

MEMORANDUM

To: Oregon Health Policy Board

From: Office for Oregon Health Policy & Research

Re: Potential Impacts of Federal Reform on OHPB Committees and Councils

The enacted federal reform legislation (H.R. 3590) includes provisions that provide coverage to 32 million uninsured people, adopt reforms in insurance industry practices, and make major investments in public health and health delivery systems.

The attached documents provide an overview of the major provisions under federal reform which will impact the work of the committees and councils of the Oregon Health Policy Board and the Oregon Health Authority.

This analysis is ongoing as further guidance will be provided by federal agencies. We will provide updated documents as new information is known.

Key Elements for the Workforce Committee

Where Does Federal Reform Get Us?

- **Prioritizes the primary care workforce:**
 - Primary care payment bonuses in Medicare (starting 2011) and Medicaid (2013-14).
 - Increased loan amounts, better repayment terms, and tax exclusions under the National Health Service Corps.
 - Primary care extension program to support local primary care physicians.
 - Unused residency slots redistributed with priority to primary care.

- Takes some steps towards **interdisciplinary education and training providers** for new models of care delivery, e.g.:
 - Gives preference to primary care training programs that “propose innovate approaches using models of primary care such as the patient-centered medical home, team management of chronic disease, and inter-professional integrated models of healthcare” for grant awards.
 - Includes training in “team-based service” in the new Public Health Sciences track.
 - Authorizes physician assistants working in collaboration with physicians to order post-hospital extended care services under Medicare, effective Jan 2011.

The bill also creates opportunities for state- and local-level experimentation with new models of care delivery, such as medical homes, community care teams, or accountable care organizations.

- Takes some steps towards **reducing the debt burden** for health professions students and faculty, e.g.:
 - New loan repayment programs for public health professionals, pediatric subspecialists, allied health professionals, dentistry.
 - Increased loan amounts for nursing students and faculty.
 - Increased faculty loans and student scholarships for minorities.
 - Tuition remission and stipend in return for service in Public Health Sciences Track.
 - See also note under first bullet about loan changes for the NHSC.
- Creates structures for **coordinated workforce data collection, analysis, and planning**:
 - National Center for workforce analysis created; state and regional centers authorized.

What Doesn't It Do?

- Does not say much about *where* the workforce should be trained or deployed, or *how* it should be used (with the possible exception of new flexibility in what kinds of training locations count for DGME and IME funding, which may allow medical residents to spend more time in community and independent settings instead of hospitals).
- Limited provisions to address immediate workforce needs, with a few exceptions:
 - Medicare 5% payment increase for psychotherapy in 2010 and 10% primary care payment bonus starts January 2011.
 - Flexibility in Medicare funding for medical education (DGME and IME) starts July 2010.
 - National Health Service Corps funding increase starts FY2010, ***if appropriated***.
- The law's provisions aimed at increasing the number of health profession students, improving the pipeline into professional healthcare training, or retaining currently employed professionals may not be large enough to have a significant impact in Oregon.

Of Note –

- The list of high-priority topics for **National Healthcare Workforce Commission** includes:
 - Integrated workforce planning and maximizing skill sets across disciplines.
 - Needs for HIT.
 - Aligning Medicare & Medicaid policies with national workforce goals.
 - Education and training capacity, projected demands, and delivery system integration of: nursing (all levels), oral health, mental & behavioral health, allied and public health, EMS, geographic distribution of providers as compared to need.

Key Payment Provisions for Incentives and Outcomes Committee

Where Does Federal Reform Get Us?

Medicare Payment –

- **Modifies payments to physicians:**
 - Increased payments for primary care physicians.
 - Beginning January 1, 2011 and continuing for five years, primary care providers will receive 10% bonus payments for evaluation and management services.
 - Increased payments for general surgeons practicing in physician shortage areas.
 - Beginning January 1, 2011, the bonus payment program for physicians practicing in physician shortage areas will be extended to include a 10% bonus for general surgeons on major procedure codes (in addition to the existing 10% bonus for primary care physicians practicing in shortage areas).
 - Quality-based payment adjustments for physicians in Medicare.
 - Physicians will continue to be paid a bonus to report quality data through 2014; beginning 2015 physicians will be penalized for not reporting the data.
 - Beginning in 2013, physician base payments will be modified based to reward quality, according to risk-adjusted measures of health outcomes and costs.
 - Feedback to physicians on resource use.
 - CMS must develop an episode grouper to allow measurement of resource utilization by physicians for episodes of care and must make the methodology public.
 - Geographic adjustments to physician payment.
 - CMS must revise the practice expense adjustment to the physician base payment to more accurately reflect practice expense variations by 2012.
 - In the meantime, the amount by which payments are modified downward to reflect lower than average practice expense under the current formula will be reduced by 50%. This affects Oregon physicians outside the Portland payment area because their practice expense under the current formula is 93% of the national average. Portland area physicians are unaffected because the geographic modifiers raise their payments above the base.
 - In addition, the legislation re-instated the physician work floor, which means that the physician work adjustment will continue to be used only to upward adjust physician payments — not to downward adjust them in communities where professionals are paid less than average.
- **Modifies payments to hospitals:**
 - Hospital inpatient payment adjustments for high readmission rates.

- Base payments will be reduced for hospitals with higher than expected risk adjusted readmission rates for conditions identified by CMS, beginning with heart attacks, heart failure and pneumonia. Reductions cannot exceed 1% in FY 2013, 2% in FY 2014, and 3% in FY 2015.
- Readmission rates will be posted on the CMS website.
- Hospital inpatient payment adjustments for high incidence of hospital acquired infections.
 - Base payments will be reduced 1% for hospitals in the top quartile for incidence of hospital acquired infections beginning FY 2014. Rates will be made public.
- Quality-based payment adjustments for hospital inpatient services (“Hospital Value-based Purchasing Program”).
 - CMS must develop a program of incentive payments that would hold back a percentage of the base rate (1% in federal fiscal year 2013 and increasing to 2% in 2017) and use those funds to reward hospitals that meet quality and efficiency standards.
 - The program does not apply to critical access hospitals or hospitals with insufficient numbers to measure quality, but requires CMS to conduct demonstration programs to test systems for rewarding quality in such hospitals.
- Geographic adjustments to hospital payments.
 - CMS must revise the hospital wage index to address specified issues.
- Bonus payments for hospitals in low cost communities.
 - Medicare will spend \$200 million each year in FY 2011 and 2012 to increase hospital payments in counties that rank in the lowest quartile for Medicare fee for service spending. Assuming Oregon hospitals qualify, they are likely to receive increases to their base pay of something less than one-half of one percent each year.
- Reduces Medicare disproportionate share hospital payments beginning FY 2014.
- **Modifies payments to other facilities and providers:**
 - Prospective payment system for federally qualified health clinics.
 - CMS must develop a payment neutral prospective payment system for FQHCs and implement it in 2012.
 - Quality reporting and payment programs for other facilities and providers.
 - CMS must begin quality reporting programs for long-term care hospitals, inpatient rehabilitation hospitals, inpatient psychiatric hospitals, cancer hospitals, and hospice programs by FY 2014. CMS must submit a plan for value-

based purchasing for skilled nursing facilities and home health programs by FY 2012.

- **Modifies Medicare Advantage:**
 - Reduces Medicare Advantage payments.
 - Beginning in 2012, payments for Medicare Advantage plans will be calculated under a new formula. Benchmarks, which are the basis of payments, have averaged 116% of fee for service cost (are old law and have resulted in payments to Medicare Advantage plans well above the cost of covering fee for service beneficiaries).
 - Under the new law the benchmarks will be no higher than 115% of fee for service cost after a six-year phase-in period. Benchmarks will be set as high as 115% of fee for service cost for counties with low fee for service costs and as low as 95% of fee for service cost for counties with high fee for service costs. [Benchmarks are the maximum Medicare will pay a plan to provide Medicare covered services. Plans that “bid” (contract with Medicare) to provide services at less than the benchmark receive the bid amount plus “rebates” (additional payments) equal to 75% of the difference between the benchmark and the bid. The average benchmark rate for Oregon plans has been well-above the new 115% cap, so Medicare Advantage payments will be reduced under the new law.]
 - Minimum loss ratios for Medicare Advantage plans.
 - Beginning in 2014, Medicare Advantage plans must have a minimum loss ratio of 85%.
- **Creates an Independent Payment Advisory Board to develop a Medicare savings plan.**
 - Beginning in 2014, a new Independent Payment Advisory Board will provide Congress savings plans if Medicare spending exceeds targets. The plans will go into effect if not overridden by Congress.
 - Reductions cannot be achieved by “rationing care,” increasing beneficiary premiums or cost-sharing, or (until 2019) reducing payments for most hospitals.
- **Increases Medicaid payments for primary care while decreasing payments for disproportionate share hospitals (DSH)**
 - Increases payments for primary care in Medicaid.
 - During calendar years 2013 and 2014, primary care physicians must be paid 100% of Medicare rates for evaluation and management and immunization services. The incremental costs for increasing the reimbursement rate over what it was in July 2009 will be 100% federally funded.
 - Reduces Medicaid disproportionate share hospital payments beginning FY 2014.

- Creates opportunities for **testing payment reform strategies:**
 - National Medicare pilot on payment bundling addressing chronic and acute conditions involving select provider.
 - National Medicaid demonstration beginning January 1, 2012 in eight states for episode payment.
 - National two-year Medicaid demonstration beginning October 1, 2011 in five states for global capitated payments to safety net hospitals or networks.
 - National shared savings pilots 2012-2016:
 - Medicare – accountable care organizations taking responsibility to care for 5,000 or more fee for service enrollees and measure quality receive shared savings achieved over a benchmark savings amount set by CMS over average fee for service costs (ACO is applicant).
 - Medicaid – accountable care organizations taking responsibility to care for children receive incentive payments if they exceed minimum savings levels established by CMS and the applicant state

Of Note –

- Center for Medicare and Medicaid Innovation funding for payment innovation.

Key Quality Standards and Measures for Incentives and Outcomes Committee

Where Does Federal Reform Get Us?

- Directs HHS to undertake **quality activities that may align with committee activities**.
 - HHS is directed to develop a National Quality Strategy to improve care delivery, patient health outcomes, and population health. An initial strategy must be submitted by January 2011 with annual updates thereafter. As part of this effort, HHS will:
 - Assemble an interagency working group on Health Care Quality to help federal agencies coordinate and collaborate on the national strategy aims. Avoiding duplication of effort and streamlining processes for quality reporting and compliance are among the goals of the working group.
 - Establish a federal health care quality website no later than January 2011.
 - In support of the national quality strategy, HHS must publish initial national quality measures by December 2011 and is authorized to receive up to \$75M over 5 years for quality measure development, improvement, updates or expansions. Measurement priorities include:
 - health outcomes and functional status of patients;
 - the management and coordination across episodes of care and care transitions
 - the efficiency of care;
 - experience, quality, and use of information to inform decision making about treatment options,
 - the meaningful use of health information technology;
 - the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;
 - the equity of health services and health disparities across populations and geographic areas;
 - patient experience and satisfaction.
 - CMS is directed to develop adult quality measures for Medicaid, similar to the child health quality measures recently published for children's health insurance (CHIPRA). (Sec. 2701). A recommended set of measures must go out for comment by January 2011 and must be finalized in 2012. State reporting on the measures begins after that point but the effective date is not clear; the Secretary has a deadline of September 2014 to "collect, analyze, and make [the data] publicly available."
 - Grants to refine and test the measures (likely very similar to the CHIPRA grant that Oregon was recently awarded) should be announced by Jan 2012 and must be funded at the same level as the CHIPRA grants.
 - An eight-member "Commission on Key National Indicators" is to be established by the National Academy of Sciences within 30 days of the law's enactment. It is not

known to what extent health (care) quality measures would be part of the national indicators; the law just instructs the Academy to identify issue areas and measures.

- By 2014, HHS must make plans for quality measurement and, ultimately, value-based purchasing in long-term care hospitals, ambulatory surgery centers, inpatient rehabilitation and inpatient psychiatric facilities, cancer hospitals, and hospices.
- Creates new approaches for **quality reporting**
 - HHS will begin a Medicare hospital quality reporting and value-based purchasing program in FY2013. Measures used must address heart attacks, heart failure, pneumonia, surgeries, and hospital-acquired infections and, starting in FY2014, efficiency measures such as adjusted Medicare spending per beneficiary.
 - The program will include demonstrations in critical access hospitals and hospitals too small to participate in the general program.
 - On the physician side, the law starts to move Medicare from pay-for-reporting to value-based purchasing:
 - Extends incentives for reporting through 2014 and begins to penalize non-participation starting in 2015.
 - 0.5% additional Medicare bonus to physicians who report via a qualified Maintenance of Certification Program 2011-14.
 - Provides physicians with feedback on their resource use, as compared to peers, beginning in 2012.
 - HHS must develop a “Physician Compare” website (like the current Hospital Compare) by January 1, 2011 for consumers to compare Medicare physician quality and patient satisfaction, using data reported as part of the Physician Quality Reporting Initiative.
 - Within 2 years of the law’s enactment, private sector health plans and insurers will be required to report to the Secretary on how their benefit designs and/or payment structures: improve health outcomes (via strategies such as quality reporting, care coordination, medical homes, etc.); reduce hospital readmissions; increase patient safety; and support wellness and health promotion.
 - Within two years of enactment, all federally-supported programs must, to the extent practicable, collect and report data on race, language, ethnicity, and disability status as well as rural or under-served populations. The Secretary will establish uniform standards for the data.

Of Note –

- Establishes a **Patient-Centered Outcomes Research Institute** in 2010 to identify priorities for and support comparative effectiveness research.
 - The Institute's findings may not be construed as mandates for practice guidelines or coverage decisions.

- Establishes a **Center for Medicare and Medicaid Innovation** by January 1, 2011, to test care delivery and payment models that reduce the cost of care while maintaining or enhancing quality.
 - The Center is funded at \$5M for 2010 and at \$10B for 2011 – 2019.

Key Provisions for Medical Liability Task Force

Where Does Federal Reform Get Us?

- **Provides Funding for States Test Tort Alternatives** (HB 3590, sec. 10607) – Authorizes the Secretary of Health and Human Services (HHS) to award five-year demonstration grants to states to develop, implement and evaluate alternatives to civil tort litigation. Models are required to emphasize patient safety, disclosure of health care errors, and early resolution of disputes. \$50 million in funds appropriated beginning in 2011; first report to Congress required by December 31, 2016.

Alternatives should:

- Make the medical liability system more reliable by increasing the availability of prompt, fair and efficient resolution of disputes.
 - Encourage the disclosure of health care errors.
 - Enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events.
 - Improve access to liability insurance.
 - Fully inform patients about the differences in the alternative and current tort litigation.
 - Provide patients the ability opt out of the alternative to tort litigation.
 - Not conflict with state law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation.
 - Not limit a patient's existing legal rights to file a malpractice claim.
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- **Extends Medical Liability Coverage to Free Clinics** (HB 3590, sec. 10608) – Extends medical liability protections for free clinics under the Federal Tort Claims Act to clinic officers, governing board members, employees and contractors. [Effective date of enactment].

Key Elements of Interest to the Public Employer Purchasers Committee

Where Does Federal Reform Get Us?

- Defines **essential benefit package** for use in health insurance Exchange and as basis for coverage satisfying the individual mandate:
 - All plans must include essential benefit package (Jan. 2014).
 - The package must cover these general categories of care:
 - Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; prevention and wellness services and chronic disease management; and pediatric services, including oral and vision care.
 - The scope of the essential benefit package should be equal to that of a typical employer-based plan, as determined by a survey by Department of Labor.
- Outlines areas of **federal insurance regulations or requirements**:
 - Guarantee issue and renewability (Jan. 2014).
 - Rate bands — allows variation based on age 3:1, rating area, family composition, tobacco use 1.5:1 (for non-grandfathered plans, Jan. 2014).
 - Pre-existing condition exclusions prohibited for children 6 months from enactment and for adults by 2014.
 - Eliminates waiting periods of more than 90 days for group coverage (Jan. 2014).
 - Prohibits lifetime limits, allows certain annual limits until 2014.
 - Dependent coverage up through age 26 for all plans 6 months from enactment.
 - Coverage of preventative services with no cost-sharing (for plan years beginning after Sept. 2010).
 - Coverage for individuals participating in approved clinical trials for cancer or a life-threatening disease or condition (Jan. 2014).
- Defines **employer responsibilities** in Oregon:
 - Waiting periods for coverage may not exceed 90 days (Jan. 2014).
 - Non-offering employers with 50+ full-time equivalent employees pay an assessment if one or more full-time employees receives a premium tax credit. (Fee is \$2,000 per full-time employee, excluding the first 30 employees.) Offering employers pay \$3,000 per subsidized full-time employee per year. (Jan. 2014)
 - Employers with fewer than 50 full-time equivalent employees exempt from assessment.
 - Employer must provide a “free choice voucher” equal to the employer’s contribution to an employer-sponsored plan to employees below 400% FPL whose premiums for

- the employer's plan are between 8-9.5% of income. Voucher allows employee to purchase non-subsidized coverage in the Exchange using employer dollars.
- Employers with 200+ full-time employees must automatically enroll full-time employees in coverage offered by the employer. Employees may opt out of coverage.
 - Excise tax on high-cost insurance plans of 40% of excess over a cap. Applies to self-insured plans and plans sold in group market (Jan. 2018).
 - All plans to pay an assessment for transitional reinsurance program (beginning in 2014 for 3 years.)
- Outlines **specific roles and duties of an Exchange** within the marketplace in Oregon:
 - Small employers with fewer than 100 employees are eligible; larger plans in 2017.
 - HHS defines the benefits package that must be offered in Exchange plans, with package be similar in scope to employer-based plans.
 - HHS establishes additional criteria for qualified health plans that may be sold in the Exchange, sets open enrollment periods, reviews insurance rate increases.
 - Plans offered in the Exchange pay for a standardized percentage of the actuarial value of covered services (bronze to platinum).
 - Federal tax credits and cost-sharing reduction payments are available only in the Exchange.
 - Establishes a federal **temporary reinsurance program for early retirees** – Plans may apply to participate, and can be reimbursed for 80% of costs in excess of \$15,000 and below \$90,000. [Within 90 days of enactment.]
 - Creates federal framework for **administrative simplification**:
 - Establishes deadlines for HHS to issue new and revised HIPAA standards for electronic transactions to eliminate variation. Compliance deadlines phased in from Jan. 2013 to Jan. 2016.
 - Requires Medicare providers to accept electronic remittance advice and funds transfer by Jan. 2014.
 - Directs HHS to develop **national quality improvement strategy**.
 - Creates a **Patient-Centered Outcomes Research Institute** at CMS.
 - Directs CDC to provide technical assistance to **worksite wellness programs** and periodic evaluation survey.

What We Don't Know

- We don't know exactly what impact the various insurance reform regulations will have on premiums, both short- and long-term.
- May be difficult to do actuarial and cost analyses until CMS provides guidance on what types of benefits are included in the essential benefit package.
- The early retiree reinsurance program will have varying degrees of impact on employers, but public employers could potentially realize significant savings.
- It will be interesting to see the reaction and response of large employers to the Exchange, since the Exchange is the only way for employees to use tax credits or cost-sharing reduction assistance.
- The administrative complexity of the insurance changes, tax credits, cost-sharing reduction assistance, and other reform implications may overwhelm employers (especially small employers) and undermine compliance.

Key Provisions for Safety Net Advisory Council

Where Does Federal Reform Get Us?

- **Expands access to coverage:**
 - Medicaid to cover all nonelderly individuals with incomes up to 133% FPL, beginning in 2014.
 - CHIP reauthorized through September 2015.

High/Direct Impact on safety net.

- **Increases funding:**
 - Mandatory Federally Qualified Health Centers (FQHC) funding increased by \$11 billion over five years (through 2015);
 - Establishes Community Health Center and National Health Service Fund to sustain national investment.

High/Direct impact on safety net, impact on state access strategies.

- Establishes a **Prevention and Public Health Fund.**
 - Appropriates \$7 billion for 2010-2015 and after for Prevention and Public Health Fund, which can be used to fund mandatory public health activities authorized by the Public Health Service Act as well as new grants and programs created by the law (e.g. Community Transformation grants).

Intermediate impact/depends on how state public health and OHA approach opportunity.

- **Authorizes School-based Health Center (SBHC) Program.**
 - Provides a federal definition.
 - Allocates \$50 million between FY 2010-2013 emergency funding for SBHC construction and the purchase of equipment. No funds allocated for operating expenses. Not a lot of money when distributed nationally.

Intermediate impact on SBHC network in Oregon.

- Provides **access to comprehensive health care services to the uninsured** at reduced fees through a demonstration project.
 - HRSA grants in up to 10 states, total funds up to \$20 million. Requires state-based public private partnership.
 - Limited impact when funds are distributed over 10 states, however Oregon could be competitive.

- Establishes a process of “**negotiated rulemaking**” between HHS and stakeholders.
 - Determines new criteria and methodology for defining Health Professional Shortage Areas (HSPA) and Medically Underserved Area (MUA) measurements.

May have Direct/High impact on designations and thus programs eligible for services. Important to track.
- Requires basic exchange plans to contract with “**essential community providers**” such as eligible 340 B entities.
 - Many plans are already contracting with these providers; however may reinforce this trend and broaden it to include more MHO’s and DCO’s

Intermediate to mild impact.
- Establishes **multiple demonstration projects and pilots:**
 - Medicaid and Medicare demonstration projects.
 - Medical Home and Payment Reform pilots.

Intermediate to high impact depending on federal and state approaches.

 - Health Care Workforce pilots.

Limited impact unless there is a highly coordinated and effective approach to optimize the number of pilot demonstrations. Somewhat limited in its impact on the safety net.
- Increases funding for the **National Health Service Corp:**
 - \$320 million in 2010 building to \$1.5 billion in 2010.
 - Increases annual maximum loan repayment.

Intermediate/High impact on safety net – some relief to state and community budgets.

Of Note –

- Establishes **Office of Minority Health** including individual offices within seven HHS agencies. *Limited impact that could build over time depending on effectiveness.*
- Requires **health disparities data collection and analysis:**
 - For federally conducted or supported programs.
 - Required within two years of enactment.

Limited impact initially but will improve data collection over time.
- Targets at-risk communities with **Maternal, Infant and Early Home Visiting Programs.**
 - Grant program optional – Title V programs eligible entities but if states do not apply, can be opened up to NGO’s (non governmental organizations).
- Improves communications by requiring “plain language” to be used.
 - Plans in the state exchanges must submit information in “plain language” including language that can be readily understood by individuals with limited English proficiency.

Intermediate/High impact on safety net population over time.

Key Provisions for Medicaid Advisory Committee

Where Does Federal Reform Get Us?

- **Expands access to coverage:**
 - Medicaid to cover all nonelderly individuals with incomes up to 133% FPL, beginning in 2014.
 - Requires income to be determined using Modified Adjusted Gross Income with a few population exceptions.
 - Option to cover all nonelderly individuals with incomes up to 133% FPL at current FMAP, beginning 2010.
 - Medicaid to cover all former foster care children up to age 26, beginning in 2014.
 - CHIP continued through at least 2019; funding reauthorized through September 2015.
 - Option to enroll children of state employees into CHIP if the employee's premium and cost-sharing contributions exceed 5% of the family's income.
- **Requires maintenance of effort:**
 - States required to maintain existing Medicaid eligibility levels for adults until 2014.
 - States required to maintain existing Medicaid and CHIP eligibility levels and enrollment procedures for children through 2019.
 - Option to provide tax credits through state Health Insurance Exchange to CHIP-eligible children unable to enroll in CHIP program due to enrollment cap.
- **Increases federal financial assistance:**
 - The federal government will pay 100% of the cost of covering newly eligible adults in "expansion states" for CY 2014 - 2016. The rate decreases gradually to 90% by CY 2020.
 - Oregon's current match rate, including the American Recovery and Reinvestment Act (ARRA) extension, is 72.6%. Prior to the ARRA enhancement, the match rate was 62.5%.
 - Oregon will likely be categorized as an expansion state as defined in the federal legislation. Further guidance from the federal Department of Health and Human Services is required to clarify this definition.
 - States will receive a 23% point increase in the CHIP match rate up to a cap of 100%, beginning FY 2015.
 - Oregon's current CHIP match rate is 73.7%.
- **Defines required benefits:**
 - Newly eligible individuals must be provided a benchmark benefit package that provides the essential health benefits as defined by HHS.
 - Free-standing birth centers become eligible for Medicaid reimbursement.

- States must offer premium assistance wrap-around benefits to Medicaid clients who are offered employer sponsored insurance (ESI) only if premium subsidies are cost-effective, beginning 2014.
 - Prohibits State from requiring that individual or parent apply for enrollment in qualified ESI.
- **Defines new reimbursement and allotment provisions:**
 - Increases Medicaid drug rebate percentages and extends rebates to Medicaid managed care plans.
 - Decreases disproportionate share hospital (DSH) allotments gradually beginning FFY 2014 based on a State's uninsurance rate and DSH designation.
 - States, such as Oregon, designated as low-DSH states will have smaller initial reductions imposed.
 - Prohibits federal payments to states for services related to health care acquired conditions.
 - Increases payment for Medicaid primary care services to 100% of Medicare payment rates for 2013 and 2014 with 100% federal financing.
 - Revises payments to institutions of mental disease for adult emergency stabilization.
- **Creates options for delivery system reform:**
 - Allows Medicaid enrollees with or at risk of developing multiple chronic conditions to designate provider as a health home. State receives 90% match rate for all services provided to individual through health home.
 - Creates opportunity for episode of care bundled payment projects.
 - Creates opportunity for safety net hospital system global capitated payment projects.
 - Creates opportunity for pediatric accountable care organization projects.

What Doesn't It Do? What We Don't Know –

- May not solve affordability issue if premium subsidies offered through health insurance exchange are not sufficient for individuals above 133% FPL.
- It is unclear how the benefits provided using the prioritized list aligns with the benchmark benefit package.
- It is not yet definitive whether Oregon will be defined as an expansion state and receive the higher federal match increase.
- We do not know what Oregon's reduction in DSH payment will be.

Key Health Insurance Exchanges Provisions

Where Does Federal Reform Get Us?

- Identifies **specific exchange functions**:
 - Certify plans:
 - Implement procedures for certification, recertification, and decertification (consistent with HHS guidelines).
 - Offer coverage:
 - Make qualified health plans available to eligible individuals and employers
 - Customer assistance:
 - Have a toll-free telephone hotline to respond to requests for assistance.
 - Maintain a website through which enrollees, prospective enrollees can get standardized comparative plan information
 - Grade health plans (in accordance with criteria to be developed by HHS):
 - Use a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage.
 - Maintain a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information.
 - Provide information to individuals, employers:
 - For anyone the exchange determines is eligible for a program, provide information regarding eligibility requirements for Medicaid, CHIP and any applicable State/local public program.
 - Provide electronic calculator to determine actual cost of coverage after application of any premium tax credit/cost sharing reduction.
 - Publish: the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse.
 - Give each employer the name of each employee who stops coverage under a qualified health plan during a plan year.
 - Administer exemptions:
 - Grant exemption certificates to individual responsibility penalty when: (1) no affordable qualified health plan is available through the exchange; or (2) the individual meets the requirements for another exemption from the requirement or penalty.
 - Provide information to federal government:
 - Give the Secretary of the Treasury the name/tax ID of each person: (1) issued an exemption certificate; (2) who was an employee and deemed eligible for

the premium tax credit because the employer did not provide minimum essential coverage or provided coverage unaffordable to the employee/didn't meet minimum actuarial value; or (3) who tells the exchange they changed employers and stopped coverage during a plan year.

- Facilitate community based assistance:
 - Establish a Navigator program.
- Directs HHS to **promulgate regulations** regarding –
 - Certification of qualified health plans.
 - A rating system to rate plans offered through the exchange (on the basis of relative quality and price, for use by individuals and employers).
 - An enrollee satisfaction survey.

Areas of State Flexibility –

- An exchange may operate in **more than one state** (requires HHS approval).
- A state may operate **one or more subsidiary exchanges**.
- A state may **contract with an eligible entity** to carry out some exchange functions. The eligible entity. An “eligible entity” is either the State Medicaid agency or an entity with experience in the individual and small group health insurance markets and in benefits coverage and that is not a health insurance issuer (or treated by the IRS as one).
- The state can **implement payment structures** that provide incentives for improving health outcomes.
- The exchange may be run by the state **government or a non-profit entity**.
- The structure of the exchange, including but not limited to its **governance**.
- The state can require that health plans sold through the exchange have **additional benefits** beyond the federal minimum, but it must defray the cost of any additional benefits.

What Doesn't It Do?

- It doesn't mandate changes to the way we pay for care or otherwise specify changes to the delivery system (though it does promote incentives for quality, etc....)
- It doesn't eliminate the possibility that insurance coverage will still be unaffordable (especially, but not only, those who work for employers offering coverage.)

Of Note –

- HHS will provide **start up grants** to states to implement exchanges.
- An exchange must have **annual open enrollment period**, special enrollment periods and monthly enrollment periods for Native Americans.
- Exchange must be **self-sustaining** by 1/1/15 by means including the use of user fees or assessments to support operations.
- Exchange must **consult with stakeholders**, including qualified health plan enrollees, individuals or organizations that help people enroll in plans, small business and self-employed representatives, state Medicaid, and advocates for enrolling hard-to-reach populations.

Key Elements for Public and Population Health – the Health Improvement Plan Committee

Highlights

- Creates a National Prevention, Health Promotion, and Public Health Council, charged with creating a national health improvement strategy.
- Appropriates \$7B for 2010-2015 and after for a Prevention and Public Health Fund, which can be used to fund mandatory public health activities authorized by the Public Health Service Act as well as new grants and programs created by the law.
- Provides Federally Qualified Health Centers (FQHCs) with \$11 billion over five years (through 2015); establishes Community Health Center and National Health Service Fund to sustain national investment.
- Authorizes many grant opportunities for community-based prevention and health promotion activities.

Where Does Federal Reform Get Us from the perspective of the Health Impact Pyramid?¹

The public health provisions of the law **do not address socioeconomic factors/social determinants of health** (the first/bottom level of the Freidan Health Impact Pyramid).

The law contains some **provisions for changing the context to make individuals' default decisions healthy** (level 2) and for **long-lasting preventive interventions** (pyramid level 3); population impact is greater at these levels:

- Menu labeling is required at chains with 20+ locations and for vending machines. The federal law preempts most provisions of existing Oregon law.
- Community Transformation Grants available through CDC for policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce health disparities. Open to state and local governments, national CBO networks and tribes; “sums as necessary” authorized for 2010-14.
- Requires employers with more than 50 employees to provide reasonable break time and a private location (other than a bathroom) for nursing mothers to pump until their children are 1 year of age.
- 5-year grants to small businesses to establish comprehensive worksite wellness programs; CDC to provide employers with technical assistance for evaluation of worksite wellness programs and conduct a national worksite health policies and programs survey.
- Grants for maternal and child health home visiting programs FY 2010-14. States, tribes or (if state does not apply) non-profits entities eligible.
- Grants for states to improve vaccine coverage among children, adolescents, and adults.

¹ Frieden TR. A framework for public health action: The health impact pyramid. *AJPH*. 2010;100(4): 590-595.

The majority of the **policy provisions and funding opportunities in federal reform address the top two levels of Frieden’s Health Impact Pyramid** (clinical interventions and counseling & education), where population impact is less and the level of individual effort required is greater, e.g.:

- Prohibits cost-sharing for preventive services in plans offered through new Exchanges; same for evidence-based preventive services, adult vaccines, and individualized wellness planning followed by annual wellness visits under Medicare. Also incentives for states to offer evidence-based preventive services without cost-sharing under Medicaid, which Oregon already does to a large extent.
- “Healthy Aging Living Well” 5-year pilot through CDC for prevention services to pre-Medicare population (55 – 64). \$50 million available to state and local health departments and, tribes.
- Allows private insurance plans and insurers to offer incentives representing up to 30% of the cost of coverage for participation and achievement in wellness programs
- Pilot projects in 10 community health centers to develop individualized wellness plans with patients.
- 3-year demonstration to provide access to comprehensive health care services to the uninsured at reduced fees. Up to 10 states, total funds up to \$20 million. Requires state-based public private partnership.
- Grants to use community health workers to support positive health behaviors and outcomes for populations in medically underserved communities.
- Appropriates \$50M/y for 2010-2013 for grants to open and operate school-based health centers.

What Does Federal Reform Do for Public Health Infrastructure?

The law contains a few provisions that could be used to **strengthen public health infrastructure**, including:

- Competitive grants to state and local health departments and tribal jurisdictions to increase epidemiologic and laboratory capacity in order to track and control communicable disease. \$190 million/year is authorized for FY 2010-2013.
- Potential grant funding through HHS for public health systems and services research; details are not provided.
- Several investments in public health workforce training, including:
 - Loan repayment for public health professionals starting FY 2010
 - Scholarships for mid-career public and allied health professionals FY 2010-15
 - Elimination of the current 2,800-person cap on the Public Health Service Commissioned Corps

- Fellowship training in public health (e.g. Epidemiologic Intelligence Service or similar) to address documented workforce shortages FY 2010-13
- Establishment of a U.S. Public Health Sciences Track (tuition support in return for services in the Commissioned Corps) to train 800 health professionals annually, beginning FY 2010.

What Doesn't It Do?

- The law **does not make fundamental transformations to the relationship between public health and healthcare** or reinvent the U.S. healthcare system. . However, it does provide funding opportunities for states and communities to innovate or experiment around integration and transformation; see previous notes.
- As noted earlier, the law has no provisions to address socioeconomic determinants of health (the bottom level of the Freidan pyramid, where health impact is the greatest) and a relatively small number of provisions for broad contextual or environmental changes in support of population health (level 2) or long-lasting preventive interventions (level 3).
- The law has **limited provisions beyond chronic disease prevention**. However, this focus aligns with the charge to Oregon's Statewide Health Improvement Plan Committee as stated in HB2009. Provisions on other public health topics include: a national campaign on oral healthcare and grants for caries disease management activities; competitive grants for National Centers of Excellence for Depression; research and support services for post-partum depression & psychosis; funding for comprehensive sexuality education *and* abstinence-only education, and others.