Model** tests the rapid transition to a new payment model where experienced organizations are paid according to their ability to improve the health of their patient population, rather than for each specific service they provide. 32 organizations are participating in the Pioneer ACO Model to test what can be achieved through highly coordinated care for more than 850,000 Medicare fee-for-service beneficiaries. According to the independent CMS Office of the Actuary, this model is projected to save Medicare up to $1.1 billion over 5 years. The **Advanced Payment ACO Model** will test whether pre-paying a portion of future shared savings will allow more physician-based and rural ACOs to participate in the **Medicare Shared Savings Program.** In the Shared Savings Program, groups of providers come together as accountable care organizations and can share in savings they generate for Medicare if they meet certain quality improvement metrics. The Innovation Center is still accepting applications for Advanced Payment ACOs, which will start in April and July of this year in concert with the first two enrollment periods for the Shared Savings Program.

Bundled Payments for Care Improvement: Patients experience care in episodes, often visiting multiple doctors' offices, hospitals, and laboratories as they seek treatment and recovery. The **Bundled Payments for Care Improvement initiative** builds on episode-based payment models pioneered in the private sector by redesigning payment to match the patient experience. It offers providers 4 patient-centered episode of care models to choose from, allowing providers the flexibility to choose the conditions they believe make sense to bundle, decide how best to work together to deliver high-quality, coordinated episodes-of-care, and determine participating providers' share of payment. Health care organizations will give Medicare a discount off the current cost of care for the episodes covered under the initiative, thereby ensuring Medicare Trust Fund savings.

Slide 19



NOTES cont'd: **These are just some of the initiatives launched to date as a result of the Affordable Care Act:**

Comprehensive Primary Care Initiative & Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration: The **Comprehensive Primary Care Initiative** is a collaboration between public and private payers and primary care practices to support patient-centered primary care in communities across the country. Primary care practices will receive new, public, and private funding for primary care functions not currently supported by fee-for-service (FFS) payments, including an opportunity to share net savings generated through this program. In return, participating practices will agree to give patients 24-hour access to care, create personalized care plans for their patients, and coordinate with other providers to ensure patients are getting healthy and staying well. The **Federally Qualified Health Center Advanced Primary Care Practice Demonstration** tests whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs. In October 2011, 500 community health centers in 44 States were selected to receive approximately $42 million over 3 years to reorganize as Patient Centered Medical Homes and improve the coordination and quality of care they give to people with Medicare and other patients.

New Models of Care & Payment to Support Medicare-Medicaid Enrollees: Working with the CMS Medicare-Medicaid Coordination Office, the Innovation Center is empowering States to test new payment and service delivery models that will help improve quality of care, and reduce the costs of care, for the nearly 9 million people enrolled in both the Medicare and Medicaid programs. These people account for 21% of Medicare beneficiaries but 36% of Medicare spending, and 15% of Medicaid recipients but 39% of Medicaid cost. To date, 15 States have been awarded design contracts of up to $1 million to develop new ways to meet the needs of this complex population. Additionally, the Innovation Center and the Coordination Office have offered States the opportunity to move beyond the design phase and test new models of payment and care coordination in their States. 38 States and the District of Columbia have expressed interest in working with CMS.

The **Innovation Advisors Program** seeks to deepen the capacity for transformation by creating a network of experts in improving the delivery system for Medicare, Medicaid, and CHIP beneficiaries. The Innovation Advisors will: use their knowledge and skills in pursuit of the three-part aim of improving health, improving care, and lowering costs through continuous improvement; Work with other local groups to drive delivery system reform; Develop new ideas for possible testing by the Innovation Center; and build durable skill in system improvement throughout their area. In December 2011, the CMS Innovation Center selected 73 individuals out of 920 applications to participate in the initiative.

A Million Hearts: A national initiative to prevent 1 million heart attacks and strokes over the next five years.

Value Based Purchasing: Starting in October 2012, Medicare will reward hospitals that provide high quality care for their patients. This program marks the beginning of an historic change in how Medicare pays health care providers and facilities—for the first time, hospitals will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide. In FY 2013, the

Hospital Value-Based Purchasing Program will distribute an estimated $850 million to hospitals based on their overall performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. This will be taken from what Medicare otherwise would have spent for hospital stays, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance. This redirection is intended to result in significant, additional savings to Medicare, taxpayers, and enrollees over time.

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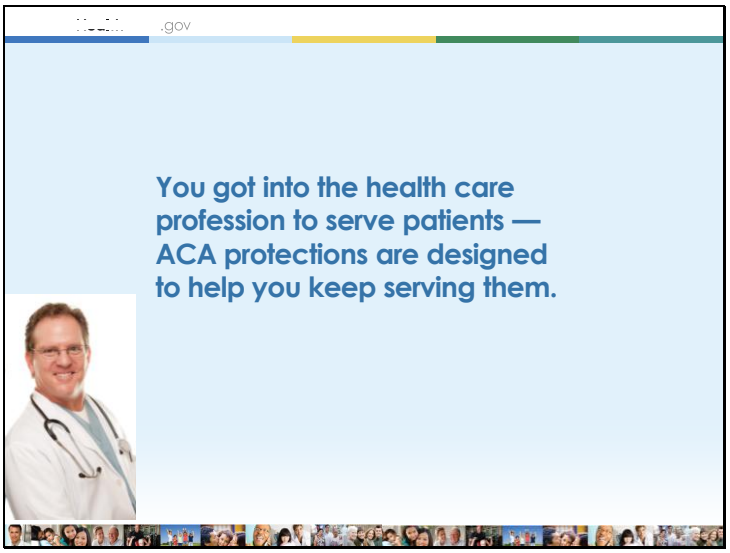

And as you think and talk about the law, you should also remember the key benefits for you and your patients:

The health care law protects people from the worst insurance company abuses. It drives down costs. It gives you support to better care for your patients. It gets your patients access to the care they need.

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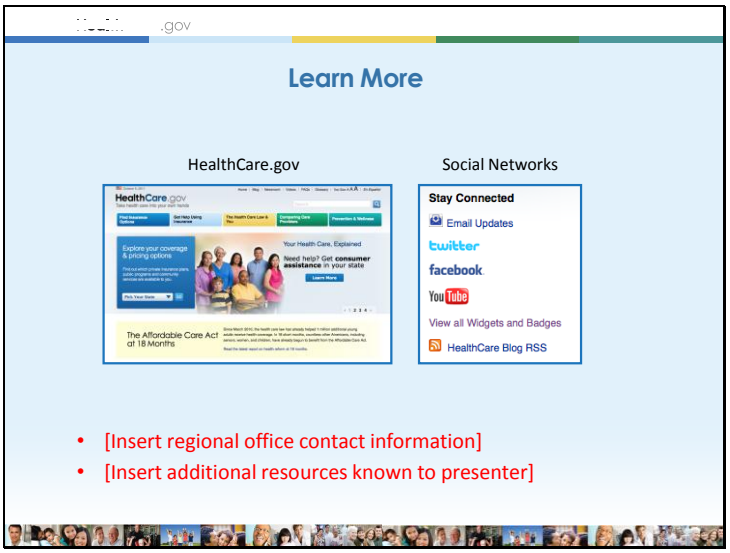
Slide 21



The health care law is a work in progress. But it has already made huge improvements that over time will touch every American in some way.

To learn more about the law and any of the new benefits I mentioned, please go to healthcare.gov. You'll find information and plenty of resources you can share with your friends and family.

Thank you.

http://www.hhs.gov/intergovernmental/acaresources/